**Julie M. Paquette, LCSW**

**South Portland, ME 04106**

**235 Greenfield Rd**

**South Deerfield, MA 01373  
207-347-1844**

**413-522-5981**

**Informed Consent for Counseling**

This document contains important information about my professional services and business policies. It also contains summary information about the Health Insurance Portability and Accountability Act (HIPAA), a federal law that provides privacy protections and patient rights about the use and disclosure of your Protected Health Information (PHI) for the purposes of treatment, payment, and health care operations. Although these documents are long and sometimes complex, it is very important that you understand them. When you sign this document, it will also represent an agreement between us. We can discuss any questions you have when you sign them or at any time in the future.

**Welcome to my practice!** Therapy is a relationship between people that works in part because of clearly defined rights and responsibilities held by each person. As a client in psychotherapy, you and your child have certain rights and responsibilities that are important for you to understand. There are also legal limitations to those rights that you should be aware of. I, as your therapist, have corresponding responsibilities to you. These rights and responsibilities are described in the following sections.

**Your rights and responsibilities as a client**: You have the right to ask questions about anything that happens in therapy. While I may offer the tools for change, it is your responsibility to utilize those tools in the change process. I am always willing to discuss your direction of treatment. You can ask me about my training or experience and can request that I provide referrals if you decide I’m not the right therapist for you. You are free to end our therapeutic relationship at any time.

**Therapist qualifications:** I am Licensed Clinical Social Worker. I am licensed in the state of Maine and Massachusetts. I abide by the code of ethics and code of conduct put forth by the Maine Board of Social Workers. I am responsible for receiving more than 30 hours of additional trainings per year to retain my licensure.

**Risks and benefits:** Psychotherapy as both risks and benefits.It is the catalyst of the transformation process and may include changes in behavior, emotions and/or thoughts. You may experience interruptions in your normal patterns, and/or changes in your social relationships. The process of therapy can be a challenging one and yet facilitate the prospect of growth and healing as well as gaining new perspectives and insights. With regards to the counseling of children and their parents, I do not make decisions for children or their parents about whether to accept or reject any of the theories, methods, or suggestions I talk about in each session.

**Other forms of treatment:** I may provide you with therapeutic recommendations other than, or in addition to, therapy. These recommendations could include medical or psychiatric evaluation and testing, referral to another therapist from a different theoretical orientation, participation in group work or nutritional/exercise therapy.

**Confidentiality:** My policies about confidentiality, as well as other information about your privacy rights, are fully described in a separate document entitled Notice of Privacy Practices. You have been provided with a copy of that document and we have discussed those issues. Please remember that you may reopen the conversation at any time during our work together.

Under most circumstances, all information about you, in written or verbal form, obtained in the counseling process (including your identity as a client) is protected ethically and legally and will remain confidential. Any information shared will only be released to other parties with your written consent. There are some exceptions to confidentiality. These exceptions are listed below and I will inform you when I am bound by ethics or law to utilize one of them.

* Reporting suspected child abuse (including witnessing domestic violence), animals, elderly persons, or the developmentally disabled;
* Reporting imminent danger to client or others;
* Reporting information required in court proceedings or by client’s insurance company, or other relevant agencies;
* Providing information concerning licensee case consultation or supervision;
* Defending claims brought by client against licensee;
* Information provided for professional consultation.
* Information shared by a child under that age of 18 that may present a danger to the child or another child (i.e drug use, pornography, medication abuse, domestic violence, non-consensual sex, ect….).

As the client of a Licensed Clinical Social Worker you have the following rights:

* To expect that a Licensee has met the minimal qualifications of training and experience required by state law;
* To examine public records maintained by the Maine and Massachusetts Board of Licensed Clinical Social Workers’,and to have the Board confirm credentials of a Licensee;
* To obtain a copy of the Code of Ethics for Licensed Clinical Social Workers;
* To report complaints to the Maine or Massachusetts Board of Licensed Clinical Social Workers;
* To be informed of the cost of professional services before receiving the services;
* To be assured of privacy and confidentiality while receiving services as defined by rule and law, excluding the following exceptions:
* Freedom from discrimination on the basis of race, religion, gender, or other unlawful category while receiving services.

**Confidentiality Between Parents and Minors:**  
While privacy in therapy is crucial to successful progress, parental involvement can also be essential. It is my policy not to provide treatment to a child under age 13 unless s/he agrees that I can share whatever information I consider necessary with a parent. For children 14 and older, I request an agreement between the client and the parents allowing me to share general information about treatment progress and attendance, as well as a treatment summary upon completion of therapy. All other communication will require the child’s agreement, unless I feel there is a safety concern (see also above section on Confidentiality for exceptions), in which case I will make every effort to notify the child of my intention to disclose information ahead of time and make every effort to handle any objections that are raised.  (Adolescent Informed Consent form).

