Phone: 845-551-2942

Informed Consent for Participation in Tele-Therapy Treatment

Name: _____ Phone: _____

Email:_____ DOB: _____

Payment Info: _____

Please read this consent form carefully, as it describes the policies and procedures followed by your therapist.

Types of Service Provided by Your/Your Child's Therapist:

I offer traditional in-office therapy and a variety of online and/or distance therapy formats. You will be interviewed and may be asked to fill out some questionnaires to assist me in determining how best to help you. Treatment usually involves individual meetings with the therapist, but may also include group treatment and/or involving family members or significant others in some individual sessions. All treatment will be conducted only with your consent.

What You Can Expect from Online Treatment:

The duration of treatment is different for each person and can be difficult to estimate; I will address any concerns that you have about this. If you are not feeling satisfied with your treatment for any reason, you are asked to discuss this directly with me. I will work with you to uncover what might be preventing progress, will modify goals with you if appropriate, and will make a referral for you to (an)other professional(s) if necessary, and/ or at your request. Sometimes people find that they have a temporary increase in their level of distress when beginning psychotherapy, because the process of working on personal issues can be difficult; please be aware of this.

You as the client understand that phone sessions have limitations (as well as benefits) compared to in-person sessions, among those being the lack of "personal" face-to face interactions, and the lack of visual and audio cues in the therapy process. You understand that telephone/online psychotherapy with me is not a substitute for medication under the care of a psychiatrist or doctor. You understand that online and telephone therapy may not be appropriate if you are experiencing a crisis or having suicidal or homicidal thoughts. If a life threatening crisis should occur, you agree to contact a crisis hotline, call 911, or go to a hospital emergency room. You also understand that I follow the laws and professional regulations of the State of New York (USA) and the psychotherapy treatment will be considered to take place in the state of New York (USA).

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Confidentiality:

What you discuss with your therapist is kept confidential, or private, with some exceptions. The Notice of Privacy Practices provides detailed information about how private information about your health care is protected and under what circumstances it may be shared.

Confidentiality of E-mail and Chat, Cell Phone Communication: Therapeutic email or chat exchanges are delivered via Gmail, Zoom, or Skype. If you choose to email me from your personal email account, please limit the contents to basic issues such as cancellation or change in contact information. I will not respond to personal and clinical concerns via regular email. If you call me, please be aware that unless we are both on land line phones, the conversation is not confidential. Likewise, text messages are not confidential.

I make every effort to keep all information confidential. Likewise, if we are working online together, I ask that you determine who has access to your computer and electronic information from your location. This would include family members, co-workers, supervisors and friends. I encourage you to only communicate through a computer that you know is safe, i.e. wherein confidentiality can be ensured. Be sure to fully exit all online counseling sessions and emails. If we are unable to connect or are disconnected during a session due to a technological breakdown, please try to reconnect within 10 minutes. If reconnection is not possible, email to schedule a new session time.

Dual Relationships:

Not all dual relationships are unethical or avoidable. However, sexual involvement between therapist and client is never part of the therapy process, nor are any other actions or dual relationship situations that might impair my objectivity, clinical judgment, or therapeutic effectiveness or that could be exploitative in nature. In addition, I will never acknowledge working therapeutically with anyone without his/her written permission. In some instances, even with permission, I will preserve the integrity of our working relationship. For this reason I will not accept any invitations via social networking sites nor will I respond to blogs written by clients or accept comments on my blog from clients.

Telephone and Emergency Procedures:

If you need to speak with me between sessions, please call 845-551-2942. Your call will be returned as soon as possible. Messages are checked daily. Messages are checked less frequently on weekends and holidays. If an emergency situation arises that requires immediate attention, you may call the emergency National Suicide Hotline at 800-784-2433 or dial 911. If a life-threatening crisis should occur, you agree to contact a crisis hotline, call 911 or go to a hospital emergency room.

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Payment for Services:

Payments for services must be made prior to the time of each session. You may make payment via Credit Card with the account information that you will provide prior to the initial session. The fee is $200 for a 45 minute phone or virtual session.

