Fishbein & Associates Performance Consulting

Policies and Consent

A) GENERAL: There are always benefits and risks to any type of psychological treatment. Successful sport psychology and counseling interventions can lead to improved performance, increased self-esteem, and overall feelings of wellness. Sport psychology and mental skill interventions requires active involvement from both the client and therapist. I, ________________________________(client), give permission to ________________________________(provider at Fishbein & Associates Performance Consulting) to apply his/her knowledge of theories, research, sport psychology techniques, counseling skills, and the like, which might include,

1) Providing information relevant to the role of psychology in sport, exercise, and health to individuals, groups, and organizations.
2) Teaching specific skills (goal setting, relaxation, imagery, etc.) to apply in exercise, physical movement, and sport settings.
3) Helping clients measure and learn how to improve psychological factors such as arousal control, anxiety, motivation, etc.

Initials: Minor Client (12-17) ______________Client (18 and older)______________ Parent_________________

B) PAYMENT: Payment in full is expected at the time of service, or according to a mutually agreed upon schedule. In addition to weekly appointments, we charge for other professional services you may need, such as any telephone conversations for any reason other than scheduling, email dialogues, attendance at sporting activities that you have authorized, and time spent performing any other service you may request. Your account is expected to be paid in full at the end of each month. Health insurance policies do not cover sport psychological services. However, if there is a pre-existing diagnosis and part of the "treatment" relates to that diagnosis, we will provide you with a bill you can submit to your insurance company. Regardless, you (not your insurance company) are responsible for full payment of our fees.

Initials: Minor Client (12-17) ______________Client (18 and older)______________ Parent_________________

C) CANCELLATION POLICY: Once an appointment is scheduled, we have a **strict 24-hour notice** for cancellation. Except in cases of family/medical emergency and illness, appointments cancelled within 24-hours will be charged full fee for the appointment.

Initials: Minor Client (12-17) ______________Client (18 and older)______________ Parent_________________

D) PRIVACY and CONFIDENTIALITY: Confidentiality is your right and our duty. The privacy of all records pertaining to your treatment will be securely maintained. Records will be kept for a minimum of seven (7) years, will be used only for appropriate treatment purposes, and will be released only with your specific written consent or authorization, as provided for by Illinois and Federal law. You have the right to review your records (including the record of disclosures made) upon your written request. We charge a reasonable fee for copying records requested by you. If at any time you feel your privacy has been violated, you have the right to file a grievance with us and/or with the Secretary of the U.S. Department of Health and Human Services. Note, however, that the law requires the release of otherwise confidential information when we reasonably believe disclosure is necessary to protect against harm to yourself or others, when there is suspicion of child or elder abuse, and when records are demanded by Court Order. Sessions will remain confidential and specific information will not be shared with the following exceptions:

1) Written permission from the client,
2) Client poses imminent threat of harm to self or others (serious and foreseeable harm),
3) Suspected that a child, elder person, or person with disabilities is being abused or neglected (serious and foreseeable harm).

In cases when confidentiality will be broken without prior consent, we will communicate with the client and/or guardian and work to first gain the clients permission to break confidentiality. During times when consent cannot be gained from the client and/or guardian and either the client or someone else is in danger, we must legally break the laws of confidentiality.

Initials: Minor Client (12-17) ______________Client (18 and older)______________ Parent_________________

E) TREATMENT OF MINOR CHILDREN OF SEPARATED OR DIVORCED PARENTS: If our services are requested for a minor child of divorced or separated parents, we must receive consent in advance for our services from a party legally authorized to give consent for healthcare services. Payments of fees will be the sole responsibility of the parent or guardian initialing here as "responsible person" notwithstanding any court order or decree assigning financial responsibility for healthcare to any other party. Our office cannot bill such third parties.

Initials: Minor Client (12-17) ______________Client (18 and older)______________ Parent_________________

F) THANK YOU: If you have any questions, please do not hesitate to ask. Your initials above indicate that you have agreed to each section of the policies and consent to treatment. Your signature below indicates that you have agreed to all sections of the policies and consent to treatment form. Thank you.

Client: ______________________________ ______________________________ ______________
(over18) Printed Name Signature Date

Client: ______________________________ ______________________________ ______________
(if child <18) Printed Name Signature Date

Provider: ______________________________ ______________________________ ______________
Printed Name Signature Date