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General Information and Consent to Treatment

Welcome to my practice. I am a licensed clinical social worker in Washington, DC (License 50081800); Maryland (21327); Virginia (0904014827); Pennsylvania (CW024004); Georgia (CSW008439); Texas (110373); and California (114720). I appreciate you giving me the opportunity to collaborate and be of help to you. Please read this agreement carefully and discuss any questions you have with me. Signing this agreement means that you understand and agree to the policies and procedures below. When people start therapy they usually have a lot on their minds and may not remember details about my office policies. Therefore, I am providing a copy of this agreement in writing for your reference.

1. **Fees and Payment:** Payment for each therapy session is due at the time of the appointment. Therapy sessions are typically 55 minutes in length and cost $180. A statement will be provided at the end of each session that shows the visit date, charge and payment.

2. **Cancellations:** Effective therapy will require your commitment to the appointments we schedule. Because your scheduled appointment time is reserved for you, **you will be charged the full fee for missed or cancelled appointments unless I am notified of the cancellation at least 24 hours in advance.** In the event of the onset of a sudden, significant illness, loss, or event, I may waive the fee at my discretion.

3. **Availability:** Services are provided by appointment during my office hours. Confidential messages can be left on my office telephone number: (202) 601-3200. You may contact me by email for scheduling purposes only: sonjaharrisonlicsw@gmail.com. Dates of my absence will be given out in advance whenever possible. **On-call or after-hour crisis services are not provided.** For urgent or after-hours care, please contact 911 and/or visit your local hospital emergency room. Clients in Washington, DC can also contact the 24-hour D.C. Department of Mental Health's Access Helpline at 1-888-793-4357.

4. **Confidentiality:** All information disclosed within sessions, and the written records pertaining to those sessions, are confidential and will not be revealed to anyone without written permission. Disclosure of confidential information is required when: 1) there is a reasonable suspicion of child, dependent or elder abuse or neglect 2) when a client presents a danger to self, to others, to property, or when the client's family member communicates that the client presents a danger to self or others; and may be required 3) pursuant to a legal proceeding by or against you.

5. **Acknowledgement and Consent for Notice of Privacy Practices (NPP):** Signing this document means that I have read the NPP, have downloaded a copy, and have been made aware of how my medical records can be used or disclosed.

Your signature below indicates that you have read this agreement and agree to its terms and conditions.

Client signature: _____ Date: _____

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