In touch therapy
FOR THE MIND & BODY

Annette BoVee-Akyurek, Ph.D, LMFT, LMHC, NCC, PT
Psychotherapy/Physical Therapy
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Therapy Agreement

I understand that services from **Dr.Annette BoVee-Akyurek** may include psychotherapy and/or physical therapy, and may involve hypnotherapy, EMDR, craniosacral therapy/somatoemotional release, access consciousness/bars, meditation, or muscle energy for my children or myself. The therapy(s) utilized will be geared towards my unique needs, and mutually agreed upon prior to services rendered.

All sessions are **strictly confidential** with the following **exceptions**:

- My therapist must honor court subpoenas that require the release of specified information.
- My therapist may take professional action to protect those in immediate danger of physical harm to self and/or others.
- My therapist is mandated by Florida law to report suspected child or elder abuse or neglect.
- My therapist may share information with me from my children's therapy sessions if she believes that my children are in imminent danger.

***I understand that my **therapist is not available 24 hours** a day and that in a **crisis situation** I should call **1-800-SUICIDE**, or **911**.

***I understand that my therapist may run a few minutes late at times due to unforeseen circumstances to address the needs of a prior appointment, but strives to adhere to timely sessions.

***Credit card information will be collected and put on file at the time of making your first appointment. I understand that **payment for services** is due at the time of service. Payment can be made with credit card, cash, or personal check. I agree to **notify my therapist at least 48 hours in advance should I need to cancel** an appointment. (If I am unable to do so, I understand that I will be charged the full amount). I understand that the **fee for service is $450 for an initial 90-minute appointment**, and thereafter **$300 for a 60-minute appointment**; if I need to have a phone consult with my therapist for more than 5-10 minutes in between scheduled sessions, I understand there will be a prorated fee for service at the therapy rate.

Client Name: _____ Signature/Date: _____

Client Name: _____ Signature/Date: _____

Guardians, if under 18: _____ Signature/Date: _____

Therapist: Dr. Annette BoVee- Akyurek Signature/Date: _____