Veronica Sullivan, Ph.D.

Licensed Psychologist

PSY#24340

518-894-8263

Informed Consent for Psychological Services

Introduction to Services:

Veronica Sullivan, Ph.D. provides a variety of clinical services including: intake assessment, short- and long-term term individual counseling, couples counseling, group counseling, and psychiatric and other referrals. Services are provided from an integrated perspective, primarily incorporating cognitive behavioral and interpersonal theories. All services and recommendations are for the best interest of the client(s).

Risks, Benefits, and Responsibilities:

I understand that there may be both risks and benefits associated with participation in counseling. Counseling may facilitate my ability to be self-supportive, improve mood and well-being, enhance my occupational performance and decision-making ability, improve relationships with self and others, expand my ability to deal with everyday stress, and provide a clearer understanding of myself, my values, and my goals. Therapy typically includes discussing uncomfortable thoughts, memories, events, situations, and more. Veronica Sullivan, Ph.D.. may determine that I would be better served by terminating services and/or making a referral to another provider. I understand that it is my responsibility to actively participate in the therapeutic process and treatment. recommended homework may be an integral aspect of treatment.

Cancellation (No-Show) Policy:

I understand that the No-Show/Late Cancellation policy states I must change or cancel my appointment at least **24 hours** ahead of the scheduled time or I will be responsible for paying the full session fee. In addition, If I No-Show, I must call 518-894-8263 **within 48 hours** to confirm that I want to keep my next scheduled appointment. If I do not call **within 48 hours** after I No-Show, my next appointment will be automatically cancelled and the time may be no longer be available.

Mandated Therapy:

Veronica Sullivan, Ph.D. provides court- and employer-ordered therapy services. I understand that it is my responsibility to inform Veronica Sullivan, Ph.D. during my first session if I anticipate requiring documentation of counseling for mandated therapy.

Counseling Records:

I understand that my counseling records are both paper and electronic and include the information I provided and documentation of any related interactions concerning me (e.g., individual/group counseling, phone calls, consultation, emails, etc.). Counseling records are protected by multiple security measures in compliance with state, federal, and professional regulations.

Confidentiality:

I understand that my counseling sessions will be confidential and my counseling records will not be released to anyone without my permission except under the following circumstances: If I present a life-threatening danger to myself or another person; if a minor child is at risk of being abused or neglected; if I am under 18 years of age and disclose that I am the victim of abuse or neglect; if an elderly person or dependent adult is being abused or neglected; or if a valid subpoena or court order is issued for my records.

I understand that to provide optimal treatment Veronica Sullivan, Ph.D. may consult with other mental health providers regarding my case without providing information identifying me.

EMERGENCY CONTACT:

I understand that Veronica Sullivan, Ph.D. is not available 24/7 for emergencies. If I have a psychological emergency, I agree to call 911 or go to my nearest emergency room immediately.

Consent:

I hereby state that I have read, understand, and agree to abide by the information outlined above regarding counseling services. I hereby give my consent to Veronica Sullivan, Ph.D. to evaluate, treat, and/or make referrals to other treatment providers as needed. I understand that I am welcome to ask Veronica Sullivan, Ph.D. questions about this form, that I can withdraw my consent to treatment at any time, and that this consent will remain in effect until such time that I inform Veronica Sullivan, Ph.D. that I choose to terminate this consent. I understand that Veronica Sullivan, Ph.D. will provide me with a list of alternative mental health treatment providers upon request.

Print Patient's Name Patient's Signature Date