***POLICIES FOR PSYCHOTHERAPY CLIENTS***

Hello and welcome to your first appointment. I look forward to getting to know you and assisting you with the problems you are having. Before we begin, I need you to be aware of the following policies, procedures, and other information. Please initial each section, and sign at the end of the form.

**TREATMENT PHILOSOPHY:** It is important that you understand that therapy can be a difficult process, and not always a successful one. You may experience periods of depression and/or increased difficulty along the way, and sometimes you may perceive that things get worse before they get better. The reasons you chose to seek therapy have likely built up over many years, so there is no “quick fix.” It will take time for us to get to know each other and to establish goals and reasonable expectations. Although you are free to terminate therapy at any time, it is my hope that we will have a chance to discuss your decision if you do choose to terminate. I may also choose to terminate the relationship if I deem it is in your best interest. \_\_\_\_\_\_\_ **INITIAL HERE**

**APPOINTMENTS AND EMERGENCY CONTACT INFO:** A standard therapy session is 45

minutes, starting with the time of your appointment, regardless of whether you are late. If I am late, I will make up the time. If you have not arrived or called within the first 15 minutes of your session, I will assume you are not coming and reserve the right to leave the office and tend to other matters. I check my messages several times throughout the day, and I try to return calls as soon as possible. I would appreciate calls during normal business hours except in emergency situations, in which case you may contact me by following the instructions on my office voice mail. If you are unable to reach me and have a life-threatening emergency, please call 911 for assistance.

\_\_\_\_\_\_\_\_\_**INITIAL HERE**

**FEES, PAYMENTS, AND INSURANCE:** My standard fee is $175 per 45-minute session for clients not using insurance. If using insurance, your financial responsibility is dependent on your plan, and I will notify you of your share of cost before the first appointment. Fees are periodically reevaluated and changed. Payments and/or co-payments will be collected on the day services are rendered. Credit/debit cards are acceptable forms of payment. There is an additional fee of 3.7% to cover the cost of using a credit/debit card. If you have an outstanding balance, including outstanding copayments, I will need to receive payment in full before scheduling your next appointment. If your insurance company fails to pay within 45 days of billing, your balance may be charged to the card on file and you may seek reimbursement from your insurance company, or, if they later pay, I will refund your account. I can provide you with a Superbill at your request. You are also responsible for any deductibles that may apply to your plan. By initialing and signing this form, you indicate your approval that your insurance company may make payments directly to me (if applicable). You also authorize release of diagnostic and clinical information to the insurance company for purpose of claims, certifications/case management, quality improvement, audits, and other purposes related to the benefits of your health plan. \_\_\_\_\_\_\_\_**INITIAL HERE**

**OTHER SERVICES:** Fees for completing any forms or letters that you request of me, such as summary letters for disability claims, alternative schooling recommendations, transfer of care to other providers, etc. will be pro-rated based on $50 per hour, depending on the time it takes me to fulfill the request. \_\_\_\_\_\_**INITIAL HERE**

**CONFIDENTIALITY:** All information between provider of treatment and client is held in strict confidentiality, unless:

1. The client authorizes a release of information with his/her signature (other than basic information required by insurance companies, if applicable).
2. Injuries result from spousal abuse or other assaultive conduct.
3. Your mental condition becomes an issue in a lawsuit.
4. The client presents with suicidal or homicidal ideation or makes a threat of physical harm to another person.
5. Child or elder abuse is suspected.

In the latter two cases, I am required by law to inform potential victims and legal authorities so that protective measures can be taken. \_\_\_\_\_\_\_**INITIAL HERE**

**APPEALS AND GRIEVANCES:** You have the right to request reconsideration (an appeal) in the case that outpatient visits are denied by your insurance certification. You may request an appeal through me, and risk nothing in exercising this right. You may also submit a complaint or grievance to your provider or the group director at any time to register a complaint about my care. If you are not satisfied with the response you receive, you may submit your complaint directly to your insurance carrier. \_\_\_\_\_\_\_**INITIAL HERE**

**RECEIPT OF NOTICE OF PRIVACY PRACTICES:** In compliance with HIPAA regulations, I am required to provide you with a notice of privacy practices, which can be found on my website, [www.shelleyrossimft.com,](http://www.shelleyrossimft.com/) under Forms. By initialing here, you acknowledge that you have been notified of the availability of this document and have read it. I will be happy to answer any questions you may have. \_\_\_\_\_\_**INITIAL HERE**

**RELEASE OF INFORMATION:** You authorize release of information in the event of consultation or professional communication with the professional referral source (i.e., your insurance carrier) and other health care providers and institutions (i.e., Your Primary Care Physician(s), Psychiatrist, or hospital) for purposes of diagnosis and treatment. You further authorize the release of information for claims, certifications/case management, quality improvement and other purposes related to the benefits of your health plan.

\_\_\_\_\_\_\_**INITIAL HERE**

**CONSENT TO RECEIVE TEXT MESSAGE REMINDERS:** I accept \_\_\_\_\_/decline\_\_\_\_\_ to receive text message reminders 24 hours before my appointment.