**Email and texting confidentiality:** Although email has become a major means of communication between individuals, internet communication has significant limitations. Please note the following guidelines for use of email as a form of communication with me.

* I do not provide personal counseling through e-mail
* I cannot guarantee that your email will remain confidential. I will keep your e-mail messages private, but I cannot ensure that experienced computer users/hackers will not have access to email, Therefore, confidentiality is not protected through e-mail.
* Absence from the office, a busy schedule, unexpected illness, or difficulty getting online may mean that several days go by before a message is received. Please call me to ensure communication.
* Texting has become a convenient way to communicate. Please be aware that the same confidentiality and therapy restrictions apply to texting as to e-mail. Texting will only be used for the purposes of scheduling and appointment reminders.

**Other Rights:**  
If you are unhappy with what is happening in therapy, I hope you will talk with me so that I can respond to your concerns. Such comments will be taken seriously and handled with care and respect. You may also request that I refer you to another therapist and are free to end therapy at any time. You have the right to considerate, safe and respectful care, without discrimination as to race, ethnicity, color, gender, sexual orientation, age, religion, national origin, or source of payment. You have the right to ask questions about any aspects of therapy and about my specific training and experience. You have the right to expect that I will not have social or sexual relationships with clients or with former clients.

**Ethics and grievances**: If you are dissatisfied with your therapy services, please inform me so we can come to some resolution. If you would like to file a formal complaint against me, please contact the State Board of Social Work Licensure.

**Professional Records:**  
I am required to keep appropriate records of the psychological services that I provide. Your child’s records are maintained in a secure location in the office. I keep brief records noting that you/your child was here, your reasons for seeking therapy, the goals and progress we set for treatment, your child’s diagnosis, topics we discussed, your child’s medical, social, and treatment history, records I receive from other providers, copies of records I send to others, and your child’s billing records. Except in unusual circumstances that involve danger to your child, you have the right to a copy of your file. Because these are professional records, they may be misinterpreted and / or upsetting to untrained readers.  For this reason, I recommend that you initially review them with me, or have them forwarded to another mental health professional to discuss the contents. If I refuse your request for access to your child’s records, you have a right to have my decision reviewed by another mental health professional, which I will discuss with you upon your request. You also have the right to request that a copy of your child’s files be made available to any other health care provider at your written request.

**Appointments**:  
Appointments will ordinarily be 45-50 minutes in duration, however, you and I will determine how many times per month we need to meet in order for therapy to be therapeutic and to meet treatment goals in a reasonable amount of time. The time scheduled for your child’s appointment is assigned to your child and any time you may need as a parent will need to be scheduled separately. It is common when working with children that some of the appointments may focus on parenting skills and parenting support.

**Fees:**

Sessions are $75-$125 (sliding scale) for 45-60 minute sessions. The standard fee for the initial intake is $125.00 and each subsequent session is between $75-$125 depending on the time of the session.  **You are responsible for payment at the time of your session, unless prior arrangements have been made.** Payment must be made by **check, cash or credit card**. Any checks returned to my office are subject to an additional fee of up to $25.00 to cover the bank fee that I incur. If you refuse to pay your debt, I reserve the right to use an attorney or collection agency to secure payment. Sliding scale fees are subject to increase at any time and the discount will be terminated if you miss two sessions without providing me 24 hour notice to cancelling the appointment.

**Cancellation and no-show policy:**

I understand that sometimes emergencies arise. If you need to cancel or reschedule a session, I ask that you provide me with 24 hour notice by leaving me a voice message or text. If you miss a session without canceling, or cancel with less than 24 hour notice, my policy is to collect the session fee for 50 minutes/$60.00 [unless we both agree that you were unable to cancel with prior notice due to circumstances beyond your control]. It is important to note that insurance companies do not provide reimbursement for cancelled sessions; thus, you will be responsible for the fee as described above. If it is possible, I will try to find another time to reschedule the appointment that week. In addition, you are responsible for coming to your session on time; if you are late, your appointment will still need to end on time.

**Other Fees and Services:**

In addition to therapy appointments, it is my practice to charge a prorated amount based on an hourly fee for other professional services that you may require such as report writing, telephone conversations that last longer than 15 minutes, attendance at meetings or consultations which you have requested, or the time required to perform any other service which you may request of me. These services are not reimbursed by your insurance coverage. If you anticipate becoming involved in a court case, I recommend that we discuss this fully before you waive your right to confidentiality. If your case requires my participation, you will be expected to pay for the professional time required even if another party compels me to testify.

