KRISTA H. SAND, LICSW, LADC-I| 13 Bowdoin Street Suite 1A/B | Boston, MA 02114 | 603.988.6486

OFFICE POLICIES AND CONSENT TO TREATMENT AGREEMENT

These policies have been established to make psychological services as effective as possible, to minimize the possibility of any misunderstanding, and to comply with certain legal requirements. Please read this thoroughly, and discuss any questions with me.

License and Code of Ethics

I am a Massachusetts Licensed Independent Clinical Social Worker (LICSW) governed by the National Association of Social Workers.

Qualifications and Scope of Practice

I am Master of Social Work and have a master's degree in social work, otherwise known as an MSW. My practice is a general mental health practice that includes psychotherapy, supervision, consultation and assessments with adolescents, adults, and groups. I also consult with agencies, organizations, and other professionals on mental health matters.

Patients' Rights

A copy of the Mental Health Bill of Rights is available upon request.

Confidentiality

Nature and Limits:

Communication between you and me, as your psychotherapist, is confidential, and will not be revealed to any other person or agency without your permission, unless under certain special circumstances. In order to obtain your permission to release confidential information, I will ask for your permission in writing to release information to a specified person or agency. That permission will have a time limit, and you may revoke permission at any time by making a request in writing.

Recognizing the benefit of second opinions, I may occasionally consult with a colleague about my work, always protecting the identities of my clients.

There are also certain situations in which I would be legally or ethically required to reveal information obtained during therapy to other persons and/or agencies without your permission. These situations are as follows: 1) If you communicate "a serious threat of physical violence against a clearly identified or reasonably identifiable victim or victims" or property, I am required by law to warn the intended victim(s) or the police, or to obtain civil commitment of you to the state mental health system; 2) If you indicate a danger of hurting yourself and refuse to accept further appropriate treatment, I may call your family, agencies, or other individuals who, in my opinion, would assist in protecting your safety; 3) If I have any reason to suspect that a child or incapacitated adult has been abused or neglected, I am required to report this to the appropriate state authority; 4) If I am aware of the existence of certain occupationally related illnesses, communicable diseases, or critical health problems, I must report this to the appropriate state agency. The law prohibits me, except under very limited circumstances, to disclose the identity of a person tested for the HIV virus; 5) If you are involved in a civil commitment proceeding, in pursuing a personal injury action, or in filing a workers' compensation claim, or if my conduct is being reviewed by licensing authorities, your privileged communication may be waived; 6) If I am issued a court order to provide information, I will be required to comply with that order; 7) If you have a serious or chronic mental illness, a person living with or providing care to you may be provided information concerning diagnosis, admission to or discharge from a treatment facility, functional assessment, prescribed

medications and manifestations of the failure to take medications, treatment plans and goals, and behavior management strategies; 8) If you are subject to an involuntary emergency psychiatric admission, I might be required to provide information essential to your care; 9) If your treatment is related to an injury from a gunshot wound or other serious injury suspected to be caused by a criminal act, I might be required to inform a law enforcement official.

Third Party Billing:

If you give me permission to bill a third party for my services, I will release information to that party necessary for the processing of that claim. If you choose to use your insurance services, most insurance agreements require you to authorize me to provide a clinical diagnosis, and sometimes additional clinical information such as a treatment plan or goals, or a summary, or copies of reports, or in some cases, a copy of the entire record. This information will become a part of the insurance company files and some of it will probably be computerized.

Electronic Communications:

Sometimes information might be exchanged between myself, my clients or other entities that is transmitted electronically, such as in the form of faxes, emails or electronic billing information. I will make every effort to safeguard the confidentiality of this information. Information that is sent by me will only contain the minimal necessary information to accomplish its purpose. Information that is received by me will be placed in your chart. Since computers can maintain information on their hard drives even when files have been deleted, and since I have no control over the way in which other persons or organizations use or store the information that they send to or receive from me, I cannot guarantee the confidentiality of this information. If you do not consent to electronic communications, please inform me immediately, before beginning treatment, so I can determine how to proceed.

Length of Appointments

Appointments are 45 minutes long. Forty five minutes are available for your appointment from the scheduled start your appointment time. At times I may elect to extend the length of the appointment if necessary. I am normally available to you during our scheduled appointment times. Communication outside of our scheduled appointments is generally limited to logistical or scheduling matters.

Recommended Treatment

After an initial evaluation, I will discuss with you my clinical impressions and recommendations for treatment, and decide with you which services are appropriate.

Length of Treatment:

The length of treatment varies according to the needs of each individual client. In many instances, a client's goals can be accomplished with short-term treatment. In other situations, it may be desired by the client or recommended by me, that treatment proceed over a longer period of time.

It is important to understand the limits of your insurance coverage and/or your own financial resources so you can make an informed decision about the affordability of treatment. Many reimbursement plans are oriented towards a short-term treatment approach, which is often appropriate. However, if a length of treatment is desired by you that is longer than your insurance company approves, it is important to understand what your financial obligations will be.

Benefits and Risks:

Obtaining psychological services, such as counseling or psychotherapy, can have benefits and risks.

Since participation in these services often involve discussing unpleasant aspects of your life, you might experience uncomfortable feelings like sadness, anger, guilt, anxiety, anger, frustration, loneliness and helplessness. On the other hand, obtaining psychological services has also been shown to have benefits for people. It can lead to better understanding of oneself, better relationships, solutions to specific problems, and significant reductions in feelings of distress.

