Lisa Knudson Psychotherapy
30 Cumberland Ave. Ste 104
Asheville, NC 28801

ADOLESCENT PSYCHOTHERAPY AGREEMENT and INFORMED CONSENT

The Therapeutic Relationship:

Psychotherapy is a process designed to help your adolescent address their concerns, come to a greater understanding of themself, and learn effective personal and interpersonal coping strategies. It involves a relationship between your adolescent and the therapist; a relationship within which therapy can take place and the individual's goals can be achieved. The duration of therapy is dependent on a number of factors including your adolescent's goals, time-frame, rate of progress, etc. It should be noted that psychotherapy resulting in lasting change is often a long-term process, lasting several months or longer. Please discuss any issues/concerns you have with your adolescent's therapist so that an appropriate treatment plan can be formulated which will best suit their needs/desires. The relationship between therapist and client is the container through which client change can take place. As such, it is often one in which close emotional bonds develop. It is also a professional relationship, in which appropriate boundaries must be maintained. For the most part, the therapeutic relationship begins and ends at the therapy office which is a necessary requirement for maintenance of the therapeutic environment.

Payment Procedure: Individual Therapy fees are $140. Sessions are 50 minutes in length. The Initial Intake fees is $195 and is 70 minutes. Family sessions are $150 and 50 minutes in length. Parent phone sessions are $55 for 20 minutes.

There are 3 ways the fees can be arranged:

1. The client pays the therapist cash at the time of appt.
2. The client pays the therapist in advance by check.
3. The client pays the therapist in advance by credit card. I accept all major credit cards including HSA cards. I use a HIPPA compliant app called IVY PAY that will store your credit card securely.

The first therapy session will begin after this agreement is signed. E-mail backup is available between sessions in case of emergencies or if changes are needed to be made with an appt. day/time.

Feedback: If, at any time, you feel that your adolescent's needs are not being met or you believe they are not getting what they want out of therapy, please tell their Therapist, so they can discuss their needs and adjust their treatment plan, as needed. We will continue to work on the goals that your adolescent defines unless they want to discontinue the therapy relationship.

After hours/Emergencies: If you are unable to reach me during regular business hours and are in an emergency, please contact the MOBILE CRISIS EMERGENCY NUMBER: 888-573-1006

Session Time: Therapy sessions are scheduled at the mutual convenience of the Therapist and the Client. At the close of each therapy session we will schedule the day and time for our next appt. The Client will attend his/her sessions at the prearranged time and location as scheduled.

Cancellations/Missed appts: You must give 24 hours prior notice if your adolescent needs to cancel or change the time of an appointment, otherwise you will be charged the full fee. Missed sessions will be charged due to the time being specifically reserved for you. A 10% additional fee charge will be added each week that the missed appointment fee isn't paid. This Therapist will make reasonable efforts to reschedule sessions that are cancelled in a timely manner.

Termination: Either party may end the therapeutic relationship by providing the other party with a one week written or verbal notice, which may be transmitted by email or in person.

Confidentiality: I will protect the confidentiality of the communications with my therapy Clients and will only release information about our work to others with your permission, or if I am required to do so by law or court order. If such a situation occurs in my relationship with your adolescent, I will make every effort to discuss it with him/her before taking any action. Limits of Confidentiality include circumstances where there is a danger to self or others. This includes, but is not limited to suicidal behavior, domestic violence, child abuse, animal abuse and elder abuse.

If your adolescent becomes involved in legal proceedings that require my participation, you will be expected to pay for all of my professional time, including preparation and transportation costs, even if I am called to testify by another party. Because of the difficulty of legal involvement, I charge 3 times my usual fee for one hour of counseling per hour of preparation and attendance at any legal proceeding. In addition, I charge at my clinical rate for any travel time that may be involved. Those fees are never reimbursable by insurance companies.

Mutual Nondisclosure: The Therapist and Client mutually recognize that they may discuss future plans, business affairs, financial information, job information, goals, personal information, and other private information. The Therapist will not voluntarily communicate the Client's information to a third party. In order to honor and protect the Therapist's intellectual property, the Client likewise agrees not to disclose or communicate information about the Therapist's practice, materials, or methods to any third parties.

Your signature below indicates that you have read the information in this document and you and your adolescent agree to abide by its terms during our professional therapeutic relationship.

Client__________________________________ Date ____________

Parent _________________________________ Date____________

Therapist________________________________ Date ____________

Lisa Knudson, LCSW
NC License # C011370
Lisaknudson65@gmail.com
www.lisaknudson65@gmail.com
512-507-4005