Elicia M. Seay, Ph.D.
5250 Cherokee Ave., Suite 410
Alexandria, VA 22312
Licensed Clinical Psychologist
Phone (703) 354-1144
Fax (703) 831-8752

Informed Consent for Therapy Services
Psychologist-Client Service Agreement

Welcome to my practice. This document contains important information about my professional services and business policies.

Appointments

Appointments are an hour in duration, once a week, particularly in the beginning. After we have been working together for a while and you begin to feel better, we will discuss meeting less often until you have accomplished what you needed from therapy and we end our work together.

The time scheduled for your appointment is assigned to you alone. If you need to cancel or reschedule the appointment, I ask that you provide at least 24 hour notice. There is a charge if you miss a session without canceling, or cancel with less than 24 hour notice. See the Consent & Payment Agreement for more details about those charges.

Professional Fees

My hourly fee is $170 for individual therapy, $200 for couple's therapy. Payment is expected at the time of your appointment.

Insurance

I am a participating provider for Anthem and BCBS PPO insurance plans. If you have a different insurance plan, I will be able to provide you with a Super bill which is an itemized bill with all of the necessary information for you to file for reimbursement with your insurance company.

Phone Calls

I am usually not immediately available by telephone, for I do not answer my phone when I am with clients or otherwise unavailable. At these times, you may leave a message on my confidential voice mail and your call will be returned as soon as possible.

Emergency

If you have a mental health emergency and you are unable to reach me, or it is a weekend or holiday, you can, 1) contact your local community Mental Health Emergency Services, 2) go to your local hospital Emergency Room, or 3) call 911.

Email

You may use email to communicate to me regarding scheduling appointments. I do not encourage you to submit private information by email since it is not a guaranteed secure form of communication.

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Agreement for Confidentiality of Treatment Statement

I understand that it is Dr. Seay's role to provide therapeutic services so that I might feel better. Dr. Seay's role is not intended to gather information for the courts or to give testimony regarding my mental health status. Therefore, I agree that I will not call upon Dr. Seay to provide treatment records or to testify in any future proceedings.

I understand that it is Dr. Seay's policy to have no court involvement in my case since such action could harm our professional relationship and the ability to achieve my goals.

By signing this form I am agreeing not to request Dr. Seay to testify or have her records of my treatment shared with the court.

Your signature below indicates that you have read this entire agreement and agree to its terms.

Signature: ____ **Date:** ____/____/______