Michelle L. Cyr, LICSW

counseling, coaching, support & growth for children, families and individuals

Welcome & Consent-To-Treat Packet for Minor Clients Under 18 Years Old

Welcome!

Thank you for choosing Michelle L. Cyr, LICSW LLC for your therapy needs. ***These documents and forms explain important details about your therapy***, including confidentiality, treatment and payments, authorizations, rights, and more. Please carefully read before signing and returning. The signed documents should be brought with you to your initial session. Alternatively, you may plan to arrive 20 minutes early to complete the forms in person. If you have any questions about the content, please ask Michelle for an explanation prior to signing. Thank you!

Confidentiality and Protected Health Information

Communication between a client and therapist is confidential and I am bound by law and ethics to safeguard your Protected Health Information (PHI).

This notice of Privacy Practices describes how I may use and disclose your PHI in accordance with applicable law, including the Health Insurance Portability and Accountability Act (HIPAA), regulations promulgated under HIPAA including the HIPAA Privacy and Security Rules, the NASW Code of Ethics and Massachusetts statutes and regulations. It also describes your rights regarding how you may gain access to your PHI.

I am required by law to maintain the privacy of PHI and to provide you with notice of my legal duties and privacy practices with respect to PHI. I am required to abide by the terms of this Notice of Privacy Practices. I reserve the right to change the terms of this Notice of Privacy Practices at any time. Any new Notice of Privacy Practices will be effective for all PHI that I maintain at that time. I will provide you with a copy of the revised Notice of Privacy Practices by posting a copy on my website, sending a copy to you in the mail upon request, or providing one to you at your next appointment.

Uses and Disclosures for Treatment and Payment

I may use or disclose your PHI for treatment, payment and health care operations with your consent as detailed below:

1. **For Treatment:** Your PHI may be used and disclosed to those who are involved in your care for the purpose of providing, coordinating or managing your health care treatment and related services. This included; consultation with clinical supervisors or other treatment team members. I may disclose your PHI to any other consultant only with your authorization.

2. **For Payment:** If you are using health insurance to pay for your care, you have already given your permission to the insurance company to access information necessary to process claims for payment, oversee services provided and perform quality assurance functions. I may use and disclose PHI so that I can receive payment for the services provided to you. This is only done with your consent. If you are paying for your care entirely out-of-pocket, you have the right to restrict disclosure of PHI to a health plan. This does not apply to out of pocket payment of health insurance deductibles. If it becomes necessary to use collection processes due to lack of payment for services, I will only disclose the minimum amount of PHI necessary for purposes of collection.

Uses and Disclosures Requiring Authorization

Uses and disclosures not specifically permitted by applicable law will be made only with your written authorization, which may be revoked at any time, except to the extent that I have already made a use or disclosure based on your authorization.

In the case of minor children, Massachusetts law allows parents the right to examine treatment records. Though you will be asked to be involved in and informed of your child's progress, release of specific communications often can jeopardize a child or adolescents willingness to be forthcoming with his/her therapist and as such may become an impediment to the child's benefitting from his/her treatment. In order to both respect the confidential nature of your child's information and facilitate the building of trust, I will ask you to agree to certain limits on the information that will be shared with you. Of course, if there are ever any concerns about potential dangerousness, you will be notified immediately.

Uses and Disclosures with Neither Consent nor Authorization

Mental health professionals are required by law to break confidentiality under the following circumstances:

1. If an individual intends to take harmful or dangerous action against another individual, we must warn the person and/or family of the person who is likely to suffer the results of the harmful behavior, as well as local authorities, in order to protect the individual and any potential victim(s).
2. If an individual poses a danger to himself or herself, we must disclose information necessary to keep the individual safe and to facilitate appropriate treatment.
3. If we, in our professional capacity, have reasonable cause to believe that a minor child is suffering physical or emotional injury from abuse which causes harm or substantial risk of harm to the child's health or welfare (including sexual abuse), or from neglect, we must immediately report to the Massachusetts Department of Children and Families.
4. Information regarding sexual contact between children under the age of 16.
5. Suspicion of the abuse of elders must be immediately reported to the Massachusetts Department of Elder Affairs.
6. Suspicion of the abuse of a disabled person must be immediately reported to the Massachusetts Disabled Persons Protection Commission.
7. In response to a court order by a judge of appropriate jurisdiction.
8. If a client introduces his or her mental condition as an element of claim or defense in a legal proceeding.
9. Court investigations into child custody or adoption.
10. Workers' compensation claims.

