Therapeutic Yoga & Counseling Services, LLC
Stephanie Siciliano, LCSW, RYT

Informed Consent for Treatment

Welcome to my practice. This document contains important information about my professional services and business policies. Please read it carefully and feel free to discuss any questions or concerns that you may have. Signing this document represents an agreement between us.

PSYCHOLOGICAL SERVICES
Therapy is not easily described in general statements. It varies depending on personalities of the clinician and client, and the particular problems you hope to address. There are many different methods I may use to provide individualized therapeutic intervention. Therapy is not like a medical doctor visit. Instead, it requires the clinician and client develop a therapeutic relationship. In order for therapy to be most successful, the client, with the support of the clinician must work towards goals established in session.

Therapy can have benefits as well as risks. Because therapy often involves discussing unpleasant aspects of your life, you may experience uncomfortable feelings such as sadness, guilt, anger, frustration, loneliness, and helplessness. Although it can be a difficult process at times, therapy often benefits those who go through the process and may lead to better relationships, solutions to specific problems, and significant reductions in feelings of distress. There is, however, no guarantees as to what you will experience from this process.

Our first few sessions will involve an evaluation of your needs and what you hope to achieve in therapy. By the end of the evaluation I will offer you my first impressions of what our work will include and a treatment plan to follow if you decide to continue with therapy. You should evaluate this information along with your own opinions about whether you feel comfortable working with me. At the end of the evaluation, we will discuss whether or not we are a good therapeutic fit. If you decide not wor work with me I will provide referrals for other practitioners that may be better suited.

Therapy involves a significant commitment and therefore you should be very careful about the therapist you select. If you have questions about my procedures, we should discuss them whenever they arise. If doubts about treatment persist I will be happy to help you set up a meeting with another mental health professional.

SESSIONS
I will conduct an evaluation that will last from 2 to 4 sessions. During this time we will decide together if I am the best person to provide therapeutic services for you at this time in order for you to meet your treatment goals. If we agree to begin therapy, sessions typically last 50 minutes per week.

CANCELLATION POLICY

In order to cancel a scheduled appointment please provide 24 hours notice. If this is not provided, you will be expected to pay for the session unless we both agree that you were unable to attend due to circumstances beyond your control.

PROFESSIONAL FEES

My hourly fee is $150. In addition to weekly appointments, I charge this same hourly rate for other professional services you may need, though I will prorate the hourly cost if I work for periods of less than an hour. Other professional services include report writing, telephone conversations lasting longer than 10 minutes, attendance at meetings with other professionals you have authorized, preparation of

treatment summaries, and the time spent performing any other service you may request of me. If you become involved in legal proceedings that require my participation, you will be expected to pay for any professional time spent on this legal matter, even if the request comes from another party.

BILLING & PAYMENTS

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 that requires another arrangement. Payment schedules for other professional services will be agreed to when such services are requested. In circumstances of unusual financial hardship, I may be willing to negotiate a fee adjustment or payment installment plan. Please note that credit cards/debit cards are accepted as a method of payment. Credit card information can be kept on file if requested. In regard to payment for group therapy, all group sessions will be paid for in full on or before the group start date.

INSURANCE REIMBURSEMENT

Clients are responsible for their full session fees. I do not participate with any insurance companies, but am an "out of network provider". I provide any assistance I can ain helping you receive the benefits to which you are entitled, however clients are solely responsible for obtaining "pre-authorization" for their treatment. Clients must contact their insurance company before starting treatment to see if they need "pre-authorization" for mental health services.

Many "Managed Health Care" plans are often limited to short-term treatment approaches designed to work out specific problems that interfere with a person's level of functioning. It may be necessary to seek approval for more therapy after a certain number of sessions. Though a lot can be accomplished in short-term therapy, some clients feel that they need more services after insurance benefits end.

Insurance companies require that I provide them with a clinical diagnosis in order to reimburse for services. Sometimes they require additional clinical information such as treatment plans, progress

notes or summaries, or copies of records, although this is rare. This information will become part of the insurance company files. Though all insurance companies claim to keep such information

confidential, I have no control over such information once it is provided to the insurance company. In some cases they may share the information with a national medical information databank. I will provide you with a copy of any records I submit, if requested. *By using insurance you authorize me to release such information to your insurance company. I will try to keep that information limited to the minimum necessary.* You always have the right to pay for services yourself to avoid the issues described above.