Cancellation policy:

You will be billed at your full fee rate if you miss an appointment without providing at least 24 hours-notice.

We will discuss this Informed Consent during our first session. If our sessions are scheduled online, please complete and email this form with your signature. EMAIL: kdioriolcsw@gmail.com

Your signature below indicates that you have read this form and understand: 1) this Informed Consent form for participation in online treatment, 2) the Notice of Privacy Practices form and how information about you may be used or disclosed, and 3) that you consent to treatment and the provisions in the Informed Consent and Notice of Privacy Practices form.

X_____ _____

Signature of Client or Client's Guardian Date

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CLIENT INTAKE FORM

Client's Name: _____

Client's DOB: _____ Age: _____ Gender: _____ Ethnicity: _____

Client's Address: _____

Phone Number: _____

Email (of Client or Parent if Child): _____

Referred by: _____

Prior Mental Health Treatment: _____

Hospitalizations Relating to Mental Health: _____

Medications: _____

Primary Care MD: _____

Emergency Contact: _____

Marital Status (of Client or Parent if Child):_____

Education Level (of Client or Parent if Child): _____

Occupation (of Client or Parent if Child): _____

Employer (of Client or Parent if Child):_____

Household Composition

Name	Age	Relationship	Occupation / School

Live Free Therapy
Kayla Diorio, LCSW
Phone: 845-551-2942

Why are you (or your child) seeking therapy at this time?

_____
_____
_____
_____

How long has this been a problem and what have you tried in the past?

_____
_____
_____
_____

What are your (or your child's) goals for therapy?

_____
_____
_____
_____

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Please read the following document carefully, as it contains important information regarding the treatment you and/or your family will receive in this clinic. After careful review, please sign your acknowledgement of our policies and procedures.

Confidentiality: The information you share with me is held in the strictest confidence and may not be released to anyone without your written consent, as prescribed by law. There are a few exceptions to this, which are also regulated by State law. For example, in cases of suspected child or elderly abuse, or if a person poses a serious and imminent danger to her/himself or to someone else, I am required by law to report this information to the proper authorities. Information subpoenaed by a valid court order is usually not protected by this limit on confidentiality. These situations rarely occur and are the only exceptions to otherwise 100% confidentiality of what you talk about during therapy. In addition, some insurance companies require very brief and limited treatment information including diagnosis, and in some cases, information about presenting symptoms and treatment planning. Upon signing consent to release information, you are encouraged to discuss the amount, type, and purpose of information to be released if you have any concerns in this area. My policy is to allow you to maintain the highest possible level of confidentiality.

Insurance: I am a licensed clinical social worker (LCSW) in the State of New York. I am fully credentialed as an Out-of-Network provider for most insurance plans. I have chosen not to take insurance directly for a number of reasons. (The Insurance Industry has gained so much power and influence that its primary interest is to make money and not in providing the best quality patient care. In order to rationalize denial of or limit of care, they have become intrusive into the privacy of the therapy process, often requiring that detailed notes on clients be sent to them.) Using your Out-of-Network benefits can be a better option for you as a consumer both financially and in protecting your confidentiality. You can contact your insurance company and ask specifically about your Out-of-Network benefits for therapy with an LCSW. I will be happy to help you devise a plan so that you can maximize your potential benefits while still seeking the quality care of a professional.

Attendance Policy: After 6 weeks of not being seen or scheduling an appointment, your case will be closed due to non-attendance. If you re-schedule an appointment more than twice in a row your case will be closed.

Fees/Billing: Each client (parent/ legal guardian for minors) is responsible for managing the finances of the therapy relationship. Please note that each client is responsible for payment for services rendered the day of the appointment. Cash or checks are both acceptable payment methods. There is an additional fee for Credit or Debit cards.

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The fee schedule is as follows:

• Initial Consultation (1 hour): $240

• Individual / Family Session (45 minutes): $180

• School staffing participation (via phone) = $60.00/per 15 minutes

• No-show fee = ***Full session rate**

*Since I reserve your appointment time, there will be a charge for any appointments missed without prior notification. It is essential for you to cancel your appointment at least 24 hours in advance to avoid this charge.

