

If you are purchasing a telephone session

Telephone consultations are not substitutes for in office Psychotherapy sessions. However Telephone sessions are valuable and provide a great deal help in a short period time. Telephone sessions can be seen as first aid or technical support. If your insurance does have benefits that pay for telephone sessions clients are responsible for coordinating their benefits from their insurance company.

Cancelled appointments require at least 24 hours notice will be billed a \$45 broken appointment fee. This is because the time you schedule is reserved to provide services to you. Less than 24 hours is not enough time to schedule services for another client. Therefore, this agency incurs a financial loss if you fail to show, or give adequate time to change a scheduled appointment. For all non paying clients, three broken appointments will result in termination of services.

Ky S. Resh, does not provide crisis services. If you are having a crisis in Tucson please call a 24 hour crisis hotline such as **Southern Arizona mental health at 520 622-6000** or **Palo Verde hospital at 520 324-4340. Or in your community call the local mental health center.**
If you are not successful in getting help and feel that you are not safe call 911 for assistance.

Everything said in therapy is confidential and will be treated with respect. However situations which are not protected by most state law are; **(1) threats of immanent harm to yourself \or another person, (2) statements indicating physical or sexual abuse to a child or vulnerable individual in your care, (3) court subpoena, (4) when participant (s) sign a release form.**

My signature below indicates that I have read and agree to abide by the above information. I give my consent for treatment. I acknowledge that I am the responsible party/custodian of the client and can legally authorize treatment. I have access to Ky S. Resh's notice of privacy practices. I authorize the release the release of any of my medical, psychiatric or other information necessary to process any claim and to provide information to another health care provider when necessary to coordinate treatment. I also authorize payment of medical benefit to the clinician for services rendered. I fully understand that if my insurance denies payment for any services defined as a non-covered service, I will be responsible for any amount due.

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Client or Legal guardian Signature Date