

CLIENT INFORMATION AND CONSENT

I. Therapist

The undersigned therapist is licensed professional specializing in child, adolescent, and family counseling engaged in private practice providing mental health care services to clients directly. The undersigned therapist provides all mental health services through Heidi Diliberto, LCPC, LCPAT as a sole proprietorship.

II. Mental Health Services

While it may not be easy to seek help from a mental health professional, it is hoped that you will be better able to understand your situation and feelings and move toward resolving your difficulties. The therapist, using her knowledge of human development and behavior, will make observations about situations as well as suggestions for new ways to approach them. It will be important for you to explore your own feelings and thoughts and to try new approaches in order for change to occur. You may bring other family members to a therapy session if you feel it would be helpful or if your therapist recommends this. There are no guaranteed outcomes of any intervention, but the most favorable outcome is likely when treatment goals, treatment options and solutions to problems are derived from collaboration of therapist and client.

III. Appointments

Appointments can be made by calling 410-203-2411, Tuesday through Friday, between the hours of 9:00 A.M. and 5:00 P.M. Typically, it is expected that appointments be scheduled at least one week in advance. Please call to cancel or reschedule at least **24 hours** in advance of the scheduled appointment.

IV. Number of Visits

The number of sessions needed depends on many factors and will be discussed by the therapist. Clients seeking reimbursements for the subject sessions should first confirm the number of allowable sessions covered by their insurance plan.

V. Length of Visits

Therapy sessions are 45-50 minutes in length and are considered a clinical hour.

VI. Relationship

Your relationship with the therapist is a professional and therapeutic relationship. In order to preserve this relationship, it is imperative that the therapist not have any other type of relationship with you. Personal and/or business relationships undermine the effectiveness of the therapeutic relationship. The therapist cares about helping you, but is not in a position to be your friend or to have a social or personal relationship with you.

Gifts, bartering and trading services are not appropriate and should not be shared between you and the therapist.

VII. Cancellations

Cancellations must be received at least **24 hours** before your scheduled appointment; otherwise you may be required to pay the customary session fee for that missed appointment. ***This policy includes cancellations due to illnesses.*** You are responsible for calling to cancel or reschedule your appointment.

VIII. Payment of Services

The fee is determined and will be explained to you before the first session. The first therapy session fee is **\$190**. The subsequent session fee is: **\$170**. The undersigned therapist does not accept assignment of insurance benefits. The undersigned therapist will look to you for full payment of your account, and you will be responsible for payment of all charges due at the time of service. Returned checks will be subject to a \$35 charge, which will be added to your bill. Unpaid bills may be sent to a collection agency or pursued in court. You will be responsible for all fees accrued if this action is necessary, including interest of the amount owed. This is not the preferred course of action, but may become necessary if the problem of a delinquent account cannot be resolved otherwise.

You will be assessed a fee of **\$80** for phone consultations that exceed 15-minute increments in length. This includes all calls that pertain to case management issues: for example, school, hospital, other professionals, as well as phone calls with you directly.

If you have medical insurance that provides coverage for mental health counseling, we are anxious to help you receive your maximum allowable benefits. We do not accept assignment of benefits (get reimbursed directly from insurance companies), nor do we participate in managed care insurance plans (HMO's, PPOs, and other organized health networks).

We will be happy to assist you in the completion of your insurance claim form for reimbursement. A completed insurance claim form must accompany any such request at each visit. You are responsible for mailing your claim form and tracking your reimbursement.

We will gladly discuss your proposed treatment and answer any questions relating to your insurance. Your insurance is a contract between you, your employer, and the insurance company. We are not a party to that contract. Our fees are generally considered within the acceptable range by most companies, called "Usual, Customary, and Reasonable" (UCR). Some companies pay a percentage of the UCR for a given area. However, some companies reimburse based on a fee schedule. Not all services are a covered benefit in all contracts. Some insurance companies select certain services they will not cover. It is your responsibility to contact your company regarding the above to find out about their reimbursement policies.

