Informed Consent & Agreement For Psychotherapy Services

This document provides important information to you regarding your treatment. Please read the entire document carefully and ask me any questions that you may have before signing it.

I am a New York Licensed Clinical Social Worker (LCSW-R), license number 73079019.

Fees. The fee for service is $175 per 50 minute individual therapy session; $200 per 90 minute couples/family session; or $60 per group. I reserve the right to periodically adjust the fee. You will be notified of any fee adjustment in advance. Fees are payable at the time that services are rendered. If there is a need for telephone contact, with you or a third-party, other than for scheduling purposes, you understand that you are responsible for payment of the fee (on a pro rata basis) for any calls longer than 10 minutes.

Appointment Scheduling and Cancellation Policies. Sessions are typically scheduled to occur one time per week at the same time and day if possible. If an appointment is missed, or canceled with less than 24 hours notice, you may be charged the full fee for that missed session. Exceptions may be made if you are sick or have an unavoidable emergency.

Insurance. Please inform me if you wish to utilize health insurance to pay for services. I will discuss the procedures for billing your insurance. I am happy to assist your efforts to seek reimbursement, but am unable to guarantee whether your insurance will pay for the services provided to you. The amount of reimbursement, any co-payments or deductible depends on your specific insurance plan. Be aware that insurance plans limit coverage to certain diagnosable mental conditions, which then become part of your medical record. You are responsible for verifying and understanding the limits of your insurance coverage and obtaining prior authorization for treatment from your insurance carrier. In the case that a claim is denied you will be responsible for full payment. Please discuss any questions or concerns that you may have about this with me.

Collaboration with Other Professionals. In order to provide quality services, I often need to speak with others, such as your physician, psychiatrist, past therapists, and/or other professionals. You will be asked to complete a release of information authorizing these exchanges; in some cases, I may not be able to provide services without this.

Records and Record Keeping. I may take notes during session, and will also produce other notes and records regarding your treatment. These notes constitute my clinical and business records, which by law, I am required to maintain. These notes are kept in a locked location and/or password protected computer that only I use. You may request a copy of these records for yourself or to be released to another party in writing.

Confidentiality. The information disclosed by you is generally confidential and will not be released to any third party without written authorization from you, except where required or permitted by law. Exceptions to confidentiality include, but are not limited to, situations where you pose a threat of serious harm to yourself or someone else; cases involving suspected child, elder or dependent adult abuse; cases in which I am court-ordered to testify or produce records.

If you participate in marital or family therapy, I will not disclose confidential information about your treatment unless all person(s) who participated in the treatment with you provide their written authorization to release such information. However, it is important that you know that I utilize a “no secrets” policy when conducting family or marital/couples therapy. This means that I do not keep secret information gathered in individual conversations (whether on the phone or in an individual session) if the information revealed in some way violates the integrity of the couples/family therapy (such as revealing an affair, substance problem, or intent to leave the relationship). Such information will need to be revealed to the other partner for therapy to effectively continue. Please feel free to ask me about how this may apply to you.

Therapist Availability / Emergencies. You may leave a message for me at any time on my confidential voicemail at 585-626-8667. If you wish me to return your call, please be sure to leave your name and phone number(s), along with a brief message concerning the nature of your call. Non-urgent phone calls are generally returned within 24 hours. Please understand that as a solo, outpatient practitioner, I am unable to personally provide continuous 24-hour crisis services. In the event of a medical emergency or an emergency involving a threat to your safety or the safety of others, please call 911 to request emergency assistance, go to the nearest emergency room, and/or call the Psychiatric Emergency Assessment Team at 585-275-5151.

Acknowledgement

By signing below, you acknowledge that you have reviewed, fully understand and agree to the terms and conditions of this Agreement.

_____ _____

Signature of Client (or authorized representative) Date

_____ _____

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