Please note that should the occasion ever arise, every effort will be made, as is clinically appropriate, to discuss and/or resolve and issues before such a breach of confidentiality takes place.

Your Rights

You have the following rights regarding PHI I maintain about you:

1. You have the right to obtain a copy of PHI, psychotherapy notes and billing records for as long as the PHI is maintained in the record. On your request, I will discuss with you the details of the request process. I may charge a reasonable, cost-based fee for copies. If your records are maintained electronically, you may also request an electronic copy of your PHI. You may also request that a copy of your PHI be provided to another person.
2. If you feel that the PHI I have about you is incorrect or incomplete, you may ask me to amend the information, although I am not required to agree to this amendment. If I deny your request for amendment, you have the right to file a statement of disagreement with me. I may prepare a rebuttal to your statement and will provide you with a copy. On your request, I will provide you with details of the amendment process.
3. You have the right to request that I communicate with you about your PHI in a certain way or in a certain location. I will accommodate reasonable requests. For example: you may request bills be mailed to a different address. I may require information regarding how payment will be handled or specification of an

alternative address or other method of contact as a condition for accommodating your request. I will not ask you for an explanation of why you made the request.

4. If there is a break of unsecured PHI concerning you, I may be required to notify you of this breach, including what happened and what you can do to protect yourself.
5. You have the right to a paper copy of this notice upon request.

Consent to Evaluation and Treatment for Children:

The therapeutic process can provide great benefit and also comes with some risks. Risks can include experiencing uncomfortable emotions such as sadness, guilt, anxiety or anger; and recalling and discussing unpleasant life experiences can be distressing. As your child's therapist, I will discuss with you the benefits and risks of the treatment modalities under consideration for your child's particular needs. Though there is no guarantee, the treatment modalities I offer have been shown to benefit people and lead to reduction of symptoms as well as improved relationships and overall ability to more successfully deal with life's challenges.

In the case of minor children, parents must provide consent for treatment. In the case of shared or joint legal custody of a child by divorced parents, the consent of one parent is required to proceed, however, the other parent must not state a clear objection. If you are the parent who is bringing your child in for appointments, you may be asked for the name, address and telephone number of your child's other parent. As a routine matter, both parents will be invited to participate in your child's treatment. The exact form and frequency of contact will be determined on the basis of need as assessed on a case-by-case basis. If one parent objects, treatment can not proceed. In order for treatment to proceed, parents must resolve the matter between them, or refer the matter to the court for resolution.

This consent remains in effect through completion of your child's care with Michelle L. Cyr, LICSW.
You have the right to revoke consent to treatment of your child at any time. Should you choose to do so, I ask that you provide this request in writing. Notice of revocation of consent will necessarily result in termination of treatment.

Treatment is confidential. Information may not be released without written consent except in the event that an issue is raised which, in the therapist's judgement, would endanger anyone's welfare. In such instances, the parent named below would be notified, as would appropriate authorities and resources.

Your signature below gives Michelle L. Cyr, LICSW consent to provide therapy and consultation services to the individual and/or family named below.

_____	_____/_____/_____
Client Name (Printed)	Client Date of Birth
_____	_____
Parent or Guardian Name (Printed)	Relationship to Child
_____	_____/_____/_____
Parent or Guardian *(signature)*	Today's Date
_____	_____/_____/_____
Michelle L. Cyr, LICSW *(signature)*	Today's Date

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Working Agreement and Responsibilities

Appointments

Your time is valuable and I want you to get the most out of your appointments. I work hard to be on time with starting sessions and I ask that if you are going to be late to a session, to please let me know. It is to your benefit to have use of your entire session, so if you are more than 15 minutes late for an appointment, I reserve the right to reschedule the appointment for another time and you may be subjected to the missed appointment fee.

Cancellation and Rescheduling Appointments

My time, like yours, is limited. When you have an appointment scheduled, that space is not available for anyone else. Cancelling or rescheduling an appointment requires a minimum of 24 hrs. advance notice.

The missed appointment or late cancellation fee is $100 and can *not* be billed to insurance. This fee must be paid by the next scheduled appointment.

Payment for Services Rendered

If you are using your insurance for services, you are responsible for all deductions, copayments and balances that are not covered by your health insurance plan.

