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WELCOME/INFORMED CONSENT

Welcome! This document contains important information about my professional services and business policies. Please read this information and raise any questions or concerns you might have with me. When you sign this document, it will represent an agreement between us.

The decision to begin therapy takes courage and commitment. I look forward to getting to know you and hope our work together will be rewarding. I provide a safe and nurturing environment in which to explore options, and also offer the respect, understanding and empathy that encourages exploration and growth. As an experienced therapist, I will be here to accompany and collaborate with you on your unique journey. You have taken the first step toward change already! As we start on this journey ahead there are a few things to consider and some nuts and bolts to know.

SCHEDULING/CANCELLATION AND PAYMENT POLICIES

- Weekly appointments are recommended in the beginning of treatment for there to be the most potential for treatment success. Appointments are 45-50 minutes in length, unless another agreement is arranged. This leaves approximately 10 minutes for billing and documentation.
- Payments and/or Co-pays are due at the time of each visit and can be made with cash, check or credit card. Please be prepared to take care of payment at the beginning of the session to make the most of your therapy time. We may discuss challenging material and you may be more comfortable leaving directly when the session is over.
- **24 hour notice is required to cancel or reschedule a session unless there is an emergency situation or contagious illness.** If you need to cancel in less than 24 hours and another time can be arranged within the same week you will not be charged. When you schedule an appointment, I commit to reserve that time for you. This affects how many other clients I can take on. **Missed appointments and late cancellations will be charged the full fee or contracted amount of the visit_____. Please note that insurance companies do not pay for this it is your responsibility.**
- If you are running late for your appointment, please phone or email me as soon as you can to let me know you will be late. If you are late for your session, we will still end at our regular time so that I have time to prepare for my next appointments and I can be on time for them.

CONTACTING ME: I check my messages at least every 24 hours. If you need to contact me, please leave a message on my voice mail with your phone number and some good times to reach you, and I will return your call as soon as possible. If I am unavailable for an extended period of time, such as away on a

vacation, I will provide you with the name of a colleague to contact, if necessary. If you are in crisis or have a psychiatric emergency, you should call 911, go to the nearest hospital, or call Psychiatric Emergency Services at 707-576-8181.

CONFIDENTIALITY

All information disclosed within sessions and the written records pertaining to those sessions are confidential and may not be revealed to anyone without your written permission except where disclosure is required by law.

Legal Exceptions to Confidentiality There are legal exceptions to confidentiality that you must know about:

1. Safety emergencies (self-harm/suicide, harm to others/homicide): In the event you pose a threat to your own safety or the safety of another identified person, it is required to take protective action, which may include breaching confidentiality (e.g., notifying law enforcement, warning others) in order to protect you or the intended victim. In general, every effort to enlist your cooperation in these circumstances will be considered.

2. Mandated reporting of child abuse: Therapists are mandated reporters. As a mandated reporter, it is required by law to report to the appropriate authorities (e.g., Child Protective Services, law enforcement) any reasonable suspicion of child abuse (i.e., sexual abuse, physical abuse, emotional abuse, neglect, and exploitation). Child sexual exploitation includes knowledge about an adult accessing pornography involving minors.

3. Mandated reporting of elder & dependent adult abuse: As a mandated reporter, it is required by law to report to the appropriate authorities (e.g., Adult Protective Services, law enforcement) any reasonable suspicion of elder and dependent adult abuse.

4. Court related or legal matters: Disclosure may be required in a legal proceeding. If you place your mental status at issue in litigation, the opposing attorney may have the right to obtain your psychotherapy records and/or my testimony.