EMERGENCIES
If you experience an emergency you should call 911 or go to your nearest hospital emergency room immediately. Mobile Crisis for Monmouth County can be reached at 732-923-6999. I do not provide emergency services.

CONTACTING ME
I am available by phone, however I often do not answer my phone as I am usually with clients, however I will return a call/text message within 24 hours. If I will be unavailable for an extended time I will inform you of this prior to my absence.

EMAIL & TEXT MESSAGING
I use email and text messaging only with your permission and only for administrative purposes unless we have made another agreement. Emails and texts are limited to things such as setting and changing appointments, billing dates, and other related issues. Please do not email me about clinical matters because email is no a secure way to contact me. If you need to discuss a clinical matter please feel free to call me so we can discuss it over the phone or wait to discuss during the next scheduled appointment.

SOCIAL MEDIA
I do not communicate with, or contact any clients through social media platforms. If I discover that I have accidentally established an online relationship with you, I will cancel that relationship as social media contact may create issues related to confidentiality.

NOTICE OF PRIVACY POLICY
In general, the privacy of all communications between a client and psychologist is protected by law, I can **only** release information about our work to others with your written permission, however there are a few exceptions.

Exceptions to client confidentiality:

1. If I have a reasonable belief that a client poses a danger to himself/herself or others, I may contact others to facilitate the client's safety.

2. If I believe that a client is threatening serious bodily harm to another, I may be required to take protective action. These actions may include notifying the potential victim, contacting the police, or seeking hospitalization for the client.
3. If I have a reasonable suspicion of child abuse or neglect, or abuse of dependent, disabled, or alder adult (age 65 or older), I am required by law to file a report with the designated protective agencies.

In most legal proceedings, you have the right to prevent me from providing any information about your treatment. In some legal proceedings, a judge may order my testimony if he/she determines that the issues demand it, and I must comply with that court order.

I may occasionally find it helpful to consult other professionals about a case. During a consultation, the client's identity will not be revealed. The consultant is also legally bound to keep the information confidential.

In order to more effectively provide counseling services, it may be important for me to communicate with any previous or concurrent treating professionals. To this end, I may request that you sign an authorization form allowing such communication.

Your signature below indicates that you have read the information in this document, you understand the content, and agree to abide by its terms during our professional relationship. All portions of this informed consent were reviewed with me and you have had ample opportunity to discuss all questions and concerns.

Client Signature: _____

Date: _____

Notice of Disclosures & Practices

I. Disclosure of Financial Interest

Public law of the State of New Jersey mandates that providers of healthcare services inform

clients of any significant financial interest which may be held in a health care service.

II. Disclosure of Relationship

Accordingly, I wish to inform you that Therapeutic Yoga & Counseling Services, LLC does have a financial interest in the healthcare services provided under the auspices of the center to which I may refer to including counseling, clinical trainings, and clinical supervision. While I strongly believe in our clinical training and expertise, you may of course seek treatment at a health care service or provider of your own choice at any time.

Upon request, I will gladly provide a listing of alternative healthcare service providers. You may also consult the classified section of your telephone directory under the appropriate provider heading or contact your insurance carrier for a listing of providers.

III. Notice of Privacy Practices

Under the Health Insurance Portability and Accountability Act (HIPAA) of 1996, it is required that all providers of medical and health services provide written notice of their Privacy Practices. Attached is a notice of our Official Privacy Policy Statement; it will Remain in effect each year unless you are notified in writing of changes.

Please sign this form, which will acknowledge that you have been informed of the above disclosures and received the official Notice of Privacy Practices.

Signed: _____ Date: _____

Therapeutic Yoga & Counseling Services, LLC
Stephanie Siciliano, LCSW, RYT

Authorization for Credit Card Use

I, _____, authorize Therapeutic Yoga & Counseling Services, LLC to charge my (or my child's) therapy sessions to the credit card I have provided. I understand that this credit card will also be used to charge any other bills associated with treatment, unless other arrangements are made.

You may request an itemized bill in association with your account at any time. Please advise if your credit card number changes so that there is no interruption in services.

