Dr. Ruthie Norman LICSW LLC
Trauma Treatment & Recovery Psychological Services

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DISCLOSURE STATEMENT & AGREEMENT FOR SERVICES CONTRACT

Welcome to my practice! You are taking a valuable step towards mental health healing. Please take a few moments to read and complete this document, which contains and describes important information about my professional therapeutic services and business policies. This document will serve as your agreement for personal treatment or, if appropriate, treatment for your child. When you sign this document, it will represent an agreement between us. Please ask any questions you may have.

CONTACT

Please feel free to reach me through phone at 413-668-2282.
I am also available by email: TTRPS@DRRUTHIENORMAN.COM, or through web services at WWW.DRRUTHIENORMAN.COM. When I am not available, my telephone is answered by an answering service voice mail that I do monitor frequently. All messages will be returned promptly if urgent. If an emergency, please state this clearly in the voicemail.I will make every effort to return your call in a timely manner. If you are unable to reach me or feel that you can't wait for me to return your call, contact local crisis at 413-733-6661, or dial 911. Additionally, if you feel you require immediate attention and can safely get to your local emergency room, ask for mental health crisis services.

THERAPEUTIC SERVICES

My approach to therapy is goal-directed, which means your counseling sessions will be designed to help you overcome your current challenges and reach your goals. I may use many different methods to treat the problems that you hope to address. However, psychotherapy is not like a medical doctor visit. It calls for a very active effort on your part. In order for therapy to be most successful, you will have to work on things we talk about both during our sessions and at home.

Change and growth involve taking risks. In deciding if now is the right time for you to pursue personal counseling, you will want to be aware of both the risks and benefits of therapy. Being aware of our true feelings can sometimes, for a time, result in uncomfortable levels of sadness, fear, anger, and related emotions. While being supported in counseling, you may choose to recall and to think in some detail about difficult moments from your past. Such remembering can be emotionally difficult. Also, clients in therapy can have increased problems with people important to them. People we care about may not be comfortable with new choices we make. The phrase that “sometimes things have to get worse before they get better” can be true in therapy. This can leave a client feeling that problems have actually increased after beginning treatment. Most of these risks are to be expected when people are making any important changes, particularly when we are pursuing healing and growth in critical areas of our lives. A final risk is simply that you would spend your time and money in counseling and not see improvement. The best protection against this risk is to talk directly with me if therapy is, in any way, not meeting your goals. Such directness is welcomed by me and may be critical for you to get the benefits you want from our time together.

While you consider these risks, you should also know that the benefits of therapy have been documented in numerous carefully designed research studies. However, therapy has also been shown to

have benefits for people who go through it. The benefits of reaching your goals can lead to improved relationships, solved problems and stable mental health. But there are no guarantees of what you will experience.Therapy can help people better manage difficult feelings such as sadness or anger. Fearful and anxious feelings can be significantly lessened and better controlled. Being in counseling also gives you the chance to talk things out fully in a setting that is confidential and respectful. Clients in therapy may grow in many directions. You can gain greater clarity about your personal goals and values; you may receive more satisfaction from social and family relationships; you may find yourself more able to simply enjoy being alive. I don't take on clients I don't think I can help. Therefore, I enter our therapeutic relationship with optimism about your progress.

Our first few sessions will involve an evaluation of your needs. By the end of this period, I will be able to offer you some first impressions and should you choose to continue with therapy we will develop a treatment plan together. Successful therapy involves a large commitment of your time so you should be very careful about the therapist you select. Whenever you have questions or concerns we will discuss them whenever they arise. If you have persistent doubts, I will be happy to make a referral with other mental health professional for a second opinion.

Most therapy relationships end when the client's goals are achieved. However, there could be circumstances in which you or I will end the relationship regardless of the other's preferences. You are free to end therapy at any time for any reason. If your plan is to end before meeting your goals, a final session can be scheduled to review your progress and discuss any referrals that might be beneficial to you. I reserve the right to end our therapeutic relationship if any policies and procedures stated in this agreement are not abided by.

