Barbara Gold, LCSW, LMFT

Please read the following information and feel free to ask if you have questions.

Fee and Cancellation Policy: Payment for Professional Services is due at the time of the scheduled appointment. I understand the fee to be $165.00 per 45-minute session and $220 for a 60-minute session. Preferred methods of payment are Zelle, Venmo or Check. Special arrangements can be made for the use of a credit card.
I understand that my appointment time is reserved for me, and any missed appointments without 24 hours prior notification, will result in my being charged in full for that time.
Should it be necessary for Barbara Gold, LCSW, LMFT to deal with my insurance company on my behalf, I will be charged at the above rates for her time.
I understand that if I fail to attend two consecutive sessions without 24 hours' notice, or if I consistently cancel appointments, this may result in termination of this therapist's services.
Request for Records: Should you request a copy of your records, or give permission to another to request a copy of your records, there will be a fee for a written summary of $50.00, due in advance.
Court Testimony: Should Barbara Gold, LCSW, LMFT be requested to engage in legal proceedings on a client's behalf, a signed release by the client, notification of a minimum of 10 days and fees paid in advance will be required. My fee is $220 per hour for each hour spent in pre-appearance preparation, $440 for each half day, not to exceed $880 for a full day.
Records and Confidentiality: All of our communications, including emails, texts and letters, will become a part of the clinical record that is accessible to you upon request. I will keep confidential anything you say to me, with the following exceptions:

1. When you authorize release of your records in writing,
2. When the possessory conservator of a child requests access to the child's records, or requests consultation with the therapist,
3. When a court of law subpoenas your record or a therapist's testimony,
4. When there is reasonable concern that harm may come to you or others (i.e. suicide, homicide, child or elder physical, and/or sexual abuse and neglect),
5. Certain client information may be given (as required) to any entity responsible for the payment or collection of client fees,
6. Information about you may be shared within the professional supervision process (anonymity will be maintained).

Psychotherapy Emergencies: In the case of life threatening emergencies, I understand that my options are to call 911 or go to a hospital emergency room.
By your signature below, you are indicating that you have read and understand this document. I understand that by signing this document, I give Barbara Gold, LCSW, LMFT my consent for treatment and agree to all of the above policies.

Client _____ **Date:** _____

Insured/Parent/Guardian _____ **Date:** _____