REYNOLDS & RUBINO
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INFORMED CONSENT TO TREATMENT

Practice Policies and Procedures

Welcome to our practice. This document contains important information about our professional services and business policies. Please read it carefully and jot down any questions you might have so we can discuss them. When you sign this document, it will represent an agreement between us.

Psychotherapy

THE INITIAL CONSULTATION. The initial consultation (intake session) will last approximately 60 minutes, but can extend to additional sessions. Typically, during the first session, we will discuss your reasons for seeking treatment and basic background information about you. Policies, fees, and scheduling will also be discussed in this meeting. To the extent possible, I will offer you some first impressions of what our work will include. You should evaluate this information along with your own opinions to determine whether you feel comfortable working with me. Therapy involves a noteworthy commitment of time, money, and energy. You should be very thoughtful about the therapist you select. If you have questions or doubts about participating in therapy at the present time or specifically with me as your therapist, please talk to me about your concerns. I will be more than happy to help you set up a meeting with another mental health professional for a second opinion.

Psychotherapy can have benefits and risks. Engaging in therapy often involves discussing unpleasant aspects of your life. Therefore, you may experience uncomfortable feelings like frustration, sadness, guilt, anger, loneliness, and helplessness. On the other hand, psychotherapy may help you change your unhealthy or maladaptive thoughts and behaviors. Consequently, you may benefit by minimizing your overall distress, learning more effective problem-solving strategies, and experiencing more rewarding interpersonal relationships.

COUNSELING SESSIONS. Frequency of counseling sessions will be determined by the severity of your presenting symptoms, your treatment goals, and agreed upon treatment plan. Counseling sessions are generally scheduled once a week, and may be reduced in frequency as your progress in treatment. A given hour is considered blocked for a particular client; this hour is comprised of 45 to 50 minutes of psychotherapy and 10 to 15 minutes of administrative procedures (i.e., note-taking, phone calls, insurance claim submissions). Counseling sessions may be longer in duration depending on the services provided (for instance, Gottman Method Couples Counseling are generally 75 to 90 minutes in length and sessions involving exposure-response prevention are generally 90 minutes).

MEDICATIONS. Medications may be indicated when your mental symptoms are not responsive to psychotherapy alone. When a mental illness markedly impacts your ability to work, maintain interpersonal relationships, or properly care for your basic needs, medication may offer much needed relief. If it is agreed that medications are indicated, I will discuss with you all of the medication options that are available to treat your current condition. I will present information in language that you can understand. You will learn how the medication works, its dosage, and frequency, its expected benefits, possible side effects, drug interactions, and any withdrawal effects you may experience if you stop taking the medication abruptly. By the end of the discussion you will have all the information you need to make a rational decision as to which medication is right for you. Not everyone is a good candidate for medication therapy. Such therapy requires strict adherence to dosage, and frequency, close follow-up, and sometimes regular blood tests. Your ability to adhere to medication treatment will be taken into consideration in making the decision to start such therapy.

24-HOUR CANCELLATION POLICY. Once an appointment hour is scheduled, you will be expected to pay for it unless you provide 24 hours advance notice of cancellation. **Note that this fee is the out-of-pocket cost of the session, and not your copay amount. Insurance companies will not reimburse for missed appointments.**

LATENESS. If you arrive late for a scheduled appointment, only the remainder of the 45 to 50 minute session will be available. If I run late with a prior appointment for some reason, you will still receive the full 45 to 50 minutes. It is the office policy, that if you arrive 15 minutes late to your scheduled appointment, without notice, it will be considered a no-show and you will be responsible for the missed appointment fee.

INCLEMENT WEATHER AND CLOSURES. If there is inclement weather and/or if local schools are closed due to weather conditions, I will do my best to contact you via phone or email if I will not be in the office and may need to reschedule the appointment.

Fees

PSYCHOTHERAPY. Our rate for the 60 minute intake session for therapy is $175 to $200, depending on your service provider. Fees for psychotherapy services are $150 to $175 per 45 minute session and $175 to $200 per 60 minute session. The fee for an initial psychiatric evaluation is $350; follow up psychiatric appointments are $175 for medication management (15-30 minute session) and $200 for medication management with therapy (45-60 minute session).

PSYCHOLOGICAL TESTING. The rate for psychological testing varies and is prorated at $200 per hour. This fee covers the initial consultation, testing administration, analysis of results, and the feedback session. Psychological assessment reports are included in the charge for testing.

OTHER PROFESSIONAL SERVICES. In addition to weekly appointments, I charge the same hourly rate for other professional services you may need, though I will break down the hourly cost if I work for periods of less than one hour. Other services include report writing, telephone conversations lasting longer than a few minutes, consulting with other professionals (with your permission), preparation of records or treatment summaries, and the time spent performing any other service you may request of me. Typically, the charge for a letter is $50 due at time of request and the charge for a clinical report is $200 due at time of request. Photocopying of records is $35. Fees may increase periodically.

