Maryellen Dabal
MA LMFT

INFORMED CONSENT FOR COUNSELING

I, _____, have fully discussed with Maryellen Dabal, MA, LMFT the various aspects of the counseling contract. This has included a discussion of the method and nature of treatment, including its extent, its possible side effects and possible alternative forms of treatment.

Maryellen Dabal, MA, LMFT has further discussed with me scheduling and office procedures, the limitations of emergency availability, the nature of the fee, and the most common exceptions to confidentiality.

I have read the above and the website explanations titled **Welcome Letter/Confidentiality/Informed Consent/ Office Policies.** I have also read the **Notice of Privacy Practices** link on the website. I fully understand the contents of the forms, including the nature of treatment, the alternatives to this treatment, the limits of confidentiality in this relationship, and the circumstances in which confidential communications may need to be breached.

_____ I understand that should there be a need for a session over the phone or communication through email/text that these are not secure means of communication and I assume the risks associated with such communication.

_____ I understand that I may be charged a fee for excessive email communication, texts or requests for statements or written reports of any kind.

_____ I understand that if I am participating in couple's or family therapy, Maryellen Dabal, MA, LMFT will not keep secrets between parties and information shared in any individual sessions is discussable in couple or family sessions as well.

_____ I understand that Maryellen Dabal, MA, LMFT does not appear in court for any reason and I agree not to ask her to do so.

_____ I am using my insurance and I agree to pay a co-pay of $ _____ at the time of each visit.

_____ I am using my insurance and I agree to pay the full fee of $_____ for any NO SHOW appointments as my insurance will not cover them.

_____ I confirm that _____ is my primary insurance company and that Maryellen Dabal, MA, LMFT will bill only this insurance company on my behalf and I am responsible for the balance they do not pay within 30 days of a request to do so.

A copy of this form is valid as the original. I certify that I am an adult over sixteen years of age, I am a resident of Texas and consent to the above conditions for therapy.

_____

Date Signature

Maryellen Dabal, MA, LMFT
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