

Heather Bellizzi, MSW, LCSW

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**Psychotherapy Consent Form**

I have chosen to receive psychological services from Heather Bellizzi, LCSW. My participation is voluntary and I am aware that I may discontinue receiving services at my discretion.

I understand that all of the information I disclose to Heather Bellizzi is held in the strictest of confidence and may not be released without my written consent. Three are some exceptions to this which are allowed or mandated by state and federal law. Some exceptions to confidentiality include situations where there is:

● Danger to myself or another person

● Actual or suspected abuse or neglect of children/minors or the elderly (Heather Bellizzi is mandated by law to disclose this information to the proper authorities)

● Presentation of a valid court order

Heather Bellizzi may disclose any and all records pertaining to my treatment to my insurance company and/or primary care physician as necessary for coordination of treatment, submission and validation of claims, or case management. I may revoke this consent in writing at any time.

I have been informed of the costs of services. While Heather Bellizzi will submit my claim to my insurance company, I understand that I am responsible for the costs of services. I have been encouraged to contact my insurance company to determine the scope of mental health services covered by my policy.

**I understand that I am responsible for the full service fee if I should fail to give 24 hour notice to cancel an appointment.**

I understand that there is no assurance that I will feel better. Because psychotherapy is a cooperative effort between me and my therapist, I will work with my therapist in a cooperative manner to resolve my difficulties. I understand that some of the information discussed in the course of psychotherapy may be necessary to help me resolve my concerns. I understand that alternatives to psychotherapy include, but are not limited to, medication treatments or no treatment at all.

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Signature Date