This authorization will remain in effect until revoked verbally or in writing.

_____ _____
Client/Responsible Part Date

_____ _____
Witness Date

Therapeutic Yoga & Counseling Services, LLC
Stephanie Siciliano, LCSW, RYT

Welcome to Therapeutic Yoga & Counseling Services, LLC

Client Information:

Client Name: _____

Date of Birth: _____ Age: _____ Sex: Male / Female

Is the client a minor? Yes / No If yes, name of parent/legal guardian: _____

If a minor, in the case of separation/divorce, which parent has legal custody? _____

Home Address: _____

Home Phone: _____ Cell: _____

Any call restrictions? _____

Email Address: _____

Referral Source: _____

Responsible Party:

Please complete the following information regarding the person who is financially responsible for this account. (If the client is a minor, the parent is considered the responsible party).

Name of Responsible Party: _____

Relationship to client: _____ DOB: _____

Address: _____

Home Phone: _____ Cell: _____

Emergency Contact Information:

In the event of an emergency, who should we contact?

Name: _____

Phone: _____

Relationship to client: _____

Therapeutic Yoga &
Counseling Services, LLC

Client Information Sheet

As a new client, please fill out the information on this form to the best of your ability.

If you are the parent of a minor child seeking services, please answer questions of their behalf.

Client Name: _____ Age: _____

Marital Status: Child Single Adult Married Separated Divorced Widowed

History of Present Circumstance:

Briefly describe the difficulties which led you to seek services at this time:

_____

_____

_____

_____

How severe is the problem on a scale of 1-10? _____

How long have you had this problem, or when did it start? _____

Medical History

Current Physician: _____ Phone: _____

Current Psychiatrist: _____ Phone: _____

Are you receiving medical treatment for any condition now or within the last year? Yes / No

If yes, please explain: _____

Please list any medications you are taking:

Medication	Dose	Reason for taking	Prescribed by

Have you ever received any of the following psychiatric services?

Service	Yes / No	Details (Provider name, date, etc.)
Outpatient Counseling	Yes / No	

Psychiatric Emergency Screening Services	Yes / No	
Inpatient Psychiatric Hospital Stay	Yes / No	
Drug/Alcohol Rehabilitation	Yes / No	
Therapeutic Residential Program	Yes / No	
Child Study Team Evaluation	Yes / No	

Social History:

School currently attending: _____ Grade: _____

Employer: _____ Position: _____

History of legal charges or arrests: Yes / No Explain: _____

Use of alcohol: Never Rarely Moderately Daily

Use of drugs (including prescription pain medication): Never Rarely Moderately Daily

Family Constellation:

Mother or wife	
Father or husband	
Siblings or children	
Step parent/child/siblings	
Others living in household	

Life Changes:

Have you or your family experienced any major life changes lately?

Move/Relocation	Change of School	Separation or Divorce
Birth of Child	Catastrophic Illness	Unemployment/Financial Problems

Trauma Victim of Crime Death
Other: _____

DCPP Involvement: Yes / No
If yes, when and why? _____

DCPP Case Manager: _____

Current Functioning:

In order to better understand you, please respond to the following:

How would you describe your mood most of the time?

Cheerful/Happy Anxious/Nervous
Sad/Depressed Angry/Irritable
Changes all the time Bland/Unfeeling Other: _____

Have you ever…
If yes, please explain.

Attempted suicide No / Yes _____

Currently have suicidal thoughts No / Yes _____

Engaged in self-injurious behavior No / Yes _____

Have you ever…

Been a victim or witnessed sexual abuse No / Yes _____

Been a victim or witnessed domestic violence No / Yes _____

Suffered a traumatic experience No / Yes _____

Is there any additional information which you feel is important to share at this time?

_____

_____

_____

_____

Thank you for your responses!