**Insurance Coverage/Plans:**  
In order for us to set realistic treatment goals and priorities, it is important to evaluate what resources you have available to pay for your child’s treatment. If you have a health insurance policy, it will usually provide some coverage for mental health treatment. With your permission, my billing service and I will file claims and ascertain information about your coverage, but you are responsible for knowing your coverage and for letting me know if/when your coverage changes.

Due to the rising costs of health care, insurance benefits have increasingly become more complex. It is sometimes difficult to determine exactly how much mental health coverage is available. Managed Health Care plans such as HMOs and PPOs often require advance authorization, without which they may refuse to provide reimbursement for mental health services. These plans are often limited to short-term treatment approaches designed to work out specific problems that interfere with a person’s usual level of functioning. It may be necessary to seek approval for more therapy after a certain number of sessions. While a lot can be accomplished in short-term therapy, some patients feel that they need more services after insurance benefits end. Some managed-care plans will not allow me to provide services to you once your benefits end. If this is the case, I will do my best to find another provider who will help you continue your psychotherapy.

You should also be aware that most insurance companies require you to authorize me to provide them with a clinical diagnosis. (Diagnoses are technical terms that describe the nature of your problems and whether they are short-term or long-term problems.  All diagnoses come from a book entitled the DSM-IV. There is a copy in my office and I will be glad to let you see it to learn more about your diagnosis, if applicable.). Sometimes I have to provide additional clinical information such as treatment plans or summaries, or copies of the entire record (in rare cases). This information will become part of the insurance company files and will probably be stored in a computer. Though all insurance companies claim to keep such information confidential, I have no control over what they do with it once it is in their hands. In some cases, they may share the information with a national medical information databank. I will provide you with a copy of any report I submit, if you request it. By signing this Agreement, you agree that I can provide requested information to your carrier if you plan to pay with insurance.

In addition, if you plan to use your insurance, authorization from the insurance company may be required before they will cover therapy fees. Many policies leave a percentage of the fee (which is called co-insurance ) or a flat dollar amount (referred to as a co-payment) to be covered by the patient. Either amount is to be paid at the time of the visit by check, cash or credit card. In addition, some insurance companies also have a deductible, which is an out-of-pocket amount, that must be paid by the patient before the insurance companies are willing to begin paying any amount for services. This will typically mean that you will be responsible to pay for initial sessions with me until your deductible has been met; the deductible amount may also need to be met at the start of each calendar year. Once we have all of the information about your insurance coverage, we will discuss what we can reasonably expect to accomplish with the benefits that are available and what will happen if coverage ends before you feel ready to end your sessions. It is important to remember that you always have the right to pay for my services yourself to avoid the problems described above, unless prohibited by my provider contract.

**Contacting Me:**  
I am often not immediately available by telephone. I do not answer my phone when I am with clients or otherwise unavailable. At these times, you may leave a message on my confidential voice mail and your call will be returned as soon as possible, but it may take a day or two for non-urgent matters. If, for any number of unseen reasons, you do not hear from me or I am unable to reach you, and you feel you cannot wait for a return call or if you feel unable to keep yourself safe, please contact Crisis Services/Opportunity Alliance at 207-774-4357 or Toll-Free: 1(888) 568-1112, for Maine clients;

413-774-5411 for Massachusetts clients, or go to your Local Hospital Emergency Room, or call 911 and ask to speak to the mental health worker on call. I will make every attempt to inform you in advance of planned absences, and provide you with the name and phone number of the mental health professional covering my practice.

**Telephone confidentiality:** At times, I may telephone you for purposes such as appointments, cancellations or to give/receive information. In the effort to maintain confidentiality please list the telephone numbers I may contact you at/or leave a message at with my name to identify myself and appointment information on the number/s below.

(\_\_\_\_\_\_)\_\_\_\_\_\_\_\_\_- \_\_\_\_\_\_\_\_\_\_\_\_\_ You may leave a voice message? □ Yes □ No

(\_\_\_\_\_\_)\_\_\_\_\_\_\_\_\_- \_\_\_\_\_\_\_\_\_\_\_\_\_ You may leave a text message? □ Yes □ No

**Billing Policy**

By signing below, you authorize Julie M. Paquette, LCSW, to provide a diagnosis, treatment plan, and other identifying data, by fax, email, U.S. mail, or phone, to your insurance provider(s) for billing purposes and to Billing Process Services. You understand that you are financially responsible for services not collected from your insurance.

**Consent for treatment**

Your signature below indicates that you have read this Agreement and the Notice of Privacy Practices and agree to their terms and consent for treatment. You understand the limits to confidentiality required by law. You understand the fee to be paid per session and your rights and responsibilities as a client. You are free to end treatment at any time you wish.

Client Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date: \_\_\_\_\_\_\_\_\_

Client Printed Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Guardian Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_

Guardian Printed Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Therapist Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_

Therapist Printed Name: Julie M. Paquette, LCSW