# DANIEL ST ROSE, MSW

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**INFORMED CONSENT FOR TREATMENT**

The following information is intended to provide you with an understanding of my services, policies, and your rights. Please read carefully and if you have any questions, I will provide you with the information you need.

Psychotherapy services are provided by Daniel St Rose (LICSW - licensed independent clinical social worker) in Washington DC.

**Session and Payment:** Individual therapy sessions are 50 minutes. Couples therapy sessions are 60 minutes. Payment is expected at the time of service and can be made by cash or check. You will be given a billing statement at the end of each visit.

**Confidentiality/Release of Information:** Verbal communication between clients and therapist, and clinical records are protected under the law. I cannot release any information without your written permission. However, there are few exceptions to the protection of confidentiality, which are covered under HIPPA/Protected Health Information. Please refer to the notice of privacy practice (copy attached).

**Cancellations:**  Your scheduled appointment is reserved for you. You are responsible for paying for any missed sessions unless notice is given 48- hours prior to the scheduled appointment. **If you do not cancel your appointment in 48 hours, you will be charged for the session**.

**Communication:** Understand that email is not a secure method of communication. There is no guarantee that your confidential information will not be at risk. If you choose to utilize email to contact me it should only be limited to scheduling an appointment or other administrative issues, not for any personal or treatment related issues. I will not send you or discuss your personal information via email.

**Availability/Emergency Policy:** Services are provided by appointment during regular office hours. I make every effort to return calls within one to two business days.If an urgent situation occurs which requires immediate attention, it is recommended you contact 911 or go the nearest emergency room.

**I/We have read this informed consent, understand the information contained, and agree to the terms of treatment**

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Client signature Date

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Client signature Date

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Daniel St. Rose, MSW Date