**I understand and agree to all the above.**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Print name of client**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Signature of client Date**

**(or parent if minor client)**

**PATIENT RECORD**

(To be completed by client prior to first session)

Patient:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State:\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Ok to leave messages? \_\_\_\_ yes \_\_\_\_\_no

Cell phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work phone:\_\_\_\_\_\_\_\_\_\_\_\_\_ Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Driver’s license #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State \_\_\_\_\_\_\_\_\_\_\_\_

Social Security # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Required. This is only used for tracking purposes if your account is sent to collections for non-payment of balance after 60 days.)

Employer/School:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Marital Status: \_\_\_\_Married \_\_\_\_\_Single \_\_\_\_\_Divorced \_\_\_\_\_Widowed

Emergency Contact:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Telephone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relevant medical conditions (history, current condition, changes in condition):

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medications (dosage, dates of initial prescription, name and phone number of prescribing Doctor):

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Allergies/adverse reactions to treatment:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Primary Care Physician Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City:\_\_\_\_\_\_\_\_ Zip:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Telephone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If I deem it appropriate or necessary, may I notify your primary care physician that you are attending counseling? \_\_\_\_Yes \_\_\_\_No

Reason for seeking counseling today (Include any prior history of counseling for mental health, alcohol, or other drug problems):

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Client’s signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# CANCELATION POLICY (Important – Please read thoroughly)

**I UNDERSTAND THAT WHEN I SCHEDULE AN APPOINTMENT, I AM FINANCIALLY**

**RESPONSIBLE FOR FULL PAYMENT (NOT JUST MY CO-PAYMENT) UNLESS I**

**CANCEL AT LEAST 24 HOURS IN ADVANCE. INSURANCE DOES NOT COVER MISSED**

**APPOINTMENTS.** If you miss a session or cancel on short notice (less than 24 hours), you will be billed for the same amount as your insurance company’s contract rate with me, plus an additional 3.7% to cover fees charged by the credit card processor. **These fees vary from $70.00-$175.00 depending on your insurance plan or cash-rate agreement with me if not using insurance.** Please ask me if you are

uncertain about your insurance carrier’s contract rate.

**I require either a credit card to be kept on file that will only be charged in the event of a missed appointment, late cancellation (less than 24 hours), or any outstanding balance more than 14 days past the date of service. If for any reason your insurance does not pay after 45 days, that balance will be charged to your credit card.** If the insurance later pays, you will be refunded that amount. All files and credit card information will be stored in a secure, locked file cabinet in a locked office at all times. If for any reason your balance remains unpaid after 60 days, your account will be turned over to a collections agency with a 25% interest rate beginning 60 days from the date of service.

**Type of Credit Card (Circle one):**

Visa MasterCard Discover American Express

Credit Card # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Expiration date \_\_\_\_\_\_\_\_\_\_\_\_\_

3-digit CSC code\_\_\_\_\_\_\_\_\_

**I understand and agree to all the above.**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Print name of client**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Signature of client Date**

**(or parent if minor client)**

**CONSENT TO USE TELEHEALTH**

As an option to “in-person” therapy, videoconferencing may be an option to conduct your session. Please discuss with me for details. Since 2016, the State of California has recognized telehealth as a form of delivery of behavioral health services which many clinicians are practicing throughout the state. “Tele-health”, is defined as a means of delivery for behavioral health and wellness services using an internet platform to facilitate the diagnosis, consultation, treatment, and care management while the client and provider are at different locations. Telehealth is usually provided through live

videoconferencing through a personal computer or smart phone or via telephone if there are technical difficulties with the video feed.

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ hereby consent to engaging in telehealth sessions with Shelley Rossi, LMFT as part of my psychotherapy. I understand that “telehealth” includes the practice of diagnosis, consultation, treatment, transfer of medical data, and education using audio, video, or data communications. I understand that telehealth also involves the communication of my medical/mental information, both orally and visually, to health care clinicians.

I understand that I have the following rights with respect to telehealth:

1. I have the right to withhold or withdraw consent at any time without affecting my right to future care or treatment or risking the loss or withdrawal of any benefits to which I would otherwise be entitled.
2. The laws that protect the confidentiality of my information also apply to telehealth. As such, I understand that the information disclosed by me during my therapy is generally confidential. However, there are both mandatory and permissive exceptions to confidentiality, including, but not limited to reporting child, elder, and dependent adult abuse; expressed threats of violence towards an ascertainable victim; and where I make my mental or emotional state an issue in a legal proceeding.
3. I understand that there are risks and consequences from telehealth, including, but not limited to, the possibility, even after reasonable efforts on the part of my clinician, that: the transmission of my information could be disrupted or distorted by technical failures; the transmission of my information could be interrupted by unauthorized persons; and/or the electronic storage of my information could be accessed by unauthorized persons. In addition, I understand that if my clinician believes I would be better served by another form of psychotherapy services (e.g., face-to-face services) I will be referred to a clinician who can provide these services to me.
4. I understand that I may benefit from telehealth, but that results cannot be guaranteed or assured.
5. I understand that I have a right to access my medical information and copies of medical records in accordance with California law.

I have read and understand the information provided above. I have discussed it with my clinician and all of my questions have been answered to my satisfaction.

Signature of client (or parent if minor) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_