If you are the parent/guardian of a minor child who is receiving services, you are accepting responsibility for that child's bills.

All payments are due at the beginning of each session.

I accept cash, personal checks, VISA and Mastercard. Checks are payable to Michelle L. Cyr, LICSW LLC. There will be a $30 charge for all returned checks. Additionally, should a check be returned, payment for the original check amount and the $30 charge will need to be made prior to the next scheduled appointment.

Insurance

If you have questions about your insurance coverage, contact your insurance company prior to your first visit. Michelle L. Cyr, LICSW LLC is not an in-network provider for all insurance companies.

If Michelle L. Cyr, LICSW LLC is an in-network provider under your insurance plan, and you wish me to bill your insurance, I will need timely and accurate information from you. Before or at your first appointment, please complete the following steps:

1. Contact your insurance company to obtain an initial authorization or approval for mental health services. If your insurance company give you an authorization number or code, please bring that information to your first appointment.
2. Complete the **Insurance Information Release Form** which provides the information I need to bill your insurance company.

Additionally, please note that if your health plan denies payment for services, you will be responsible for all charges if the denial is due to:

1. A lapse, termination or limitation of your coverage
2. Lack of prior authorization for which information needed was not provided in time.
3. Your failure to respond to your insurer's request for information from you.

Some services are NOT covered by health insurance, including any service provided outside of face-to-face therapy sessions. These services are self-pay for all clients and include, but are not limited to:

1. Phone calls or email between sessions (except for emergencies or for scheduling purposes) lasting more than 15 minutes. This includes calls with clients, family members, school personnel, attorneys or others on behalf of the client.
2. Report or letter writing for purposes beyond documentation of client care.
3. Review of records.
4. Attendance at meetings.

Your signature here acknowledges that you understand and agree to the above working agreements and responsibilities.

_____	_____/_____/_____
Client Name (Printed)	***[Date of Birth]***
_____	_____/_____/_____
Client Signature	Today's Date
_____	_____/_____/_____
Michelle L. Cyr, LICSW *(signature)*	Today's Date

[The rest of this page is left intentionally blank]

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Insurance Information Release Form

Effective in 1976, all health insurance policies written in the State of Massachusetts must include mental health coverage. This coverage could cover all or part of the therapy session cost. At the time of our first meeting, I will take the necessary information from you and explain billing.

Under the Massachusetts Health Parity Law, "Parity" refers to Mental Health being guaranteed coverage on a "par", or to the same degree, as physical illness. What this may mean to you: If the Parity Law applies to your insurance and to your Mental Health condition, the number of sessions you are allowed in a calendar year is unlimited as long as your condition meets the criteria for medical necessity. If you have any questions, please call your insurance company to determine if or when the Parity Law will apply to your policy. I may be requested to send in a request or speak to someone at the insurance company to indicate that sessions continue to be "medically necessary." This entails giving a certain amount of information about your situation.

Please complete the following to help me process the insurance claim. If your insurance company requires a special form, please bring it with you to your next appointment.

Client's Name: _____ Client's DOB: ___/____/____

Client's Social Security #: __ __ __ - __ __ - __ __ __ __

Insurance Company Name: _____

Policy #: _____ Group #: _____

Subscriber's Name: _____ Subscriber's DOB: _____/_____/____

Subscriber's Social Security #: __ __ __ - __ __ - __ __ __ __ Relationship to client: _____

PLEASE NOTE IT IS YOUR RESPONSIBILITY TO INFORM ME OF ANY CHANGES IN INSURANCE COVERAGE. _____ **(*Please initial your acknowledgement.)***

I authorize the release of all information necessary for billing to the insurer identified on this document, either electronically or in paper format.

_____ _____ ____/____/____
Client Name (Printed) Signature Today's Date

I authorize the release to the above insurer to make direct payment to: Michelle L. Cyr, LICSW LLC.

_____ _____ ____/____/____
Client Name (Printed) Signature Today's Date

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Communication Policy

There are many forms of communication available to you. In a therapy setting, there are also potential privacy considerations as well as opportunity for miscommunication and/or misunderstandings. I acknowledge that email, phone, text and US Postal mail are not secure means of communication and could unintentionally result in a release of Protected Health Information (PHI).

