Introductory Letter & Informed Consent

Welcome to my practice. I look forward to the opportunity to work with you to address your concerns and help you meet your personal goals. This form reviews my practice business policies and offers information that answers many of the questions people ask when beginning therapy. Please feel free to ask me any additional questions that you may have or if you simply want clarification of any portion of this form. Your signature on this form reflects a formal agreement between us.

Included in this agreement is a review of your rights to confidentiality along with explanations of the Health Insurance Portability Act (HIPPA), a federal law that provides for privacy protection and patient rights regarding your Protected Health Information (PHI). Attached to this agreement form is the HIPPA Notice of Privacy Practices for use and disclosure of PHI for treatment, payment and healthcare operations. The notice also explains HIPPA and its application to your personal health information in greater detail.

Sessions

Individual counseling sessions are scheduled in advance and are usually 45 minutes in length. The duration and frequency of appointments vary depending on your circumstances and needs. I usually consider the first three sessions to be consultation sessions which serve as an initial evaluation of your concerns, history, goals and needs. By the end of this evaluation, I will provide you with impressions of how our work might proceed. You should also consider this information along with your own impressions and your comfort level with me, so together, we can decide whether I am the best person to provide services to meet your treatment goals.

Emergency Contact

If you need to reach me between sessions you may contact me at 973.865.9900. This is a confidential voicemail line. I check my messages often and return calls as soon as possible. In the event of a clinical emergency, please call 911 or go to your nearest hospital emergency room.

Insurance Reimbursement

If you plan to use out-of-network mental health coverage, please be aware that you (and not your insurance provider) are ultimately responsible for full payment of my fees. This means that you must pay my fee up front and collect reimbursement from your insurance provider. It is very important that you find out exactly what mental health services your insurance policy covers. I will work with you to make sure you have all the information you need to collect reimbursement.

Billing and Fees

My fee is based upon a 45 minute session. **I require payment at the time of service.** Once a month, I will provide you with a bill detailing the service provided and the total amount paid.

Confidentiality

I will make every effort to safeguard the privacy of information concerning our work together. All clinical records are protected from public viewing and access. Patient information will not be shared without written consent of the client. You should be aware that there are some additional legal and

ethical exceptions or limits to confidentiality and some situations in which I am permitted our required to disclose information without your consent our authorization. The following are the examples of the limits to your rights to confidentiality.

Judicial/Legal Proceedings

Health care professional are required by law to cooperate with and disclose court ordered information. Only the limited amount of information necessary to fulfill the law will be released.

If you have been referred by the court or an agency of the court, I may be required to provide information to them.

If you are involved in litigation and inform the court of our services, you may be waving your rights to keep your records private.

Duty to Warn and Protect

Health care professionals are required by law to report any intentions of harming others or self. Responsibilities may include contacting the client's family or authorities to protect the public or the client from harm.

Abuse

Health care professional are required by law to report legal and social service authorities any suspicion of abuse.

Insurance Companies

I do not participate in "in network" insurance panels. However, I do provide the necessary paperwork for you to submit to your insurance carrier for "out of network" reimbursement. This information may include diagnoses, type of service, dates and times of service, treatment plans, progress of therapy, and summaries of the entire clinical record. Only the minimal amount of information necessary will be released.

**You have the right to ask your clinician not to share certain information for counseling and payment reasons. Please inform me of that in writing.

**You have the right to revoke consent after signing it. Please let me know in writing and I shall honor your request. After you have read the above information if you have any questions please feel free to ask me.

**If you are a minor, specific details of your discussions will not be revealed without your permission unless it is decided that your safety is at risk. Parents and guardians will be informed generally of your progress if they inquire.

Appointment Time and Cancellation Policy

Your appointment time is reserved exclusively for you from week to week. Sessions begin promptly at our scheduled time. If you are late for a session it will end at our regularly scheduled time.

Session cancellations must be made at least 48 hours in advance to avoid being billed for the session. With advance notice, I will make every effort to reschedule your session for the same week to avoid a cancellation charge but I cannot guarantee availability in my schedule. If for some reason there is no available time, and our schedules do not permit a makeup session during that week, you will be charged for the original appointment. In the event I cancel a session, you will not be charged.

Thank you,

Dina Cagliostro LLC

Dina Cagliostro LLC Informed Consent for Treatment

I have read and received a copy of the above information and agree to abide by these guidelines. I hereby consent to my or my child's) treatment. If I am bringing a minor for treatment, I have the legal authority to consent to the minor's treatment and hereby do so consent. If the minor is 14 years old or older I understand that the minor will also need to sign this form.

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Client's Name (print) Date Signature

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Client's parent(s) or Guardian(s) Name (print) Date Signature

I have received the notice of informed consent and I have reviewed it.

Name____ **Date of Birth**________________

Signature____ **Date**_______________________

I acknowledge and have read the Financial Disclosure and agree to its terms. I understand my obligation that payment is due at the time of treatment unless other arrangements are made. I agree that parents, guardians or personal representative are responsible for all fees and services rendered for a treatment of a minor/child or to the patient for whom I have legal responsibility. I understand that filing a claim with my insurance company does not relieve me of my responsibility for the payment of all charges. I hereby authorize Dina Cagliostro LLC to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

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Client(s), Parents(s) or Guardians(s) Name (print) Date Signature

Consent for Release/Receipt of Information

I ___________________________, hereby give consent for Dina Cagliostro, LLC, to share/seek information with/from:

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Regarding: ____

______________________________ ______________________________
Parent Name Parent Signature

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Date