

**J. Ben Barnes, PhD**  
**Eastern Massachusetts Personalized Behavioral Health, LLC**  
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**IMPORTANT INFORMATION AND CLIENT CONSENT:** Please read and sign at the end stating you have fully read and understand the information below.

**RISKS AND BENEFITS OF THERAPY:** Therapy is beneficial, but as with most treatments, there are inherent risks. During therapy, we will have discussions about behavioral patterns and personal issues, and we will face fears with the goal of overcoming them. These interventions may cause some discomfort. The benefits of therapy can far outweigh any discomfort encountered during the process. Some of the possible benefits are reduced levels of distressing symptoms, improvement in functioning, increased feelings of life satisfaction and wellbeing, and improved relationships. I cannot guarantee these benefits but we will work together to help you attain your goals for therapy.

**APPOINTMENTS:** Appointments are typically scheduled on a weekly basis and are approximately 55 or 85 minutes long. If you must cancel or reschedule your appointment, I ask that you call me at (617) 804-1176 at least 24 hours in advance. This will free your appointment time for another client.

**FEE SCHEDULE:**

Regular Office Visits	50 minutes	\$250
Extended Session (helpful for some treatments)	85 minutes	\$375
Returned Check Fee (per check)		\$25
Late Cancellation (within 24 hrs)		\$100

**EMERGENCIES:** You may encounter a personal emergency which will require prompt attention. In this event, please contact me at (617) 804-1176 regarding the nature and urgency of the circumstances. While I will make every attempt to return your call as soon as possible, I can only guarantee a response within 24 hours. If you are experiencing a life-threatening emergency, in any form, immediately call 911 or have someone take you to the nearest emergency room for help.

**CONFIDENTIALITY:** I follow all ethical standards prescribed by state and federal law. I am required by practice guidelines and standards of care to keep records of your therapy sessions. These records are confidential with the exceptions noted below and in the Notice of Privacy Practices provided to you.

Discussions between a Therapist and a client are confidential. This means no information will be released without your written consent unless mandated by law. Possible exceptions to confidentiality include but are not limited to: 1) if I have reason to believe you have intent to seriously harm yourself, 2) if I have reason to believe

you have intent to seriously harm another individual, 3) if I have reason to believe you are abusing a child, elderly, or otherwise susceptible individual, and 4) if mandated by a court of law. Additionally, if you choose to bill your insurance they will require some basic information about types of services, diagnoses, and fee payment.

**CONSENT TO TREATMENT:** By signing this Client Information and Consent Form, I acknowledge that I have read, understand, and agree to the terms and conditions contained in this form and the Notice of Privacy Practices. I have been given appropriate opportunity to address any questions or request clarification for anything that is unclear to me. I am voluntarily agreeing to receive mental health assessment, treatment, and services for me (or my child if said child is the client), and I understand that I may stop such treatment or services at any time.

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Client/Guardian Signature

Date

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J. Ben Barnes, PhD

Date