Deedee Shaw LICSW
330 North 48th St, Suite A
Lincoln, NE 68504-3515
Phone 402-326-9168

PRACTICE POLICIES

APPOINTMENTS AND CANCELLATIONS

The standard psychotherapy session time is 50 minutes. It is up to you, however, to determine the length of your sessions. Requests to change the 50-minute session need to be discussed with the therapist to schedule time in advance.
A $20.00 service charge will be charged for any checks returned for any reason, for special handling. Should you fail to schedule an appointment for three consecutive weeks, unless other arrangements are made in advance, for legal and ethical reasons, I will consider the professional relationship discontinued.

TELEPHONE ACCESSIBILITY

If you need to contact me between sessions, please leave a message on my voicemail. I am often not immediately available; however, I will attempt to return your call within 24 hours. Please note that face-to-face sessions are highly preferable to phone sessions. However, if you are out of town, sick, or need additional support, phone sessions are available. If a true emergency arises, please call 911 or go to the nearest emergency room.

SOCIAL MEDIA AND TELECOMMUNICATION

Due to the importance of your confidentiality and the importance of minimizing dual relationships, I do not accept friend or contact requests from current or former clients on any social networking site (Facebook, LinkedIn, etc). Adding clients as friends or contacts on these sites can compromise your confidentiality and our respective privacy. It may also blur the boundaries of our therapeutic relationship. If you have questions about this, please bring them up when we meet, and we can talk more about it.

ELECTRONIC COMMUNICATION

I cannot ensure the confidentiality of any communication via electronic media, including text messages. If you prefer to communicate via email or text messaging for scheduling or cancellation issues, I will do so. While I may return messages promptly, I cannot guarantee an immediate response and request that you do not use these methods to discuss therapeutic content or to request assistance for emergencies. Services by electronic means, including but not limited to telephone communication, the Internet, facsimile machines, and e-mail are considered telemedicine by the State of California. Under the California Telemedicine Act of 1996, telemedicine is broadly defined as the use of information technology to deliver medical services and information from one location to another. If you and your therapist choose to use information technology for some or all of your treatment, you need to understand that:

PRACTICE POLICIES

1. You retain the option to withhold or withdraw consent at any time without affecting the right to future care or treatment or risking the loss or withdrawal of any program benefits to which you would otherwise be entitled.

2. All existing confidentiality protections are equally applicable.

3. Your access to all medical information transmitted during a telemedicine consultation is guaranteed, and copies of this information are available for a reasonable fee.

4. Dissemination of any of your identifiable images or information from the telemedicine Interaction with researchers or other entities shall not occur without your consent.

5. There are potential risks, consequences, and benefits of telemedicine. Potential benefits include, but are not limited to improved communication capabilities, providing convenient access to up-to-date information, consultations, support, reduced costs, improved quality, change in the conditions of practice, improved access to therapy, better continuity of care, and reduction of lost work time and travel costs.

Effective therapy is often facilitated when the therapist gathers within a session or a series of sessions a multitude of observations, information, and experiences about the client. Therapists may make clinical assessments, diagnoses, and interventions based not only on direct verbal or auditory communications, written reports, and third-person consultations, but also from direct visual and olfactory observations, information, and experiences. When using information technology in therapy services, potential risks include, but are not limited to the therapist's inability to make visual and olfactory observations of clinically or therapeutically potentially relevant issues such as: your physical condition including deformities, apparent height and weight, body type, attractiveness relative to social and cultural norms or standards, gait and motor coordination, posture, work speed, any noteworthy mannerism or gestures, physical or medical conditions including bruises or injuries, basic grooming and hygiene including appropriateness of dress, eye contact (including any changes in the previously listed issues), sex, chronological and apparent age, ethnicity, facial and body language, and congruence of language and facial or bodily expression. Potential consequences thus include the therapist not being aware of what he or she would consider important information, which you may not recognize as significant to present the therapist verbally.

MINORS

If you are a minor, your parents may be legally entitled to some information about your therapy. I will discuss with you and your parents what information is appropriate for them to receive and which issues are more appropriately kept confidential.

TERMINATION

Ending relationships can be complex. Therefore, it is essential to have a termination process to achieve closure. The appropriate length of the termination depends on the treatment's duration and intensity. I may terminate treatment after proper discussion with you and a termination process if I determine that the psychotherapy is not being effectively used or if you are in default on payment. I will not terminate the therapeutic relationship without first discussing and exploring the reasons and purpose of terminating. If therapy is terminated for any reason or you request another therapist, I will provide you with a list of qualified psychotherapists to treat you. You may also choose someone on your own or from another referral source.

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BY SIGNING BELOW, I AGREE THAT I HAVE READ, UNDERSTOOD, AND AGREE TO THE ITEMS CONTAINED IN THIS DOCUMENT.

Patient Signature _____ Date _____

Guardian Signature _____ Date _____

Relationship to Patient _____

Witness Signature _____ Date _____