INFORMED CONSENT FOR THERAPY

Therapist: Thetis Cromie, DMin, PhD, LCSW, Board Diplomat
Contact: 312-922-1025 | Cromie1000@mac.com

I understand and agree to the following:

1. **Services:** Telehealth therapy sessions (45-50 minutes) addressing anxiety, depression, spiritual issues, relational challenges, and problems of living. I also receive supervision for psychoanalytic candidacy.

2. **Fees:** $160/session. Payment required at time of service. 24-hour cancellation notice required; late cancellations incur full fee.

3. **Confidentiality:** My information remains confidential except when: (1) I risk harm to self/others, (2) abuse of minors/seniors is suspected, (3) court orders disclosure, or (4) I authorize release. Telehealth uses secure, HIPAA-compliant encrypted platforms.

4. **Voluntary Participation:** I am participating voluntarily and may terminate therapy at any time with discussion.

5. **Emergency:** Therapist is not available for emergencies. Contact 911 or local crisis services if needed.

6. **Complaints:** I will contact Therapist directly first. Unresolved issues may be filed with Illinois Department of Financial and Professional Regulation (IDFPR) at 1-800-560-6420.

Client Signature: **Date:**