Forensic and Litigative Services

It is the stated philosophy of this practice that we do not participate in lawsuits of any type on a plaintiff's behalf, unless compelled to do so by subpoena or court order. If you become involved in legal proceedings that require my participation, you will be expected to pay for all of my professional time, including preparation, deposition, telephone time, transportation costs, court appearance, report writing, consultation and supervision, even if I am called to testify by another party. Because of the complexity of legal involvement, any court appearance or telephone contact with the court during a court case regarding the client or the client's family members in a civil or criminal matter will be charged at $2500 per day, paid two weeks in advance and non-refundable. Travel time will be billed at an hourly rate of $200 per hour, plus mileage portal to portal. Depositions will be charged at $200 per hour plus travel time, wait time, and transportation costs portal to portal. In the events that records or other materials are subpoenaed, a charge of 50 cents per page will be made for copying and file preparation.

Insurance

Most health insurance plans provide for some outpatient mental health benefits. I participate and am in-network for certain insurance providers. For other insurance companies, you may receive full or partial reimbursement according to guidelines they have established for out-of-network providers. I will fill out forms and provide you with whatever assistance I can in helping you receive the benefits to which you are entitled; however, **you (not the insurance company) are responsible for full payment of our fees.** It is very important that you find out exactly what mental health services your insurance policy covers. You should carefully read the section in your insurance coverage booklet that describes mental health services. If you have questions about the coverage, call your plan administration.

You should also be aware that most insurance companies require you to authorize me to provide them with a clinical diagnosis. 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. Though all insurance companies claim to keep such information confidential, I have no control over what they do with the information. I will

provide you with a copy of any report I submit, if you request it. It is important to remember that you always have the right to pay for services yourself to avoid problems described above.

Billing and Payments

PAYMENTS. Payment is due at the time of service, unless we agree otherwise. Cash, check, or credit cards are acceptable forms of payment. Payment schedules for other professional services will be agreed to when they are requested. A credit card is required to be kept on file to hold all scheduled appointment times. Missed sessions (including sessions cancelled within 24 hours) will be charged to the credit card on file.

CREDIT CARD AUTHORIZATION. Your signature authorizes Reynolds & Rubino Psychology Group, LLC to charge your credit card for late cancellations, missed appointments, and outstanding balances (over 30 days):

Payment method MASTERCARD VISA AMERICAN EXPRESS DISCOVER

Credit card number _____

Print name as it appears on credit card _____

Zip code_____ Security code_____ Expiration date _____/_____

Email address for receipts _____

Authorization signature _____ Date_____

By signing this agreement, you are confirming that you understand that it is your responsibility for full payment of our fees. Further you understand that we may submit your claims to your insurance company(ies), if applicable, for direct payment to Reynolds & Rubino Psychology Group and that if your insurance company does not cover 100% of your bills for services provided that it is your responsibility for full payment of our fees, not your insurance company's. Further, you confirm that you understand that it is your responsibility to:

- pay, at the time services are rendered, the agreed upon session fee, co-pay, co-insurance, deductible, or any other fees relating to services rendered that are denied or not fully covered by your insurance company(ies);
- provide current mailing address and phone numbers, as well as notification when there are any changes to this information.
- **confirm with your insurance company that the therapist is a participating provider under your specific insurance plan prior to your initial appointment;**
- provide appropriate and current insurance information and updates to ensure efficient billing and payment;
- obtain all necessary referrals or authorizations required prior to treatment

ASSIGNMENT OF BENEFITS. By signing this agreement, you authorize payment of all medical insurance benefits, which are payable under the terms of your insurance policy to be paid directly to Reynolds & Rubino Psychology Group for services rendered. You further authorize the release of any information needed for the purposes of treatment, payment and health care operations, including, but not limited to the processing of these insurance claims. A copy of this authorization may be used in place of the original. **You understand that you are financially responsible for charges not paid by your insurance company.**

DELINQUENT ACCOUNTS AND COLLECTIONS. You are responsible for payment of your therapy fees, regardless of whether or not they are covered by your insurance carrier. **Outstanding balances of more than 30 days will be charged to the credit card on file.** If your account has not been paid for more than 60 days and arrangements for payment have not been agreed upon, I have the option of using legal means to secure the payment. This may involve hiring a collection agency, and this could affect credit. You agree to the costs of any action necessary to collect your portion of the fee due, including court and attorney fees that might accrue. You will receive appropriate notice of efforts to obtain this debt. **There will be a $30 charge for the return of a check from the bank.**

Contacting Me & Emergencies

Because this is a limited private practice, I am often not immediately available by telephone. When I am unavailable, please leave a message on our voicemail. I monitor our voicemail frequently during the day on weekdays, and at least daily on weekends and holidays. I will make every effort to return your call within 24 hours, with the exception of weekends and holidays. If I will be unavailable for an extended time, such as for a scheduled vacation, I will provide you with the name of a colleague to contact if necessary.

EMERGENCIES. In the event of a psychiatric emergency, and you are unable to reach me, please call a local Mental Health Hotline or CALL 911 or go to the nearest Emergency Room of your nearest hospital and ask to be evaluated by the psychologist or psychiatrist on call. Mental Health Hotline numbers include 703-573-5679 (Fairfax County), 703-228-5160 (Arlington County), and 202-673-9300 (Washington, DC). For less urgent matters or for scheduling issues, please leave a message on my voicemail or by email. Email is not a secure, confidential form of communication and should not be used for discussion of clinical issues or for urgent communications.

