Linganore Counseling and Wellness, LLC
11670 Old National Pike, #103
New Market, MD 21774
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STATEMENT OF UNDERSTANDING

Welcome to Linganore Counseling and Wellness, LLC. Our goal is to provide you with quality mental health care. Your informed consent and active participation an important parts of your counseling experience.

Psychotherapy has both benefits and risks. Risks may include experiencing uncomfortable feelings, such as sadness, guilt, anxiety, anger, frustration, loneliness and helplessness, because the process of psychotherapy often requires discussing the unpleasant aspects of your life. However, psychotherapy has been shown to have benefits for individuals who undertake it. Therapy often leads to a significant reduction in feelings of distress, increased satisfaction in interpersonal relationships, greater personal awareness and insight, increased skills for managing stress and resolutions to specific problems. But, there are no guarantees about what will happen. Psychotherapy requires a very active effort on your part. In order to be most successful, you will have to work on things we discuss outside of sessions. You have the right to not participate in any research project.

Client Information will be confidential. Information will be released only with your written permission.
The ONLY exceptions are when the information is required by law (such as in cases of child abuse or immediate threat of harm to self or others) or by court order.

If the primary client is under 18 years of age, the therapist reserves the right to disclose certain information to their parents or other responsible adult if the therapist believes information may jeopardize the safety of the client or others.

If you need your therapist to go to court, the fee is $1200 per day to be on call or to appear in person. A minimum of two weeks' notice is required. If there is a legal conflict over child custody or visitation, we may require that the child be assigned an attorney through the courts.

We request that you call to cancel an appointment at least 24 hours before the time of the appointment.
If you cancel, within 24 hours of appointment or do not show up, you will be charged a $50.00 fee as insurance does not compensate for late cancellations or no shows. In the event your insurance or EAP does not allow for such fees we reserve the right to discontinue your services after two late cancellations or no shows.

Your signature below shows that you understand and agree with all of these statements and have been provided a copy of a Notice of Privacy Practices, in accord with The Health Insurance Portability & Accountability Act (HIPPA) and that you have received a copy of our "About Fees and Insurance" form.

_____ _____
Signature of Client (or person acting for client) Date

_____ _____
Printed Name Relationship to client (if necessary)

I, the therapist, have discussed the issues above with the client (and/or his or her parent, guardian, or other representative).

_____ _____
Signature of Therapist Date

☐ Copy accepted by client ☐ Copy kept by therapist

This is a strictly confidential patient medical record. Re-disclosure or transfer is expressly prohibited by law.

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