MARGARET BAILEY, LCSW
80 East 11th St., #541, New York, NY 10003
mbaileylcsw@gmail.com | 212.255.3370

CONSULTATION AND PSYCHOTHERAPY SERVICES AGREEMENT

Please read the following sections regarding important guidelines for the provision of consultation and psychotherapy services in this practice. In order for our work to be most productive and effective, it is important for you to have a clear understanding of your rights and responsibilities as a client, as well as what you can expect in terms of the structure of sessions, confidentiality, clinical records, scheduling and payment.

INTAKE/CONSULTATION: It is helpful to view the first 1 – 3 sessions as part of an initial consultation during which we will determine together whether further work would be beneficial. This is an opportunity for me to gather information and clarify presenting concerns and a chance for you to ask any questions regarding my professional background, training and credentials.

PSYCHOTHERAPY: The psychotherapy process is collaborative and interactive and I endeavor to create an environment of safety and security to address presenting concerns. We will discuss the frequency of sessions with the focus on determining the plan that is most helpful for resolving your concerns. Sessions are typically 45 minutes in length and take place in person.

PATIENT RIGHTS: The Health Insurance Portability and Accountability Act (HIPPA) is a federal law that provides protection and patient rights with regard to the use and disclosure or your clinical records, also called Protected Health Information (PHI), used for the purpose of treatment, payment and health care operations.

Please review the Confidentiality section below. You will be asked to provide your signature to acknowledge your understanding of your rights under the privacy policy. Please feel free to ask me any questions you have about these rights.

CONFIDENTIALITY: Confidentiality is the keystone of our work together, ensuring that you can address your concerns with the assurance that information addressed in session is protected. In general, law strictly protects the confidentiality of all communications between an client and psychotherapist. With the exceptions noted below, I will release information about your treatment to others only with your written consent. There are situations that require only that you provide written, advance consent, and your signature on this form provides that consent for the following:

- At times it can be productive to consult with other health and mental health professions, without revealing any identifying information about you. Other professionals are also legally bound to keep this information confidential.
- Disclosures required by health insurers or to collect fees (direct billing to insurance companies on-line or in written form), providing written statements of services to clients, as noted elsewhere in this agreement.
- If a client threatens imminent harm to himself/herself, I may be obligated to seek hospitalization for him/her, and/or to contact family members or others who can help provide protection.

There are situations in which I am legally obligated to take actions that I believe are necessary to attempt to protect others from harm, and I may have to reveal some information about a client's treatment:

- If I receive information in my professional capacity that gives me reasonable cause to suspect abuse or neglect of a child, the law requires that I report this to the appropriate government agency, usually the statewide central register of child abuse and maltreatment, or the local child protective services office. Once such a report is filed, I may be required to provide additional information.

- If a client communicated an immediate threat of serious physical harm to an identifiable victim, I may be required to take protective actions. These actions may include notifying the potential victim, contacting the police or seeking hospitalization for the client.

These situations are very rare in my practice. If any such situation arises, I will make every effort to fully discuss it with you before taking any action, and I will limit my disclosure to what I deem essential.

CLINICAL RECORDS: As required by law, I maintain clinical records of our sessions containing Protected Health Information (PHI). All records are kept secure in compliance with the Health Insurance Portability and Accountability Act (HIPPA).

SCHEDULING: Your scheduled appointment time is reserved for you and due to the difficulty of scheduling on short notice, I require 24-hour advance notification if you cancel an appointment. If appointments are cancelled within 24 hours or missed without notice, I reserve the right to charge your appointment fee for this time. Please bear in mind that most insurance companies do not reimburse for cancelled or missed appointments.

INSURANCE REIMBURSEMENT: I am an in-network provider for the NYU student health insurance (CHP) and for United HealthCare (including UHC/Oxford). Unless we arrange otherwise, I will bill the insurance company directly for services and collect only the co-pay from clients with CHP or UHC insurance. For all other insurances, I will provide the needed paperwork/statements for you to submit to insurance. In these cases, I will collect the full fee directly from you and you should be reimbursed by the insurance company for any covered expenses.

PAYMENT: Unless we make other arrangements, payment is due at the time of the session whether a co-payment or the full fee for services. If at any point during treatment, you anticipate difficulty with payment on the agreed-upon schedule, please raise this concern as soon as possible so that we can develop a plan in response to the change.

INFORMED CONSENT: Your signature below indicates you have read this agreement and agree to its terms.

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Printed Name

____ __________________

Signature Date

In the unlikely event of an accident or illness, please provide your emergency contact information:

____ __________________

Name and relationship to you Phone