Barbara MacLeod Counseling Telephone Sessions
Statement of Responsibility

By signing this statement, I _____ acknowledge the following:

(Print Name Clearly)

1) I understand that if mental health services by a mental health professional are needed, I am responsible for seeking those services.

2) I agree I am responsible for the direct payment for telephone sessions and understand that medical/mental health insurance plans are not applicable to these services. Payments are to be sent immediately after each session by check or money order.

3) I understand that the content of my telephone consultations are confidential, that information about my consultations may not be released to any one or agency without specific written permission.

4) I understand that there are two exceptions to the confidentiality rule above: Confidentiality will be broken in the event that present danger to myself or others, and confidentiality will be broken if I share information that a child is being sexually or physically abused.

Client Signature _____ **Date** _____

Please Print Clearly Below

Client Name _____

Address _____

_____

_____

Phone _____

Email _____

Prior to receiving services, please sign, date and return this Statement of Responsibility to:

Barbara MacLeod

205 Seymour Ave

Scranton, PA 18505

If you have questions or need clarification of this form, please call 570-347-8771 or FAX to 570-347-2697

Please keep a copy of this completed form for your personal records.