ATTENDANCE POLICY

Once psychotherapy has begun we will initially meet weekly for a 50 minute session, although sometimes sessions will be longer or more frequent. Once an appointment time has been agreed upon and scheduled, you will be expected to attend and responsible for payment of it unless you cancel with at least 24 hrs notice [unless we both agree that you were unable to attend due to circumstances beyond your control]. If you do not cancel an appointment with at least 24 hours notice, or do not cancel your appointment at all, it is considered a no show. No shows may be subject to a $25.00 missed appointment fee if applicable. In such event, an invoice will be mailed to you and payment is due in a timely manner. In order to receive the greatest therapeutic benefit, it is important that you attend your appointments as scheduled. If you are late for your appointment, you will have the remaining time allotted for the meeting unless I am otherwise able to extend our meeting past the original appointment time. If you need to reschedule, please contact me as soon as possible so that I can attempt to find another time to reschedule the appointment but cannot make any guarantees. Please use the office phone line or e-mail to cancel sessions.
Chronic attendance concerns or 3 or more no shows of scheduled appointments may result in a closing of your case at this office.

INSURANCE REIMBURSEMENT

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 treatment. If you have a health insurance policy, it will usually provide some coverage for mental health treatment. 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 your insurance company) are responsible for full payment of my 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 administrator. I will provide you with whatever information I can based on my experience and will be happy to help you in understanding the information you receive from your insurance company. If it is necessary to clear confusion, I will be willing to call the company on your behalf.

FEES AND PAYMENT

If you are not utilizing health insurance benefits to pay for services, my hourly fee is $140. In addition to weekly appointments, for other professional services you may need, my hourly fee is broken down into 10 minute increments. Other services can include report writing, telephone conversations, attendance at meetings, and the time spent performing any other service you may request of me.
You will be expected to pay for each session at the time it is held, unless we agree otherwise or unless you have insurance coverage which requires another arrangement. Payment schedules for other professional services will be agreed to when they are requested. In proven circumstances of extreme financial hardship, I may be willing to negotiate a fee adjustment or create a payment installment plan. If your account has not been paid for more than 60 days and arrangements for payment have not been agreed upon, you may be liable for a late charge of $25. Additionally, the option of using legal means to secure the payment may become necessary. This may involve a collection agency or going through small claims court. If such legal action is necessary, its costs will be included in the claim. In most collection situations, the only information I release regarding a patient's treatment is his/her name, the nature of services provided, and the amount due.

COURT OR LEGAL INVOLVEMENT

If you become involved in legal proceedings that require my participation, you will be expected to pay my hourly rate of 140.00$ for my professional time. Dr. Ruthie Norman, LICSW, LLC involvement in court or legal matters will be strictly limited to that which will benefit my client/ your child. This means, among other things, that you are to not attempt to gain advantage in any legal proceeding from my treatment. In particular, you agree that in any such proceedings, Dr. Ruthie Norman, LICSW, LLC, will not be asked to testify in court, whether in person, or by affidavit. Additionally, you agree to inform your attorney of the above agreements made, and agree to not subpoena Dr. Ruthie Norman, LICSW, LLC or to refer in any court filing.

Note that such agreement may not prevent a judge from requiring my testimony, despite Dr.Ruthie Norman, LICSW, LLC attempts to prevent such an event. If I am required to testify, I am ethically bound not to give opinions about either parent’s custody or visitation suitability. If the court appoints a custody evaluator, guardian ad litem, or parenting coordinator, Dr. Ruthie Norman, LICSW, LLC will provide information as needed (if appropriate releases are signed or a court order is provided), but will not make any recommendation about the final decision. Furthermore, if I am demanded to appear in court, the party responsible for my participation agrees to pay for court preparations and agrees to pay my current rate of $140.00 per hour for time spent traveling, preparing reports, testifying, attendance and any other case-related costs. These expenses are not refundable.

