

***Kat Derrig-Palumbo, PhD***

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**Voicemail: (818) 615-4722 ♦ Office: (818) 401-0301 ♦ fax: (818) 401-0305**

Therapy is a very personal and life changing experience. Your commitment to your own growth in this process will determine largely how much you will benefit from it. There are a few things you should know about the process of therapy that will assist in making it most beneficial for you:

**LENGTH OF SESSIONS**

Our time together is 50 minutes. If I am able to continue a session over the 50 minutes, we can discuss doing another session if needed.

**SCHEDULING**

I see all of my patients at least once a week in order for them to receive maximum benefit from therapy. All canceled sessions will be charged full fee unless I am notified 24 hours before or I am able to reschedule you within the week. If you are out of town or unable to make it in to my office and would like an appointment, an online chat or video conferencing session can be scheduled.

**PHONE CALLS**

My answering service number is **(818) 615-4722**. I check for messages and emails frequently during the day and several times during the evenings and weekends. I will get back to you with in 24 hours. If a problem arises and you are unable to make your appointment, please let me know within 24 hours. YOU can also call my main office at 818-401-0301. If you are experiencing a life threatening emergency, please dial 911.

**CONFIDENTIALITY**

Our meetings will always be held in confidence. No information about you or your family will be released to anyone without your written permission unless there is a danger to self and/or others, child abuse and/or elder abuse.

**REPORTING**

I am mandated by law to report any case of potential suicidal or homicidal risk and/or dependent adult, elderly abuse or child abuse (sexual, physical, emotional abuse, exploitation, neglect). I will abide by these mandates.

**HIPPA**

I have received a copy of the HIPPA standards.

**FEES**

We have agreed upon your fee. Your fee will be consistent, but is reviewed annually and is sometimes increased moderately. All fees are the responsibility of the patient regardless of insurance.

Please sign and return this form to signify your understanding and acceptance of these conditions for treatment. If you have any questions, please feel free to discuss them before signing.

Signed \_\_\_\_\_ Date \_\_\_\_\_

Fee: **\$275.00 per session**