PAMELA BASS COUNSELING SERVICES, PC
11330 Q ST, SUITE 207 OMAHA NE 68137 (402) 960-1652

CONSENT FOR TREATMENT

Therapy is designed to help you cope more effectively with daily stressors, inner conflicts, and common problems which have adversely affected your life. Your active participation, in and out of session, is encouraged. The work at times may be hard. I have over 29 years experience working with a diverse clientele. I come from a Christian worldview and have helped many clients who do not share the same worldview. If at any time you have any questions, please contact me. You may withdraw from counseling at any time.

Your signature below indicates that you have read this Consent for Treatment statement and agree to therapy with Pamela A. Bass.

_____ _____

Signature of Client/Guardian **Date**

CONFIDENTIALITY AND CONTRACT

The laws of the state of Nebraska require that most issues discussed in therapy with a licensed psychotherapist or supervising psychologist are confidential. However, the release of confidential materials is required in situations of suspected child or elder abuse or neglect; of potential harm to yourself or others; or where a judge has subpoena records. If you wish me to communicate with someone, you will be asked to sign a Release of Information Form.

CONFIDENTIALITY AND ELECTRONIC DEVICES

You may want to communicate via email and/or text message for convenience. Please be aware that Confidentiality **CANNOT** be ensured using these methods. Please indicate if you want to make contact with me or want me to contact you using either method. Please select preferred method(s).

EMAIL: YES NO **TEXT: YES NO**

Address:_____ Phone: _____

#2 Address:_____ Phone #2:_____

APPOINTMENTS AND CANCELLATIONS:

Appointments are weekly and as needed. A therapy hour is 50 minutes. If you are late, the session will still end on time. Sessions will decrease as therapeutic goals are met. Please discuss your expectations with me during the first session. A missed appointment occupies a significant portion of professional time and keeps this therapist from assisting someone else in need. **Therefore, except in the case of an acute emergency, if I fail to give a 24 hour notice of any cancellation, I agree to pay a fee of $60. This $60 must be paid in full before any future appointments will be scheduled. I agree to keep a current credit card in my file, which will be billed immediately upon a missed appointment without advance notice.**

Credit Card_____

Co-Payment is required at time of service. There will be a $50 charge for a bounced check.

MY SIGNATURE BELOW INDICATES THAT I HAVE READ AND AGREED TO THIS CONTRACT

_____

CLIENT SIGNATURE **DATE**