The laws and standards of my profession require that I keep treatment records. You are entitled to receive a copy of your records. Because these are professional records, they can be misinterpreted and/or upsetting to untrained readers. If you wish to see your records, I recommend that you review

them in my presence so that we can discuss the contents. I am also willing to conduct a review meeting without charge.

CONFIDENTIALITY

Confidentiality is maintained as a part of the counseling process in accordance with the ethical standards set forth by my profession and applicable law. All communication between client and therapist is kept strictly private and confidential. No one other than your therapist may have access to this information without your WRITTEN permission, with the exception of the following legal limitations: (1)If you are in danger of doing immediate harm to yourself or to others, your therapist may have to contact other individuals or agencies to assist in protecting your safety and the safety of others. (2)In certain criminal or civil matters, our records and/or professional testimony may be subpoenaed at the request of the court or attorney. Such events are rare, but if they occur you would be notified by the clinician. (3)If the therapist suspects a child, senior citizen, or disabled person is at risk for abuse or neglect, the therapist is bound by state law to report this to the state agency responsible for investigating allegations of abuse. In such circumstances, therapists will work with the person served to coordinate appropriate action and intervention.

Another exception is that I may occasionally need to consult other professionals about a case. During a consultation, I make every effort to avoid revealing the identity of my client. The consultant is also legally bound to keep the information confidential. If you don't object, I will not tell you about these consultations unless I feel that it is important to our work together.

PRIVACY & CONFIDENTIALITY FOR A MINOR

Prior to beginning treatment, it is important for you to understand my approach to child therapy and agree about your child's confidentiality during the course of his/her treatment. The information herein is in addition to the information contained in the prior confidentiality/consent
to treat sections.

One risk of child therapy involves disagreement among parents and/or disagreement between parents and therapists regarding the best interest of the child. If such disagreements occur, I will strive to listen carefully so that I can understand your perspectives and fully explain my perspective. We can resolve such disagreements or we can agree to disagree, so long as this enables your child's therapeutic progress. Ultimately, you will decide whether therapy will continue. If either parents or client decides that therapy should end, I will honor that decision however, I ask that you give the option of having a closing session to appropriately end the treatment relationship if clinically appropriate.

Therapy is most effective when a trusting relationship exists between the therapist and the client. Privacy is especially important in building and maintaining that trust. One goal of treatment is to promote a stronger and better relationship between children and their parents. However, it is often necessary for children to develop a "zone of privacy" whereby they feel free to discuss personal matters with greater freedom. This is particularly true for adolescents or teens who are naturally developing a greater sense of independence and autonomy. If your child is an adolescent or teen 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. If I ever believe

that your child is at serious risk of harming him/herself or another, I will inform you as soon as possible.

PARENT INVOLVEMENT
It is also vital that the parent is involved in the treatment of said child. Parental involvement is required at Dr. Ruthie Norman, LICSW, LLC. It is imperative that at least once a month you, the parent or guardian , are available by phone or appointment at my office for a consultation. As your child's therapist, I will make every effort to communicate with you at least monthly regarding your child's progress.

CONSENT TO TREATMENT
I authorize and request that Dr.Ruthie Norman, LICSW, LLC provide psycho-therapeutic services determined to be clinically appropriate for myself, the client. I have read and understand the terms stated in this therapy contract form. I fully understand the scope of the services, policy, and treatment. I agree to abide by the terms stated throughout the course of our therapeutic relationship.

CONSENT TO TREATMENT FOR MINOR
I authorize and request that Dr.Ruthie Norman, LICSW, LLC provide psycho-therapeutic services determined to be clinically appropriate for my child. I understand that the primary goal of these services is to help my child be at his/her most successful emotionally, socially and academically. I hereby represent that I have the legal authority to obtain medical treatment and counseling for the minor child for whom I am requesting treatment. I am a biological parent or legal guardian. If group home or foster family settings, I am designated to authorize treatment. If divorced, I am the primary custodial parent and can secure treatment without the authorization of the other parent.