THE PROCESS OF THERAPY/EVALUATION AND SCOPE OF PRACTICE:

Participation in therapy can result in a number of benefits to you, including improving interpersonal relationships and resolution of the specific concerns that led you to seek therapy. Working toward these benefits, however, requires effort on your part. Psychotherapy requires your active involvement, honesty, and openness in order to change your thoughts, feelings, and/or behavior. Sometimes more than one approach can be helpful in dealing with a certain situation. During evaluation or therapy, remembering or talking about unpleasant events, feelings, or thoughts can result in you experiencing considerable discomfort or strong feelings of anger, sadness, worry, fear, etc., or experiencing anxiety, depression, insomnia, etc. Some of your assumptions or perceptions may be challenged and I may propose different ways of looking at, thinking about, or handling situations. Psychotherapy may result in decisions about changing behaviors, employment, substance use, schooling, housing, or relationships. Change will sometimes be easy and swift, but more often it will be slow and even frustrating. There is no guarantee

that psychotherapy will yield positive or intended results however together hopefully we can achieve them.

TERMINATION: As set forth above, after the first couple of meetings, I will assess if I can be of benefit to you. If I believe that I may not be the best person to help you I will provide you with appropriate referrals. You have the right to terminate therapy and communication at any time. It is recommended that you bring up any concerns about your care or progress before terminating.

MINORS IN THERAPY

If you are under eighteen years of age, please be aware that the law may give your parents or guardians the right to obtain information about your treatment and/or examine your treatment records. I will provide them with general information about our work together subject to your approval, or, if I feel it is important for them to know in order to make sure that you and people around you are safe. If I think it is appropriate, I will involve them if I feel that there is a high risk that you will seriously harm yourself or another/others. Before giving them any verbal or written information, I will discuss the matter with you, if possible. I will do the best I can to resolve any differences that you and I may have about what I am prepared to discuss.

If your child is an adolescent, it is possible that he/she will reveal sensitive information regarding sexual contact, alcohol and drug use, or other potentially problematic behaviors. Sometimes these behaviors are within the range of normal adolescent experimentation, but at other times they may require parental intervention. We must carefully and directly discuss your feelings and opinions regarding acceptable behavior. If I ever believe that your child is at serious risk of harming him/herself or another, I will inform you.

Insurance Reimbursement Insurance payment can be accepted two ways:

1. As an Out-of-Network Provider: Some insurance plans, particularly PPOs, provide out-of-network benefits to members. This means that your insurance provider will pay for services provided by a clinician who is not on their network panel. In this case, we will bill you directly at the standard fee and provide you with a monthly written receipt (called a "Super Bill") that you may use to seek reimbursement from your insurance provider. If you have health insurance and hope to be reimbursed, it is important that you find out exactly what services your policy covers for "out-of-network providers."

2. As an In-Network Provider: If you decide to use your mental health (sometimes called "behavioral health") insurance benefit for psychotherapy, please be aware of the following:

a. Typically, insurance carriers require clinicians to provide a diagnosis, information regarding symptoms associated with that diagnosis, and how therapy will address those symptoms to insurance carriers.

b. You are responsible for verifying and understanding the limits of your insurance coverage, as well as any copayments, coinsurance, or deductibles.

c. You are responsible for any and all fees not reimbursed by the insurance plan.

d. As a contracted, in-network provider on your insurance plan, I have agreed to a specified fee for our services and will bill the plan on your behalf.

e. You must pay all copayments, coinsurance, or deductibles, if applicable, at the time of service, unless otherwise arranged.

f. Your insurance carrier will not pay for sessions missed or cancelled within 24 hours (see Cancellation Policy). You are therefore responsible for paying the contracted fee we would normally collect from your insurance carrier plus any part you normally pay (i.e., copayments or coinsurance).

g. By signing the Informed Consent Signature Page below, you authorize your therapist to release information (including identifying and diagnostic information) needed to authorize sessions, process claims, request additional sessions, or satisfy the insurance provider's quality review.

h. By signing the Informed Consent Signature Page below, you authorize insurance payments to be made to Dr. Scaliatine.

Informed Consent

Your signature below indicates you have read and understood the above information in the Practice Policies & Informed Consent form and agree to its terms.

Client's printed name_____

Client's signature_____ Date_____

Client's printed name_____

Client's signature_____ Date_____

Parent/Guardian_____ Date_____