Therapeutic Yoga & Counseling Services, LLC
Stephanie Siciliano, LCSW, RYT

Authorization for Disclosure of Client Records or Communication

I hereby authorize Stephanie Siciliano, LCSW, RYT to disclose information and/or receive information to the extent or nature indicated to/from:

Recipient Name and address: _____

_____ for the purpose of _____.

The information to be disclosed shall be limited to that information necessary to fulfill the above stated purpose regarding:

Client's Name: _____ DOB: _____

I understand that in New Jersey the communications between clients and mental health practitioners are privileged and confidential and, in most instances, may only be released with my written consent. I also understand that I may revoke this consent at any time except to the extent action has been taken in reliance theron. This consent is effective immediately and will expire 1 year from the date of signature. However I also understand that I may revoke my consent before 1 year elapses by writing to you and withdrawing my consent. This consent is for the above stated purposes only and specifically does not authorize the release of documents or information therein to any other party except as required in the filing of court documents in connection with the aforesaid purpose. I understand that treatment, payment, enrollment, or eligibility for benefits in an insurance plan cannot be a condition of authorization of psychotherapy notes (not progress notes as defined by HIPAA, federal law). I understand that once information is released, there is potential for that information to be re-disclosed and no longer protected by HIPAA. A photocopy of this consent form is as good as the original.

I hereby release Stephanie Siciliano, Therapeutic Yoga & Counseling Services, LLC from any and all legal responsibility or liability resulting from the release of the above information to the extent indicated and authorized herein.

Signed: _____ Date: _____
Client age 14 or older

Signed: _____ Date: _____
Parent/Legal Guardian if Client under 18 years of age

Signed: _____ Date: _____
Other Parent if joint custody of Minor

Therapeutic Yoga &
Counseling Services, LLC

Insurance Information

Name of Insured _____ Relationship to Client _____

Address of Insured _____ Phone #

of Insured _____ Insured's Birth date _____ SS# _____ Employer _____ Occupation _____

Insurance Company _____

Policy # _____ Group # _____

Insurance Company Contact Phone # (on card) _____

Responsible Party

Please complete the following information regarding the person who is financially responsible for this account. (If the client is a minor, the parent bringing the child in for services is considered the responsible party)

Name of Responsible Party_____ Relationship to client_____

Date of Birth _____ SS# _____

Address _____ City _____ State _____ Zip_____

Employer _____ Occupation _____

Work Phone _____ Ext. _____

Home Phone _____ Cell Phone_____

Emergency Contact Information

In the event of an emergency, whom should we contact?

Name _____

Phone _____ Relationship to client or family _____

Therapeutic Yoga &
Counseling Services, LLC

Authorization and Release

I authorize the release of any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such care to third party payers and/or other health practitioners.

I authorize and request my insurance company to pay directly to the doctor or doctor's group insurance benefits otherwise payable to me.

I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

X_____ Date_____ Signature of client or parent/guardian of minor.

A Note about Insurance

As a courtesy, our office will complete and submit your insurance forms to achieve maximum reimbursement to which you are entitled. Please remember that you are ultimately responsible for all expenses incurred. We urge you to read your policy and/or contact your insurance provider so that you are fully aware of coverage and any limitations of the benefits provided.

Cancellation Policy
Your time is reserved especially for you. As a courtesy to other clients and our staff, if you are unable to keep your appointment, we require a 24-hour notice of cancellation.

We charge the full session fee for any failed appointment or appointment cancelled with less than 24 hours notice. This fee will NOT be reimbursed by your insurance provider. Medical emergencies are exempt from this policy.

For the Initial Evaluation a 50% credit card deposit is required to schedule ($150) and will be billed for any failed appointment or appointment cancelled with less than 24 hours notice. Please

Initial here x_____

Insurance Company Information

The following information sheet is to inform clients about their responsibilities as well as help manage client expectations about the billing process at our office.

1) Clients are 100% responsible for their full session fees. There are no exceptions to this rule.

2) Clients must pay their full session fee at the time of each session.

3) Medicaid, Medicare and all HMOs do NOT reimburse for any fees.

4) TY&CS does not participate in any insurance companies. I am an “out-of network” provider.

5) Clients are solely responsible for obtaining “pre-authorization” for their treatment. Clients must contact their insurance company before starting treatment to see if they need “pre-authorization” for mental health services.

6) The Billing Consultant submits claims monthly.

7) Although claims are submitted electronically, it will take a minimum of 45 days for each claim to be processed. Insurance Companies may report that claims are “missing” or “can not be located in the system” when the claims have, in fact, been filed correctly and in a timely manner. Please give at least 60 days before contacting about a missing claim.