Professional Records

The laws and standards of my profession require that I keep treatment records. You are entitled to receive a copy of your records unless I believe that you seeing them would be emotionally damaging, in which case I will be happy to send them to a mental health professional of your choice. Alternatively, I can prepare a summary for you instead. Because these are professional records, they can be misinterpreted by and/or upsetting to untrained readers. If you wish to see your records, I recommend you review them in my presence so that we can discuss the contents. Clients will be charged a fee for any professional time spent in responding to information requests.

Minors

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 that I will provide parents only with general information about our work together, unless I feel there is a high risk that you will seriously harm yourself or someone else. In this case, I will notify them of my concerns. I will also provide them with a summary of your treatment when it is complete. Before giving them any information, I will discuss the matter with you, if possible, and do my best to handle any objections you may have about it.

Confidentiality

In general, the law protects the privacy of all communications between a client and a therapist/psychologist/psychiatrist, and I can release information about our work to others only with your written permission. All aspects of your treatment are confidential, and I will need your written permission if you wish me to discuss your treatment with anyone else, including your insurance company. Even the fact that you are a client in my practice is protected by confidentiality. However, there are some situations in which I am legally obligated to take action to protect others from harm, even if I have to reveal some information about a client's treatment. For example, if I believe that a child, elderly, or disabled person is being abused, I am required to file a report with the appropriate state agency. If I believe that a client is threatening serious bodily harm to another, 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. If the client threatens to harm himself or herself, I may be obligated to seek hospitalization for him or her or to contact family members or others who can help provide protection. I will make every effort to fully discuss it with you before taking any action.

In most legal proceedings, you have the right to prevent me from providing any information about your treatment. In some proceedings involving child custody and those in which your emotional condition is an important issue, a judge may order my testimony if he or she determines that the issues demand it.

I may occasionally find it helpful to engage in professional consultation with another professional regarding some aspect of a client's treatment. During a consultation, I make every effort to avoid revealing any identifying information about my client. The consultant is also legally bound to keep the information confidential.

While this written summary of exceptions to confidentiality should prove helpful in informing you about potential issues, it is important that we discuss any questions or concerns you have. I will be happy to discuss these issues with you, but if you need formal legal advice please consult an attorney.

Ending Therapy

My goal is to provide a quality service in the shortest period of time that is necessary for you to derive benefit from the therapy. You have the right to withdraw from treatment for any reason at any time. I ask that you agree to have a final session after you notify me of your voluntary termination of treatment, so that I may responsibly review and evaluate your reasons, and make recommendations related to the termination of treatment.

Severability

If any of the provisions of the Agreement shall be held to be invalid or unenforceable, all other provisions shall nevertheless continue in full force and effect. The Agreement shall be interpreted in accordance with and controlled by the laws of the State of Virginia in effect at the time of the execution of this Agreement.

HIPAA NOTICE OF PRIVACY PRACTICES ACKNOWLEDGMENT:

_____ *(Initial)* I HAVE REVIEWED AND BEEN PROVIDED A COPY OF THE HIPAA NOTICE OF PRIVACY PRACTICES. I HAVE BEEN GIVEN THE OPPORTUNITY TO ASK QUESTIONS ABOUT THESE POLICIES, AND I UNDERSTAND THAT I MAY ASK QUESTIONS ABOUT THEM AT ANY TIME IN THE FUTURE. I CONSENT TO ACCEPT THESE POLICIES AS A CONDITION OF RECEIVING MENTAL HEALTH SERVICES.

INFORMED CONSENT TO TREATMENT:

I HAVE READ, UNDERSTOOD, AND HAD OPPORTUNITY TO QUESTION, AND I AGREE TO THE ABOVE CONDITIONS AND POLICIES. I AGREE AND CONSENT TO PARTICIPATE IN BEHAVIORAL HEALTH CARE SERVICES OFFERED AND PROVIDED AT REYNOLDS & RUBINO PSYCHOLOGY GROUP. IF THE PATIENT IS UNDER THE AGE OF EIGHTEEN OR UNABLE TO CONSENT TO TREATMENT, I ATTEST THAT I HAVE LEGAL CUSTODY OF THIS INDIVIDUAL AND AM AUTHORIZED TO INITIATE AND CONSENT FOR TREATMENT AND/OR LEGALLY AUTHORIZED TO INITIATE AND CONSENT TO TREATMENT ON BEHALF OF THIS INDIVIDUAL.

I ALSO PERMIT THE USE OF A COPY OF THIS SIGNED AUTHORIZATION IN PLACE OF THE ORIGINAL.

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Signature of Client / Legal Representative | Print Name of Client / Legal Representative | Date Signed

_____ _____

Client's Date of Birth | Relationship to Client

_____

Signature of Therapist/Psychiatrist | Print Name of Therapist/Psychiatrist | Date Signed