Steffani Brandenburg LCSW, CASAC, CEAP

Fostering Growth in Individuals and Couples

Confidentiality, Fee and Cancellation Policy Agreement

Welcome! I am looking forward to our work together. Below are a few policies that are important to discuss as we begin. This helps to ensure clarity and safety.

Confidentiality

Your privacy is of the utmost importance and to this end, what we speak about will be held confidential. You are free to tell whomever you wish of our work together. There may be times that you may want me to speak with others on your behalf. In these circumstances I will need your permission either verbally or in writing. I may discuss your therapy without full identification for educational and supervisory purposes. There are a few exceptions to confidentiality that are important to review.

•If I learn of any alleged child/elder abuse or neglect, I am required by law, as a mental health professional, to report this to the State Child Abuse Registry or State Adult Protective Services.

•If in my judgment you are deemed to be dangerous to yourself or others, I may need to break confidentiality in order to assure your safety or the safety of others.

•If I am court ordered to disclose your therapy.

Fees

My fee is $150.00 *per hour* and is due at time of service. For those wanting to use their health insurance, I will provide you with a monthly statement that you can submit to your insurance company. For those that are requesting extended sessions, fees will be pro-rated based on my hourly fee.

Cancellation Policy

I request a minimum of 48 hours notice for cancellations. Shorter notice will result in being charged for your full session.

I understand and agree to the above policies. They have been fully discussed and I have received a copy for my records.

Client Name: ________________________________ Date____________________________

Client Name: ________________________________ Date ____________________________

Steffani Brandenburg ________________________ Date:_____________________________

For children and adolescents: I, ______________________________________(print), am the legal guardian of _________________________, and I give permission for Steffani Brandenburg LCSW,CASAC,CEAP to provide counseling/psychotherapy services.

Parent/Guardian _____________________________ Date______________________________

153 Main Street Suite G Mt. Kisco, New York 10549 (914) 882-8478

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