

**Kathy Radina, M. Ed.**  
**Licensed Professional Counselor**  
**480-488-6096**  
**CONSENT FOR TREATMENT**

**About Counseling;** Together we will identify your problem, set goals for therapy and a time frame in which these goals will be accomplished. We will discuss a diagnosis and whether I am qualified to address your concerns. If treatment of your problem reveals conditions that are outside my areas of expertise, I will refer you to another professional for treatment. You will not be paying me to be your friend, lover, mentor or surrogate parent.

I am a humanistic therapist with strong beliefs in how biology affects personality and behavior. I have advanced training in Gestalt, Gottman and Imago therapy for couples. I am also EMDR level II trained and use it for trauma, addictions, and self-esteem. I have worked with adolescents and young adults my entire career both as a teacher and therapist. Please consult my web page [www.kathyradina.com](http://www.kathyradina.com) for further details.

I will not disclose information about your counseling without your written consent. Exceptions will be made if you indicate that you may be of harm to yourself or another, or if you disclose any type of child or elder abuse. In these cases, I am obligated by law to contact any parties involved, and/or the appropriate reporting agencies.

I keep progress notes in a private file. You may have access to this file anytime you wish, however, if you participate in couple or family therapy, in order to respect the confidentiality of the other parties involved I will not be able to disclose the contents of the files without everyone's signature. Your records will not be released without your prior written authorization, unless they are required by court order. If you sue for mental health injury, your mental health history (my file) may be requested by the court. In the event of my disability or demise, my administrator will refer all my files to an associate of equal credentials for disposition.

As you might imagine, I may not be reached at all times. You may find yourself in the middle of a crisis after hours, or maybe even when I am on vacation and won't be available for several days. In the event of such an emergency, please call **Maricopa County Crisis line, 1-800-631-1314**; they have 24 hour crisis counseling. Understand that I am not affiliated with this agency, and they will know nothing about your case. Do not hesitate to call.

**The Details:** The fees for my services are as follows:

\$125 for a 50-minute session, individual or couple

\$187.50 for an extended session of 75 minutes

Often clients schedule a double session of 100 minutes or an extended session for the initial visit.

\$50 for appointments canceled with less than 24-hour notice. (Insurance does not cover this.)

Fees are payable at the time of service. It is nice if you have your check made out in advance so we do not waste counseling time. I cannot accept credit cards. These fees are negotiable; if they present a hardship please let me know.

The first five minutes of telephone counseling is free, after that I will bill you in 15 minute intervals payable at our next session. I am happy to counsel you on the phone if prior arrangements have been made, but it is my sincere belief that face to face counseling is the most effective.

My fee for writing letters or reports is billed at the session rate. My fee for consulting and travel time when applicable is \$250 per hour with a one half hour minimum. I do not have the qualifications to give expert court testimony, but if you insist, my fee is \$300 per hour, with a one-hour minimum, plus costs for reports and travel time as per above. Time spent waiting in court will be billed as travel time.

I am happy to give you a receipt that is accepted by insurance companies for reimbursement. Please be aware that a diagnosis ascribed for insurance purposes will be a part of that receipt. It is your responsibility to be aware of your benefits, and all fees are your obligation.

I understand the contents of this document, and by signing below do voluntarily consent to this agreement, and grant Kathy Radina, M. Ed., permission to provide outpatient therapy to me and/or

\_\_\_\_\_ (child/minor).

Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_\_

Kathy Radina, M. Ed. \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_\_