Phone calls and other contacts: The scheduling and canceling of appointments are handled through the same phone number (though follow-up appointments will generally be set up at the end of the previous session). If you need to reschedule your appointment, please leave a message on my voicemail, and I will return your call by the end of the next business day. You may also leave a message on the voicemail to cancel appointments within 24 hours of your scheduled time. Please include your name, the appointment time, and a contact phone number.

I recognize that there may be times when you need to speak to me outside of your scheduled appointment. If a need for this does arise, please feel free to leave me a message at the same number. I will make every effort to return your call by the end of the next business day. Please reserve these messages to times when the matter is urgent, as it is necessary to devote most of my time to direct patient care. If you simply need to pass along information to me and do not need a response, feel free to contact me via email. I check my mailbox daily and this is generally the best method of communication between sessions. My email address is **kdioriolcsw@gmail.com**.

In the event of an emergency, I recommend you contact your medical doctor (or after hours number if their office is closed) or call 911, whichever is most appropriate for the situation. I can assist you with referrals for a medical or psychiatric consultation if needed.

X_____ **Date:** _____

Signature of client or parent/guardian if client is a minor

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NOTICE OF PRIVACY PRACTICES

Receipt and Acknowledgement of Notices

Client's Name _____

DOB: _____

I have read Kayla Diorio, LCSW's **Terms of Care** and agree to follow all policies and procedures as described.

X_____ **Date:** _____

Signature of client or parent/guardian if client is a minor

I read a summary of the Privacy Practices of Kayla Diorio, LCSW. I acknowledge that a copy is available upon my request.

X_____ **Date:** _____

Signature of client or parent/guardian if client is a minor

Client Refuses to Acknowledge Receipt:

Signature of Therapist Date

_____ _____

Live Free Therapy
Kayla Diorio, LCSW
Phone: 845-551-2942

Client Name: _____ **DOB:_____**

Statement of Understanding for Child Therapy

My theoretical focus combines expressive therapies; particularly play therapy, with cognitive behavioral work and skills training. A primary focus of treatment is to create a safe place for children to express feelings about life stressors. At times, in the case of *divorce, custody/visitation* issues arise. To safeguard the therapeutic relationship with the child, the following statement of understanding was developed. If you feel you cannot agree to the terms below, I will be glad to assist you in locating another provider.

As the parent of_____, I understand and agree to the following:

- I understand that the information discussed in therapy sessions is for therapeutic purposes and is not intended for use in any legal proceedings involving divorcing or divorced parents.
- I agree NOT to subpoena the therapist to testify for or against either parent or to provide records in a court action.
- I understand that involving the therapist in a court action may result in termination of the therapeutic relationship and referral to another provider.
- I understand that parental participation is critical to the success of treatment for my child. In the case of divorced or divorcing parents, both parents may be asked to participate. This is up to the discretion of my child's therapist. I understand that I may request or my therapist may require a referral to another provider if I am not in agreement with treatment recommendations.

_____ _____
Signature of Parent/Guardian Date

_____ _____
Signature of Parent/Guardian Date

_____ _____
Signature of Therapist/Witness Date

Live Free Therapy
Kayla Diorio, LCSW
Phone: 845-551-2942

FEE FOR ANY COURT APPEARANCE

Please note that my fee to appear in court is $2,500 (two thousand-five hundred dollars), per appearance. In the event that you wish for me to appear in court to testify on the behalf of you, your child, or any other family member, there will be a fee of $2,500.

Note that this fee is payable 7 days prior to your court date. Since I will be forced to clear my calendar of all appointments and prior engagements so that I may be available to appear in court, this fee is non-refundable. If your court date is postponed and I must again clear my calendar to attend court you will again be charged the full fee. If your court date is cancelled this fee is non-refundable.

No further appointments will scheduled until this fee is paid in full.

I have read this notice and fully understand the statement. I agree to pay the full fee of $2,500, 7 days in advance, for any court appearance this therapist may need to make on behalf of myself, my child, or any other family member.

Client signature (or guardian signature if minor child)

X_____