Communication through email and text cannot be used for urgent matters or emergencies; nor can it substitute for therapy sessions. Any electronic communication will become part of your legal medical record. In accordance with Michelle L. Cyr, LICSW LLC's confidentiality agreement, I need written permission from you regarding your preferences for communication. This authorization will remain in effect, unless revoked in writing, until the completion of care.

I understand that I have the right to revoke this authorization at any time and will submit such revocation in writing. It is my understanding that should I initiate communication with Michelle L. Cyr, LICSW through a text, phone number, or email address not listed below that I am giving implied consent for communication.

I do hereby authorize Michelle L. Cyr, LICSW to communicate by the below identified modalities for my own convenience and without restriction or further qualification. *Please indicate **all** methods by which you give permission to be contacted.*

❑ Email(s): _____

❑ Cell Phone(s):

Name: _____ Phone #:_____ OK to Text: ❑

Name: _____ Phone #:_____ OK to Text: ❑

Name: _____ Phone #:_____ OK to Text: ❑

❑ Home Phone:_____ ❑ Other Phone: _____
Please specify type (work, etc.)

❑ Mail Address(es): _____

A Note regarding Social Media:
I do not communicate with, or contact, any clients through social media platforms such as Twitter, Instagram, Snapchat and/or Facebook. Should I discover that I have accidentally established an online relationship with you, I will cancel that relationship. These types of casual social contacts can create potential privacy risks for you. If you have an online presence, there is a possibility that you may encounter my personal information by accident. If that occurs, please discuss it during our time together. Communications with clients online have the potential to impact the professional relationship. In addition, please do not try to contact me via social media. As my priority is our therapeutic relationship, I will not respond and will terminate any online contact.

My signature below acknowledges Michelle L. Cyr, LICSW LLC's Communication Policy. With my acknowledgement of this policy, I hold harmless Michelle L. Cyr, LICSW for any unintended or unintentional release of information that may occur.

_____ _____/_____/_____
Client Name (Printed) ***[Date of Birth]***

_____ _____/_____/_____
Client Signature Today's Date

_____ _____/_____/_____
Michelle L. Cyr, LICSW *(signature)* Today's Date

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Client Health Form

Please complete all sections to the best of your ability.

Client Information

Client Name: _____ Date of Birth: ____/_____/_____ Age: _____

Gender: ❑ Female ❑ Male ❑ Non-Binary ❑ Other _____

Emergency Contact: _____ Phone: _____ Relationship: _____

Medical History

Primary Care Provider (PCP) Name: _____ Phone #:_____

Address: _____

Other Health Providers (Specialists, Psychiatrists, etc.):

Name	Specialty	Contact Information

Diagnoses/Conditions (Please include any mental health, medical or others):

Diagnosis/Condition	When Diagnosed?	Comments/Notes

Current Medications (please include prescriptions, over the counter, supplements):

Name	Dose/Frequency	Reason for Taking	Prescriber Name, if any

Allergies? ❑No ❑Yes: _____

Any other medical concerns? ❑No ❑Yes:_____

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Family Psychiatric History

Has anyone biologically related to the client been treated or diagnosed with the following?
(please indicate relationship to client if checking box)

❑ ADD/ADHD	_____	❑ Anxiety	_____
❑ Depression	_____	❑ Bi-Polar Disorder	_____
❑ Eating Disorder	_____	❑ OCD	_____
❑ Suicide or Attempted	_____	❑ Alcohol/Drug Problem	_____
❑ Schizophrenia	_____	❑ Psychiatric Hospitalization	_____

Personal Habits and Self-Care

Exercise: ❑ No ❑ Yes (How often?) _____

Sleep: _____ hours/night? Do you wake up rested? ❑ Yes ❑ No

Eating meals regularly? ❑ Yes ❑ No (If no, why not?) _____

Find enjoyment in work/school? ❑ Yes ❑ No

Take Vacations? ❑ No ❑ Yes (weeks/year?) _____

Hobbies/Interests outside of work/school: _____

_____

Hours per day used for:

Watching TV: _____ Online/Video Games: _____ Using Phone: _____ Reading: _____

Guns/weapons in the home? ❑ No ❑ Yes

Alcohol use? ❑ No ❑ Yes ____ drinks/day ____days/week

Tobacco use? ❑ No ❑ Yes ____ pack(s)/day

Vaping? ❑ No ❑ Yes _____

Recreational Drug use? ❑ No ❑ Yes _____

Additional Information (Optional)

Please feel free to share any relevant health information here: