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INFORMATION & CONSENT FOR TREATMENT

Welcome to my private practice. As your psychotherapist, I look forward to working with you and I want to give you some important information about the services you will receive. The outcome of your treatment depends largely on a successful, collaborative rapport between us and on your willingness to engage in the process. Psychotherapy can be exciting and rewarding. However it can also be challenging. Therapy might deal with sensitive or difficult topics, and it might bring up uncomfortable feelings. The goal of therapy is to know oneself better, improve relationships and help you to face challenging situations more confidently. There might be times during this process when you experience periods of strong, perhaps difficult emotions and/or thoughts, which we will work through together. You have the right to end your treatment at any time for any reason. You have the right to question any aspect of your treatment. You also have the right to expect me to maintain professional and ethical boundaries by not entering into other personal, financial or professional relationships with you, all of which would compromise our work.

CONFIDENTIALITY

As your therapist, I am legally prohibited from revealing to another person that you are in therapy with me. I cannot reveal what you have said to me in any way that identifies you without your written permission. However, in the following instances, your right to confidentiality could be set aside as required by law or professional guidelines:

• Instances of actual or suspected physical or sexual abuse, emotional cruelty or neglect of a child, elder or dependent adult must be reported to the appropriate protective services.
• If I have reason to believe that a client poses an unavoidable and imminent danger of violence to another person or to another's property, I must warn whoever might be in danger, and I must notify the appropriate authorities.
• If a court has ordered your treatment or if I am served with a subpoena; for example, in the context of a legal proceeding in which your psychological state is an issue, I am required to release information to the court or may have to appear in court.
• If you reveal a serious intent to harm yourself, I am ethically bound to do what I can to keep you safe, which might involve notifying others who can help.

In all of the above cases, it is incumbent upon me to release only the information necessary to fulfill my responsibilities; your confidentiality still remains my ethical priority.

PAYMENT FOR SERVICES

Fees, once agreed upon, should be paid at each session unless other arrangements have been made. I accept cash, check or credit card. Sliding scale fees are based on the ability to pay. Any fee change is negotiated in good faith. Please notify me if your financial situation changes. I do accept some insurances, so please discuss this with me as needed.

CANCELLATIONS

Our appointment time is reserved specifically for you and will not be offered to anyone else seeking treatment. I appreciate receiving a 48 hour notice if you need to cancel or reschedule the appointment, so that I can offer the session to another individual who maybe needing the support. Please understand that if you are late for your session your appointment will still need to end on time.

ACCESSIBILITY & EMERGENCIES

My phone number is (707)307-5489. My email address is stephaniesnydermft@gmail.com. I will make every attempt to return calls and emails during business hours. Calls received after 9:00pm will be returned the following day. Calls received over the weekend will be returned the following Monday during business hours.

Please understand that I do not work on an emergency basis. If an emergency situation arises, please call 911, the Napa County Mental Health 24 hour Crisis Line (707)253-4711, the

National Suicide Prevention Lifeline (800)-273-8255 or go to the nearest hospital emergency room.

By signing below you indicate you have read, understood and agreed to the above policies and have received a copy of this information.

Patient Name: (Print) _____ Date_____

Signature: _____