



# BRENNAN INSTITUTE FOR MIND-BODY HEALING

## Group Therapy Services Contract

Here follows some essential information about group therapy and our practice. Please read and sign at the bottom to indicate that you have reviewed this information.

**Length and frequency of treatment:** Group therapy involves ongoing regular weekly sessions 75 minutes in length at a set day/time.

**Confidentiality:** Information you share with the group will be kept strictly confidential and will not be disclosed without your written consent. By law, however, confidentiality is not guaranteed in life-threatening situations involving yourself or others, or in situations in which children are put at risk (such as by sexual abuse or neglect). If I need to discuss your treatment with a colleague, I will take pains to disguise identifying information, including using a pseudonym.

**Fee and Cancellation Policies:** The fee for an initial consult to join the group is \$100. The fee for an on-going participation in group therapy is \$100/session. Fees will be collected monthly at the beginning of the month. If you need to cancel an appointment, please contact us at least 24 business hours in advance; otherwise, you will be charged for the missed session. Emergency medical or family situations are the only exceptions. In signing this services contract, you agree to have fees for late cancellations, no-shows, as well as any unpaid balances charged to a credit card. Please list relevant credit card information below. Your credit card account information will be kept secure and confidential.

Name of Cardholder (as appears on card): \_\_\_\_\_

Card #: \_\_\_\_\_ Exp. Date (month/year): \_\_\_\_\_

CVV# (3-digit security code on back of card) \_\_\_\_\_ Zip Code (Billing Address): \_\_\_\_\_

**Phone and emergency contact:** If you need to contact me by phone, do not hesitate to call. When I am not available, please leave a voicemail message. I am usually able to return calls within the same day. You will not be charged for phone calls unless we have a scheduled conversation of an information-exchanging or problem-solving nature that lasts more than 10 minutes. Phone sessions as such will be indicated on clinical invoices. If you cannot reach me in an emergency, you can find more immediate assistance by calling 911 or proceeding to your nearest emergency room.

**Physician Contact:** Physical and psychological symptoms often interact. I encourage you to seek medical consultation if warranted. In addition, medication may sometimes be helpful for psychological problems. When appropriate, I will arrange a referral for medication evaluation.

**Freedom to Withdraw:** You have the right to end group therapy at any time. If you wish, I will give you the names of other qualified psychotherapists.

**Informed Consent:** I have read and understood the preceding statement and have had an opportunity to ask questions about them, and I agree to enter a professional counseling relationship with Brennan Institute for Mind-Body Healing.

**Client's Signature:** \_\_\_\_\_ **Date:** \_\_\_\_/\_\_\_\_/\_\_\_\_

**Parent/Guardian/Personal Representative  
Signature (If applicable):** \_\_\_\_\_ **Date:** \_\_\_\_/\_\_\_\_/\_\_\_\_

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