Although, it is the goal of the undersigned therapist to protect the confidentiality of your records, there may be times when disclosure of your records or the therapist's testimony concerning your treatment will be compelled by law. Confidentiality and exceptions to confidentiality are discussed below. In the event law requires disclosure of your records or testimony, you will be responsible for and shall pay the cost involved in preparing for and giving testimony. The fee for this service is \$400 for every hour the therapist is in court. There are additional costs of travel, administrative, and legal representation of the therapist. This fee will be estimated at the time of service since this can vary for each client. Such payments are to be made at the time or prior to the time the therapist renders the services.

IX. Confidentiality

Discussions between a therapist and a client are confidential and medical records documenting such discussions also are confidential. No information will be released without the client's written consent unless mandated by law. Circumstances where the law requires exceptions to the confidentiality include but are not limited to the following situations: suspected abuse or neglect of a child or adult; a negligence suit brought by the client against the therapist; a court order requiring disclosure; a subpoena under certain circumstances; or the filing of a complaint against the therapist with the licensing board. If you have any questions regarding confidentiality, you should bring them to the attention of the therapist. By signing this information and a consent form, you are giving consent to the undersigned therapist to share confidential information with your insurance carrier, if you should seek reimbursement.

X. Duty to Warn

In the event that the undersigned therapist reasonably believes that I am a danger, physically or emotionally, to myself or another person, I specifically consent for the therapist to warn the person in danger and to contact the following persons, in addition to medical and law enforcement personnel:

NAME	TELEPHONE NUMBER
_____	_____
_____	_____
_____	_____

I consent for the undersigned therapist to communicate with me by mail and by phone at the following addresses and phone numbers, and I will immediately advise the therapist in the event of any change:

ADDRESS	TELEPHONE NUMBER
_____	_____
_____	_____

XI. After-Hours Emergencies

A mental health professional or your therapist is on call when your therapist’s office is closed, and can be reached for emergencies on a twenty-four-hour, seven-days-per-week basis, by calling 410-203-2411. Emergencies are urgent issues requiring immediate action. If you are a threat to yourself or others, calling 911 or going to your local emergency room is the preferred action. You may also call Grassroots, which has a 24 hour hotline and mobile crisis unit at 410-531-6677.

XII. Therapist’s Incapacity or Death

I acknowledge that, in the event the undersigned therapist becomes incapacitated or dies, it will become necessary for another therapist to take possession of my file and records. By signing this information and consent form, I give my consent to allowing another licensed mental health professional selected by the undersigned therapist to take possession of my file and records and provide me with copies upon my requests, or deliver them to a therapist of my choice.

XIII. TELEHEALTH COMMUNICATION POLICY

Please note that your correspondence with Heidi Diliberto, LCPC, LCPAT on the chosen electronic platform is compliant with HIPAA regulations and National and State telehealth requirements as per the Business Associate Agreement with this provider. By this notice you grant Heidi Diliberto, LCPC, LCPAT, permission to treat you via telehealth. You acknowledge the risks, and release Heidi Diliberto, LCPC, LCPAT m liability for the risk to your confidentiality. You understand that Heidi Diliberto, LCPC, LCPAT is limited in the ability to treat a crisis during the course of telehealth and understand in the event of an emergency you are responsible for contacting Emergency Medical Services or going to the nearest emergency room. By signing this addendum, you acknowledge that you understand your options for support of a crisis, non-emergency situation such as calling a member of your support system or a National Hotline. You acknowledge that telehealth is not a platform under which an emergency or crisis can be treated and release Heidi Diliberto, LCPC, LCPAT, from liability for these risks. Heidi Diliberto, LCPC, LCPAT, staff typically returns emails and text messages during the next business day after they are received. Emails and texts should be limited to administrative issues such as scheduling. As a provider for Heidi Diliberto, LCPC, LCPAT, I do not accept requests on Facebook, Linked In or other social media platforms.