ELECTRONIC SIGNATURE AUTHORIZATION
Electronic signatures are a method of reducing paperwork and streamlining the collection of information. The purpose of this consent is to ensure that you are fully aware of your rights and responsibilities of agreeing to receive and sign documents electronically. This Agreement governs the rights, duties, and responsibilities of "Client" in the use of an electronic (written or verbal) signature with Dr Ruthie Norman, LICSW, LLC. You will be given sufficient opportunity to review any document prior to electronically signing the document. You have the right to have any document provided in paper or non-electronic form. A paper copy of any electronically signed document can be provided upon request at no charge. You have the right to withdraw or change your consent to sign electronic documents with electronic signature at any time. You have a choice. You do not have to participate in electronic signing of documents. By signing this consent form, Client is providing consent to the use of electronic and verbal signatures to establish Client's identity and sign electronic documents and forms associated with the provision of treatment by Dr Ruthie Norman, LICSW, LLC. Client further agrees that, for the purposes of authorizing and authenticating electronic health records, Client's electronic signature or verbal approval has the full force and effect of a signature affixed by hand to a paper document. I accept the use of electronic and verbal signatures as a valid form of my written signature for documentation associated with my treatment.

_____I do **NOT** accept the use of electronic and verbal signatures as a valid form of my written signature for documentation associated with my treatment. ***(Initial if applicable)***

EMAIL AND TEXT (SMS) MESSAGING INFORMED CONSENT

In order to communicate with you by email or text message, It's important to make sure you are aware of the confidentiality and other issues that arise when we communicate this way and to document that you are aware of these and agree to them. I understand that all e-mail messages are sent over the Internet and are not encrypted, are not secure, and may be read by others. I understand that my email communications with my therapist will NOT be encrypted and, therefore, my therapist can NOT guarantee the confidentiality and security of any information I send to her or that she sends to me via email. I understand that SMS messages are even less secure than e-mail, and the same conditions apply. I understand that for this reason my therapist has advised me not to send sensitive information via e-mail or SMS message. I hereby give permission for my therapist to reply to my messages via e-mail and text messaging. I agree that Dr. Ruthie Norman, LICSW, LLC shall not be liable for any breach of confidentiality that may result from this use of e-mail via the Internet/ SMS messaging.

_____I do **NOT** give permission for my therapist to reply to my messages via e-mail and text messaging. ***(Initial if applicable)***

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Client Affidavit

I confirm that each of these sections in the Disclosure Statement & Agreement for Services Therapy Contract have been explained in a manner that is clear to me and that all questions I had regarding this contract, were answered to my satisfaction. I hereby attest that I have read, understand, and agree to Dr.Ruthie Norman, LICSW, LLC Disclosure Statement & Agreement for Services Therapy Contract.

Disclosure Statement & Agreement Contract Document

Contract Sections	
Contact	Consent to treatment
Therapeutic services	Consent to treatment for a minor
Attendance policy	Notice of privacy practices
Insurance reimbursement	Consent to treatment
Fees & payments	Electronic Signature
Court or legal involvement	Email & Text (SMS) Messaging
Confidentiality	
Privacy and confidentiality for a minor	
Parent involvement	

_____ ***I do NOT agree to the following section(s)***
(Initials)

My signature below authorizes Dr.Ruthie Norman, LICSW, LLC to provide psycho-therapeutic services determined to be clinically appropriate for myself, the client. I have read and understand the terms stated in this therapy contract form. I fully understand the scope of the services and confirm that this contract has been explained in a manner that is clear to me and that all questions I had regarding this document, were answered to my satisfaction.I agree to abide by the terms outlined and stated in this contract and throughout the course of our therapeutic relationship.

Parent/Guardian Name	Parent/Guardian Signature	Date
Client Name	Client Signature (If applicable)	Date

Dr. Ruthie Norman LICSW LLC

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