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I am a Licensed Independent Clinical Social Worker in DC and a Licensed Certified Social Worker Clinical in Maryland as well as a Maryland Board Certified Supervisor. Please check to be sure you have read, understood, and discussed all questions with me as this informed consent has the force of a contract. When people start counseling they usually have a lot on their minds and do not always remember details about my office arrangements. Therefore, I am providing my policies in writing. I encourage you to take the time to read these through and please feel free to bring up any questions you may have.

Treatment

Goals of treatment are arrived at by mutual collaboration through exploring the issues you feel are most critical and important. Depending on your initial issues and symptoms, benefits of treatment include living to the best of your capacity and experiencing more emotional intimacy in relationships. You may experience an increased sense of well-being and confidence. With a more thorough understanding of yourself and your behaviors, you are likely to be able to make changes that enhance your relationships and find deeper satisfaction in them.

There are both benefits and side effects associated with psychotherapy. During the therapeutic process, you may experience intense and unwanted feelings, including sadness, anger, fear, guilt, or anxiety. It is important to remember that these feelings may be natural, normal, and part of the healing process. During our work together, I hope to discuss any of your assumptions and concerns regarding psychotherapy. As I only accept patients whom I believe I can help using my professional services, knowledge, and training, I expect to enter our relationship with optimism and hope.

Appointments

I will usually schedule one 45-minute session per week, although some sessions may be more frequent or longer. The length of treatment depends on the goals we establish together. The schedule of sessions will be agreed upon during the first few appointments, and may be modified during the course of treatment. It is essential to keep scheduled appointments to receive maximum benefit from treatment.

Fees

The fee for services is $ 180.00 for the standard 45-minute individual or couples psychotherapy session. Cost of living increases may occur on an annual basis. Telephone calls may be charged at approximately the same rate as personal consultation.

Payment for professional services is expected at the time of each individual, couple, or group session. Checks can be made out to Leyla Kenny and given to me at the beginning of the session. As a courtesy to my clients, I also accept payment by credit card and if you would like to do so, you may fill out your information below to have sessions charged to your account. In the event that there is an outstanding balance at the end of the month or there is a cancellation with less than 24 hours notice, your balance will be charged.

▫ MasterCard ▫ VISA ▫ AmEx ▫ Discover

Name on card: _____

Expiration Date: ____/____

CVV: _____

Account Number: _____

Billing Zip Code: _____

Payment becomes past due sixty days after a statement has been issued. If an account is overdue and you have not made arrangements for payment with me, I may turn your account over for collection. All reasonable expenses, including collection agency or attorney's fees will be charged to the patient. The collection agency or attorney would be provided only with the dates, types of service, and charges (no clinical information will be revealed).

Fees may be reimbursable by insurance carriers. Please contact your insurance company to inquire the extent and provisions of your policy. I will complete forms and documents necessary for you to obtain your reimbursements. My billing statement has all the information required by most insurance carriers.

If there is an increase in my fees, you will receive notice one month in advance. If there is an adverse change in your financial status, we may work together to adjust the fee structure together to reflect this change accordingly.

Cancellations

When you schedule an appointment, the time is reserved especially for you. **If you do not come for your appointment, or cancel in less than 24 hours, you will be charged the regular session fee.** Please note that insurance companies do not reimburse you for missed appointments, and require that they be so noted on the statement.

Availability

Services are by appointment during regular office hours. Dates of vacations and other exceptions will be given out as far in advance as possible. On-call or after-hours services are not provided. For urgent or after-hours care, call 911 or go to your nearest emergency room.

Notice of Privacy Practices (HIPPA)

Signing this document means you are aware an electronic copy of the NPP (Dated 10/1/2008) may be viewed on the website, www.washingtondcpsychotherapy.com, which details how medical records may be used and disclosed. If the NPP is not available on the website, a hard copy will be provided to you.

I am bound to hold in confidence all that is disclosed during your sessions with me, including the fact that you met with me. Legal exceptions to the general rule of confidentiality require me to release information in the following situations:

1. When I have reason to believe that there is a clear and imminent threat to your physically harming yourself or another person. To protect you or the other person from harm, I am required by law to disclose information or take other actions to protect you or another person from physical harm. Protective actions may include contacting the police or seeking hospitalization for the patient.
2. When I have reason to believe that child abuse has occurred, the District of Columbia requires that it be reported to the Department of Social Services. Child abuse includes neglect of medical needs, abandonment, sexual exploitation, and physical or mental injuries that result in impaired functioning.
3. When a court issues a legitimate subpoena and the court determines that confidentiality is not privileged.
4. When you are seeking third party reimbursement for mental health services, the third party payer has the right to request information for determination of your eligibility for payment. Your signature on the claim gives consent for me to disclose dates of treatment, type of treatment, and the nature of the issues being treated including a diagnosis.

Minors and Parents

If you are under 18 years of age, please be aware that the law may provide your parents the right to examine your treatment records. It is my policy to request an oral agreement from parents to respect the confidentiality of your therapeutic disclosures. If parents agree, I will provide them only with general information about our work and progress. I will, however, notify parents if I feel there is a high risk that you will seriously harm yourself or someone else. Before giving parents information, I will first attempt to discuss this matter with you.

Consultation

Consultation is a standard, ethical, and accepted part of high quality mental health practice. Because I intend to provide you with the highest quality of care, I may periodically consult with other experienced licensed mental health professionals regarding your treatment. During a consultation, I share limited information and avoid revealing the identity of my patient. The consultant is also bound to keep the information confidential.

Medication, Referral, and Hospitalization

If medication is indicated as part of your treatment, you and I will discuss various referral options. I will refer you to one of the psychiatric consultants with whom I work.

If during the course of treatment a referral to specialist is necessary, I will collaborate with him/her to supplement or replace our therapeutic work as necessary.

In certain circumstances a higher level of care may be required. If this should become necessary, you and I will discuss the need for a hospital stay or admission to a residential treatment program.

YOUR SIGNATURE BELOW INDICATES THAT YOU HAVE READ THIS AGREEMENT AND AGREE TO ITS TERMS.

Client Signature_____ Date _____

If Client is a Minor, Guardian's Signature:_____
Date_____

Therapist Signature _____ Date_____