XIV. ELECTRONIC COMMUNICATION POLICY ADDENDUM

It is impossible to guarantee the confidentiality of email or text messaging content. By this notice you grant Heidi Diliberto, LCPC, LCPAT permission to email and text you. You acknowledge the risks, and release Heidi Diliberto, LCPC, and LCPAT from liability for the risk to your confidentiality. Heidi Diliberto, LCPC, LCPAT staff typically returns emails and text messages during the next business day after they are received. Emails and texts should be limited to administrative issues such as scheduling. As a provider for Heidi Diliberto LCPC, LCPAT I do not accept requests on Facebook, Linked In or other social media platforms.

XV. Consent to Treatment

I, voluntarily, agree to receive Mental Health assessment, care, treatment, or services, and authorize the undersigned therapists to provide such care, treatment, or services as are considered necessary and advisable.

I understand and agree that I will participate in the planning of my care, treatment, or services, and that I may stop such care, treatment, or services that I receive through the undersigned therapist at any time.

I agree to give Heidi Diliberto, LCPC, LCPAT permission to send correspondence through the mail, with her name and credentials imprinted Heidi Diliberto, LCPC, LCPAT on the envelope or post card.

I understand that there will be an initial intake/assessment rate of \$190 per 50 minutes and a rate of \$170 for subsequent 50-minute sessions.

I understand that payment is expected in full each week (at the beginning of each session if paying by check or cash unless I have worked out another payment plan with my therapist.

I understand that there is a cancellation fee of either \$190 or \$170 if I cancel a session less than 24 hours in advance for a non-emergency reason or do not show for a session.

I understand that there is a \$35 fee if I pay by check and my funds are insufficient.

I understand that my therapist will give me at least 2 weeks' notice if she decides to raise her rates upon reviewing them annually.

I understand that I will have the remainder of my appointment time if I arrive late to a session.

I understand that therapy treatment does not offer guarantees.

I understand my therapist's privacy policy and how to access the Notice of Privacy Practices.

I understand that if I choose to use text messaging and email with my therapist, they are only permitted to discuss appointments, and I accept risk of breach of confidentiality.

I understand that my therapist will return my phone calls ASAP but may take up to 24-48 hours during business days. I also understand that phone calls longer than 10 minutes will be charged at prorated rates (per every 15 minutes).

I understand that if I am actively suicidal or experience another emergency, going to an ER, calling a mobile crisis team, or otherwise calling one of the numbers my therapist gave me is more appropriate than contacting my therapist since she may not be available immediately.

I understand my therapist's prorated fees for letters and meetings as well as the state-based fee for copies of my record.

Confidential

I understand that my therapist may refer me to other mental health professionals during the course of treatment for consultation, assessment, and/or adjunctive treatment.

I understand that I will tell my therapist if I have to terminate therapy early and will discuss any associated risks. I understand that my therapist may end my treatment if I cancel too frequently or we are not progressing.

I understand that my therapist does not “friend” or otherwise connect with current or former clients on social media. I also understand that if I choose to follow my therapist on social media, interact with her social media pages, or leave comments on her blog, I am accepting the risk of compromising my confidentiality. I also accept the risk of compromising my confidentiality if I decide to write any reviews for my therapist online.

I understand my therapist’s recommendation regarding legal matters, which is made to protect my confidentiality and our therapeutic relationship. I understand that there is a \$400 hourly charge if my therapist has to attend court because I do not follow this recommendation.

By signing this Client Information and Consent form, I, the undersigned client, acknowledge that I have both read and understood all the terms and information contained herein. Ample opportunity has been offered to me to ask questions and seek clarification of anything unclear to me.

Client/Parent

Date

Address

Client/Parent

Date

Address

As witnessed by:

Heidi Diliberto, LCPC, LCPAT

Date