**Reshma Stafford, PsyD**

20 Nassau Street, Suite 511, Princeton, Nj 08554

732.440.8011

reshma@drreshmastaffford.com

**INFORMED CONSENT TO TREATMENT**

I provide psychotherapy to children, adolescents, adults, and families. Please take the next few minutes to read about my policies and sign the informed consent agreement. If you have any questions, please ask.

**PRIVACY OF INFORMATION**: It is my policy to maintain your information confidentially. I will **NOT** release any information regarding your use of my services, or any personal matters discussed within therapy without your written consent, **except in the following situations:**

• If you request and authorize me to release records or any other information to an individual/agency of your choice. This may be done only with your expressed written consent.

• In the event that there is **clear and imminent danger** to you or another person, I am required by law to report pertinent information to the appropriate authorities and to the person in danger.

• If you (or your child) report or I witness any action of abuse to a child under the age of 18, I am required by law to report such action to the appropriate authorities.

• In the event that records are required to be released per a court order.

• If you give me information that leads me to believe that a licensed healthcare professional is impaired, I may be required to report this.

• If you are using a health insurance company to pay for part or all of your bill, they will require at least a diagnosis, and they can also demand a review of the chart.

**TERMINATION:** Please inform me if you are planning to discontinue treatment for whatever reason. The final session is an important part of the helping process and should be discussed in advance, just as any other mutually agreed upon decision.

**RISKS and BENEFITS:** Psychotherapy has been demonstrated to help many individuals. This is particularly true when you want to address your concerns and follow through with assignments and other activities that you and your therapist agree would be helpful. The primary risk of treatment is that the process may involve discussing problems or life events that may evoke unpleasant feelings. If this occurs, it is important to let me know so that I can help you deal effectively with those concerns.

**APPOINTMENTS:** If you need to reschedule an appointment, please notify me as soon as possible. If you do not cancel your session 24 hours in advance, you will be charged for the missed session.

**FEES:** My current rates are as follows:

• Psychotherapy and Psychological Assessment (45 to 50 minute session): $175

• Hourly services, such as report writing or third party consultations: $175

**METHODS OF COMMUNICATION:** You may contact me by telephone at **732.440.8011** or by email at **reshma@drreshmastafford.com**. Communication via e-mail is associated with a somewhat greater risk to confidentiality than is communication by telephone. Because of these risks, I do not discuss clinical matters by email or text.

I am often not immediately available by telephone or email. If you leave me a message or send me an email, I will make every effort to return your call or email on the same day you make it, with the exception of weekends and holidays.

If the case of emergencies, please visit the nearest hospital emergency room or call **911.** You can also call one of the toll-free national crisis hotlines at **1-800-784-2433 (1-800-SUICIDE)** or **1-800-273-8255 (1-800-273- TALK).**

**I have read (or have had read to me) and understand the nature and limits of the services provided by Dr. Reshma Stafford, Licensed Psychologist, and I voluntarily agree to participate in the psychotherapy process. I consent to take part in treatment with Dr. Reshma Stafford.**

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Client’s Signature date

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Reshma Stafford, PsyD date