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INFORMATION FOR CLIENTS AND CONSENT FOR TREATMENT

Client's Name _____ Date of Birth _____

Parent's/Guardian's Name (if client is a minor) _____

About Therapy
Therapy is a partnership between client and therapist. You define your concerns and we work together to establish therapy goals. Ongoing treatment requires your active participation and regular attendance. Therapy can be hard work and may be uncomfortable at times. Through exploring your experiences, thoughts, and feelings, therapy can help to achieve your goals. Therapy may enable and empower you to make changes in your patterns of thinking and behaving. In family therapy, family members have the opportunity to effectively communicate with one another and to improve relationships.

Miscellaneous
I am an independent practitioner; shared office space does not imply partnership. Parents bringing their children for therapy agree not to enlist my involvement in child custody/visitation related matters or legal proceedings associated with custody and visitation decisions. Furthermore, I will not testify in court about child custody or visitation as these issues require specific protocols, including investigations and evaluations, which we will not be doing. Additionally, involvement in such matters poses a risk to therapeutic progress.

Records
The laws and standards of my profession require that I keep treatment records. You are entitled to receive a copy of the records unless I believe that seeing them would be emotionally damaging or injurious to your health, in which case I will be happy to send them to a mental health professional of your choice. Because these are professional records, they can be misinterpreted and/or upsetting to untrained readers. I recommend that you review them in my presence so that we can discuss the contents.

Confidentiality
Information that you discuss in therapy is confidential. I will not reveal to anyone that you are receiving services from me, unless I have your written permission. For example, with your written permission I may provide a diagnosis, treatment plan or summary. There are several situations in which confidentiality may be breached or I am legally obligated to report or take action:

- if testimony is required by a judge for certain judicial or criminal proceedings
- if abuse or neglect of a minor is suspected (I will make every effort to discuss the matter with you before I make a report, unless I judge that there is imminent danger that someone will be harmed.)
- emergency situations such as:
    1) if a client threatens to harm him/herself or another person
    2) if a client is in danger due to extremely severe symptoms (e.g., severe depression, psychosis)

⇒ If there is an emergency while you are in therapy, please list a person whom you authorize me to contact:

Name: _____
Relationship to you: _____
Phone number: _____
Address: _____

I may occasionally find it helpful to consult other professionals about a case. During a consultation, I make every effort to avoid revealing the identity of my patient. The consultant is also legally bound to keep the information confidential. If you don't object, I will not tell you about these consultations unless I feel that it is important to our work together.

If a client is less than 18 years of age, the legal guardian or parent has access to the records. If documentation is needed, the parent agrees to accept a summary of treatment notes instead of exact treatment notes in order to safeguard the child's confidentiality and willingness to be forthcoming within sessions. We will discuss a more specific plan for informing parents/guardians about treatment progress during the initial session. My policy is to have parents waive their right to access their child's information, and for me to have discretion in what I share with them about therapy.

If you have questions about confidentiality, I will be happy to discuss them with you. If there are legal issues involved, it may be necessary for you to seek legal advice.

Outside of Session Contact
You can leave a message on voice-mail at any time. I retrieve my messages frequently and generally return calls within 48 hours. On weekends and holidays, phone calls may not be returned until the next business day. If you have an emergency and cannot reach me immediately by telephone, go to the nearest hospital emergency room. If needed, here are emergency hotline numbers: Montgomery County Crisis Center (crisis intervention) at 240 777-4000 or Montgomery County Hotline (supportive listening) 301 738-2255.

Please do not use text messaging or e-mail to convey urgent information. Although Dr. Frank uses encrypted email, please be aware that e-mail and text messaging are subject to breaches in confidentiality.

☐ Yes, I would like to be able to communicate clinical and private information that is not urgent, via email.

☐ Yes, I would like to be able to communicate general information that is not clinical and not urgent, via email.

Email address: _____

☐ No, I would not like to communicate via email.

About Fees, Payments, and Billing
Therapy services (family, marital, or individual therapy): For a 50-minute session, the standard fee is $170. The initial session cost is $180 and may include gathering information from various sources. You should carefully read the section in your insurance coverage booklet that describes mental health services. If you have questions about the coverage, call your plan administrator. Of course I will provide you with whatever information I can based on my experience and will be happy to help you in

understanding the information you receive from your insurance company. If I am a participating provider on your health insurance plan, I am obligated to accept their usual and customary fee. If I am not a participating provider on your health plan, you will be responsible for the session fee and I will provide the necessary paperwork to submit to your insurance. You are responsible for notifying me about pre-authorization or treatment plans which are due. I may be required to provide clinical information to your insurance company. Payment of your co-pay or full payment is due at each session.

Other services: Charges for other services (such as school consultations and consultations with lawyers) are $180 per hour. These charges are not billable to insurance. There will not be a fee for brief telephone contact (< 15 minutes) with the client or other professionals involved with the client. Longer telephone contact (>15 minutes) will be charged at the hourly rate for therapy ($170 per hour).

Missed sessions or cancellations: If you are unable to keep an appointment, please let me know at least 2 days in advance. Without such advance notice, you will be charged $50 for the missed session. Please note that I cannot bill your insurance company for a missed session and you will be responsible for the fee. If there is any problem with billing or paying the fees, please bring it to my attention. Such problems can interfere with our work, so they must be resolved openly and quickly.

Billing Arrangement

I (Dr. Sheryl Frank) may receive direct payment from the payment source. When there is a third party payer, I may need to submit diagnosis, treatment plan, progress notes, treatment summary, or evaluation report to the payer. You (client) are responsible for payment even if the insurance company denies the claim. If there is an outstanding balance for more than 3 months, I reserve the right to submit the debt to a collection agency or file in small claims court. Any collection fees and expenses will be billed to you.

_____ _____

Signature Date

Treatment Agreement

Consent for adult clients and parents/caregivers: _____ has read this brochure and understands its contents. You have had the opportunity to read the Notices of Privacy Practices. Any of these materials are available upon request. You agree to participate in psychotherapy (or allow your child to participate in psychotherapy) and pay the fees associated with these services.

_____ _____

Signature Date