Thoughts & Emotions
MENTAL HEALTH THERAPY
7981 Eastern Avenue Suite C-5 Silver Spring MARYLAND 20910

ABOUT YOUR PARTICIPATION IN COUNSELING

I look forward to working with you and am eager to be of assistance whenever possible. The following includes information about what you may expect from treatment and my expectations of you during treatment. Please feel free to speak with me at any time regarding these materials or other questions you may have.

ABOUT ATTENDANCE:

Regular attendance in counseling sessions is very important. ***If you are unable to attend a scheduled session, please call to cancel 24 hours prior to the session taking place. All sessions that are not canceled in this manner will be billed 50% of the session fee.***

It is also very important that you arrive on time for meetings. A pattern of unexcused absences or tardiness can lead to your being terminated from counseling.

In the event of inclement weather you will be contacted if the session is to be rescheduled.

CONFIDENTIALITY

Information about you and your family will be confidential. Information will not be shared with others without the prior written consent of your family except in situations where there is a danger of injury to someone or as required by Maryland's Child Protection laws which require reporting any suspected child abuse, child sexual abuse and/or neglect to the local County Department of Social Services.

As appropriate I am also willing to provide reports to other professionals, a school, family doctor, etc. In these cases, written consent will need to be authorized by your family prior to the release of information. In order to respond to your request for such a report, you are asked to speak with me at least two weeks before the report is needed.

If you have been referred by Child Welfare Services, reports regarding attendance, participation and progress will be provided to your case manager midway through treatment and at the end of treatment.

Information given to a counselor during a private individual session will not be shared with other family members without informing the individual involved. On the other hand, information obtained during family sessions can be discussed at other times with various family members.

ABOUT RATES & INSURANCE:

Many health insurance plans do cover a portion of fees on a reimbursement basis. Please consult your specific plan for details. An itemized statement suitable for submission to your insurance plan, flexible spending account or health savings plan for your reimbursement from your plan is provided upon request. ***All payments are due prior to the beginning of each session.*** Cash, check, and all major credit cards are accepted for payment.

$197.00 per 45 minute session, free initial phone consultation

Phone sessions exceeding 10 minutes will be billed at $45.00 per every 10 minutes. Teletherapy sessions will be billed as regular sessions.

CONTACTING THE THERAPIST:

If you need to leave a message for me when the office is closed, you may call (703) 862-1087. All messages are kept confidential. Information about absences, illness, or requests for a call from me should be left in this manner.

ABOUT THERAPY & YOUR RIGHTS

The purpose and nature of an evaluation or treatment process is to allow you to reach your personal goals and also alleviate negative symptoms you may be experiencing due to any underlying mental health concerns.

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In this practice only individual, family and couples therapies are offered. You should be aware that group therapy could also be appropriate for you, in which case you would be referred out accordingly. The type of therapy that you decide upon is something that can be determined as a part of your treatment plan in collaboration with your therapist.

Teletherapy is offered and often used when there are scheduling conflicts, illness, or school closures. This is a beneficial feature that allows us to continue our work despite obstacles that may arise. Sessions are conducted on a HIPPA compliant platform.

There are times when email/text correspondence is necessary for sending information regarding sessions & treatment, if you would rather not communicate in this manner, please indicate this on the referral sheet so alternative plans can be made. By signing below you agree to this type of communication.

Potential reactions to the proposed treatment: Therapy can be an emotionally intensive experience, which over time will hopefully lead to an improvement in your life. Please feel free to discuss any concerns or reactions you may have during/after session with your therapist in order to ensure that you get the most out of treatment.

Your have the right to withdraw from treatment at any time. It is hoped that termination of treatment would be a planned process as you reach your goals of treatment. Despite this, there are times when individuals/families decide they are unable or unwilling to commit to therapy. There may be risks associated to your mental well being if this is the case. Specific concerns would be discussed on a case-by-case basis should you choose to withdraw from treatment. Additionally, clients have the right to decline treatment, if part or if the treatment is to be recorded for research or review by another person.

Your signatures are requested on this document to certify that you have received a copy of this form. Further, the certification indicates your decision to cooperate as best you can with the points discussed above. If you have any questions, please feel free to discuss them with your therapist.

CERTIFICATION

This is to certify that I/we,

_____ _____

Client's Name Client's Name

_____ _____ _____ _____

Client's Signature Date Client's Signature Date

_____ _____

Therapist Date

Have received a copy of this document and agree to participate as best I/we can, within the guidelines presented.