Records

Maintenance of Records:

I maintain a file for each client. The file includes information related to intake, diagnosis, treatment plan, billing, consent to treatment, treatment notes and any other written or electronic information I received from or about the client. Treatment notes include the date of each session and might include information about facts or issues discussed, and treatment recommendations. By law the client is entitled to a copy of the records for a fee, which covers copying and administrative costs. The client can also see a copy of the records. If you wish to review a copy of your record, I recommend that you review it with me so we can discuss its contents.

Release of Records:

I am able to release your records, or any part of them, with your written permission, provided you pay for any reasonable copying or administrative costs in advance.

Minors:

The treatment of a minor must be authorized by a parent or guardian (with limited exceptions). In the treatment of minors, parents (even non-custodial parents) have the right to access and authorize release of information. In order for me to be effective in working with a minor, however, the minor needs to have some degree of privacy in order to trust me and to talk about their most important concerns.

Therefore, if you are a parent of a minor who is receiving services from me, you agree that the information that I reveal to you about the minor will be limited to information necessary to preserve the safety of the minor and others, and information that, in my opinion, will help you to be helpful to the minor in the context of your relationship with him or her. Parents or guardians do have the right to *general* information, such as information on how the therapy is going.

Group Therapy:

Unlike individual treatment, group therapy is not protected by law. Client concerns about confidentiality should be discussed prior to beginning treatment.

Professional Boundaries and Sexual Misconduct

Licensed psychotherapists are obligated to establish and maintain appropriate professional boundaries (relationships) with present and past clients and their family members.

Sexual relations by a mental health professional with a client or a former client is considered sexual misconduct and is subject to disciplinary action. According to the ACA Ethics Code, for the purposes of determining sexual misconduct, a former client is a person who was provided psychotherapy within the previous five years of the beginning of a sexual relationship.

Billing and Insurance Coverage

Fees:

My billing rate is $175 for individual therapy per 45 minute session for standard psychotherapy and related work. My billing rate is $200 for the initial intake appointment. Related work includes, but is not limited to, telephone consultations, my attendance at meetings on your behalf, with your consent, including

travel time, review of records or files and the preparation and writing of reports. In cases of unusual financial hardship, I may be willing to negotiate a reduction in fee or an installment payment plan. Payment for services is due at the time of service or, in the case of related work, upon the receipt of a bill for my services. At times, I require pre-payment for my services.

Statements and Payment:

You will be provided with a monthly statement of your account. All outstanding balances are due upon receipt of the statement, unless another arrangement has been agreed upon. For checks that are returned to me for insufficient funds, you will be assessed all related bank fees.

Unpaid Balances:

If you are having some difficulty making payment because of your financial situation, it is important to let me know immediately so we can work out some plan or timetable for payment that will be manageable for you. As long as you communicate with me about your situation I am confident that we can work out a reasonable arrangement for payment.

If your account is more than sixty (60) days in arrears, and suitable arrangements for payment have not been agreed to, I reserve the option of referring your account to a collection agency or an attorney to pursue collection of the unpaid balance. If such action is necessary, the costs of bringing that action or securing that collection will be billed to you, which will be in addition to the balance due. Alternatively I reserve the right to charge the credit card on file in the event your account is more than 60 days overdue. Using a credit card to pay for therapy services may incur an additional fee by the card reader company. Currently that fee is 3.5% plus $0.15 for the total amount due however the fee amount may change without notice.

If an outstanding balance remains in your account after you have left therapy, I will make a reasonable effort to contact you, usually by email or phone, to arrange payment. If you are unable to pay your balance in full at that time, I will be happy to work out a payment plan with you at your request. However, if after reasonable efforts to collect from you have failed, I reserve the option of charging the credit card on file, referring your account to a collection agency or an attorney to pursue collection of the unpaid balance and to bill you for the costs of bringing that action or securing payment.

Missed Appointments

Appointment times are reserved for you to the exclusion of anyone else. If you cancel or miss your appointment time, for any reason, you will be billed directly for my full fee, not the fee that I might have contracted for with your insurance company, which only pertains to services which I provide that is covered by the insurance company. This fee cannot be billed to your insurance or other third parties. Your signature indicates your agreement with this policy.

Charging for missed appointments is not intended to be punitive and I understand that emergencies and illness occur unexpectedly. My income depends on my being able to use my available time.

I try to be as flexible as possible with this policy and, therefore, there are certain exceptions. You will not be charged for a missed appointment in the following circumstances: 1) If you cancel your appointment and we can reschedule your appointment during the same calendar week, 2) If you cancel with 24 hours notice or 3) If, using reasonable judgment, you feel it is unsafe to travel due to weather. Generally speaking, if the MBTA is running, I consider my practice to be open and consider it to be safe to travel around the area.

Complaints and Privacy Inquiries

Reports of professional misconduct should be directed to the Division of Professional Licensure, Office of Investigations, 239 Causeway St., Suite 500, Boston, MA, 02114, 617-727-7406.

_____Please Print your name

CONSENT TO TREATMENT

I have received and read, and understand and agree to, the OFFICE POLICIES AND CONSENT TO TREATMENT AGREEMENT of Krista H. Sand, LICSW, LADC-I and have had the opportunity to ask questions, and agree to receive her services. I consent to my protected health information (PHI) being used by Krista H. Sand, LICSW, LADC-I to provide psychological services to obtain payment for those services, and to maintain health care operations.

_____Signature of client

_____ Date

_____Signature of Parent or Guardian

_____ Date