HEIDI B. HAMERNIK, PH.D., P.C.
CLINICAL PSYCHOLOGIST

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Informed Consent for Psychological Services

This document contains information about my professional services. Please read and keep one copy for your records. If you have any questions please discuss them with me. I want you to understand your rights before you agree to treatment.

Treatment, Risks & Length of Services: You have the right to know about the psychological services that you may receive. I will try to give you as much information as I can about what to expect before I begin an evaluation or therapy. I provide mental health services to children, adolescents, families, and adults. These services may include an initial interview-assessment, individual and/or family therapy, consultation, and/or formal psychological assessment battery. The type of treatments or what I may do to help will depend on the needs of the client. I will explain what will happen during therapy. Most individuals who obtain psychotherapy benefit. Therapy and/or assessment may have positive and negative effects.

Usually I meet with clients once a week for 50 minutes. Sometimes I will recommend meeting more often, sometimes less often, again depending on your needs. While a formal assessment battery is usually a circumscribed amount of time, therapy will vary in length depending on the client's goals.

Confidentiality: The privacy and confidentiality between us is generally legally protected. I will abide by the state law on confidentiality. Normally, what you say and the records I keep will be kept private. Information can only be released with your written permission. There are times, however, when I may be compelled to release information about clients such as: 1) if there is a reasonable suspicion of abuse/neglect of a child, adolescent, elderly, dependent or disabled person; 2) if you may be in danger of harming yourself or another person; 3) as required by a third-party to obtain reimbursement; and 4) as otherwise ordered or required by law. This form does not cover every possible exception. I keep confidential records of each session.

Emergency Services: If an **emergency** situation should arise I can be reached on my main line at **(708) 297-1969.** While it is my full intention to be available, unforeseen circumstances may arise. If I have not responded to your call as quickly as needed, it is important that you contact emergency services by dialing **(911)** or by calling the nearest emergency room. An alternative service is the Crisis Line for parts of Cook County (708-681-HELP), DuPage County (630-682-7000), the Crisis Team at the Swedish Covenant Hospital (773-989-1609), or your local community mental health center. If I am out of town I will have a licensed professional in the mental health field cover for me while I am away.

Rights to Treatment & Alternatives to Treatment: You have the right to terminate treatment or an evaluation at any time. If you are not satisfied with the service you are receiving please tell me, I may be able to fix the problem. If you really feel that you are not getting what you need from our therapy together I can assist you with a referral to another professional or you may contact your local community mental health center.

I have read and understood this agreement and have had my questions answered by Dr. Hamernik. I fully understand my privileges. I accept, understand and consent to participate in treatment.

Print Name_____

Signature of Patient/Guardian: _____Date: _____

Signature of Child (if age 12 or older): _____ Date: _____

Witness: _____ Date: _____