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Licensed Psychologist, #3085

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INFORMED CONSENT

The following information is provided to acquaint you with the policies and procedures of my practice and to better assist you in your efforts towards personal growth.

I. Your Rights as a Client

_____
(INITIALS)

1. You have the right to ask questions about any procedures used during therapy.
2. You have the right to decide at any time to not receive therapy from Dr. Eric Herschman. If you wish, he will provide you with the names of other qualified professionals who service you might prefer.
3. You have the right to end therapy at any time without any moral, legal or financial obligations other than those already accrued.

II. Confidentiality

_____
(INITIALS)

1. Within certain limits, information revealed by you during therapy will be kept strictly confidential and will not be revealed to any other person or agency without your permission.
2. If clients enter into family therapy or couples therapy (relational therapy), confidentiality will be kept within the family. The relationship unit is considered the client. Dr. Herschman is unable to keep secrets that may be harmful to the relationship. If someone wants him to keep a secret that can be harmful, treatment may be terminated. If someone needs to work through something prior to sharing the information, he will help the client move to a place where this can be shared. If the person cannot share the information, termination may be necessary and a referral may be provided. During the course of our work together, a smaller portion of the relational unit may be seen for one or more sessions. These sessions should be seen as part of the work we are doing together. If you as an individual are involved in any such sessions, please understand that any information that is disclosed in these sessions may need to be shared with the entire relational unit.
3. There are certain situations where Dr. Herschman is required by law to reveal information obtained during therapy to other persons or agencies without your permission. These situations include:

a. If you threaten bodily harm or death to another person, Dr. Herschman is required by law to inform the intended victim and appropriate law enforcement agencies.
b. If you threaten bodily harm or death to yourself, Dr. Herschman will inform the appropriate law enforcement agencies and others (such as spouse, friend or an inpatient psychiatric institution) who can aid in prohibiting you from carrying out your threats.
c. If you reveal information related to the abuse or neglect of a child, dependent adult or elderly person, Dr. Herschman is required by law to report this to the appropriate authorities.

4. I understand that no promises have been made to me as to the results of treatment or of any procedures provided by this therapist.

_____ (INITIALS) III. **If you are the guardian of a minor or are a minor, please read the following:**

By signing below, I give my consent for Dr. Herschman to conduct therapy sessions with the minor listed below. I have also been informed of the limitations of confidentiality in terms of the treatment of the minor. I understand that special care and sensitivity may be required in releasing information to me about certain topics such as substance use and sexual activity. I accept Dr. Herschman's judgment in regards to releasing information related to treatment of this minor. In addition, I understand that at any time if Dr. Herschman believes this minor is in danger of hurting him or herself, I will be notified immediately.

_____ IV. Therapy Services and Fees

1. Fees are based on the amount of scheduled time with the therapist. Individual and couple/family sessions are typically 45 minutes. If sessions go beyond the scheduled time, I agree to pay the amount listed below.

Initial Consultation	$350
45 minute session	$300

2. Payment in full is due at the time of the visit and balances cannot be carried over to the next session, unless other arrangements are made with Dr. Herschman.
3. Receipts will be provided after every session and can be submitted to insurance companies for reimbursement.
4. 24-hour notice is required for cancellation of a scheduled session. If I do not meet this requirement. I agree to pay the full session fee. I understand that this is solely my responsibility and I will not be able to submit this fee to my insurance company for reimbursement.

5. I understand the therapist has the right to seek legal recourse to recoup any unpaid balance. In pursuing these measures, the therapist will only disclose biographical information and the amount owed in order to ensure confidentiality.
6. Dr. Herschman can be reached at 973-983-8521 at any time to leave a message. Messages will be checked daily and returned as soon as possible. If you are in need of immediate care please dial 911 or go to your local emergency room.
7. If information is to be released to a third party each member who participated in treatment will be required to consent to and sign a release of information.
8. Clients participating in couples/marriage therapy agree they will not seek to subpoena material for litigation against each other at any time.

Client/address:
_____
(*Please include your full mailing address*)

Available numbers where you can be reached:_____

Email address:_____

Print Name: _____ Signature:_____

Date:_____

Therapist Signature:_____ Date:_____