Andrea Cohen, Psy.D.

New York Licensed Clinical Psychologist

Informed Consent Document

Welcome to my therapy practice. I look forward to working with you. This document contains information about my professional services and practice policies. Please review the following information carefully and do not hesitate to ask questions if any of the following information appears to be unclear.

Explanation of the Therapeutic Process:
Psychotherapy is a difficult process to describe in general terms. The process of psychotherapy typically focuses on change, which will hopefully result in improvements in various areas of your life. Although you can receive many benefits from therapy, this process can sometimes be frustrating and challenging. Since therapy often involves discussing challenging aspects of your life, the process of therapy may cause you to experience strong and often difficult emotions. On the other hand, the potential benefits of participating in therapy might include improved relationships with others, impactful transitions, reduced negative emotional states in your day to day life, an increased ability to manage stress and other life problems, and discovering new ways of thinking about yourself, others, and the environment.

I offer free 15 minute phone consultations for prospective clients. If you decide that you could benefit from therapy with me, I will schedule 45 minute sessions during a particular recurring day and time. Consistency is essential to building trust and safety. The sessions are conducted virtually through video and if you would prefer to connect through a phone call that is an option.

I work collaboratively and always respect where you are in the therapeutic process. You are always in control of what, when and how personal information is shared. You have the right to discontinue at any time for any reason.

Contacting Me:
I may not be immediately available if you reach out in between sessions but I make every effort to get back to clients on the same day that they reach out with exceptions for weekends and holidays. If there is an emergency and you can not reach me quickly enough, please go to the nearest hospital emergency room.

Confidentiality:
Following the New York state law and the American Psychological Association (APA) code of ethics, the therapist-patient relationship is privileged and confidential. In most cases, I can only release information regarding our work together with your permission. However, there are several limitations to confidentiality depending on your particular circumstances. If your health insurance carrier falls under the federal ERISA act, this carrier is entitled to and may request information about your treatment. In most legal proceedings, you have the right to prevent me from sharing information about your treatment.

If I believe that a child is being abused or neglected, I must report this suspected abuse to the appropriate state agency. If I believe that you are an imminent danger to yourself or others, I am required to take protective actions (i.e. call the police, warn a potential victim, or seek emergency psychiatric care for you).

Financial Agreement:
I am an out of network provider. I am not under contract with any insurance providers, but I provide invoices for clients to submit to their insurance carriers for potential reimbursement. I am happy to discuss the questions to ask your provider to ascertain what coverage you may have. If you are at least partially covered, payment would go directly to you from the insurance company.

Full payment is due at the time services are rendered via credit card. If you cancel a session within 72 hours, you will be charged for the session unless the session is rescheduled within the same business week. I do my best to accommodate these requests. In cases of unusual financial hardship, I am available to discuss payment arrangements.

Therapy Contract

By signing below, I verify that I have read and understand the therapeutic contract and give my consent for treatment:

Signature:_____ Date:_____

Notice of Privacy Practices

By signing below, I verify that I have received and reviewed the Notice of Privacy Practices. I understand that Dr. Cohen is committed to protecting my privacy and confidentiality as described in the notice of Privacy Practices.

Signature:_____ Printed Name:_____