**Information for New Clients and Treatment Consent Form**

Welcome to my practice. I appreciate that you are giving me the opportunity to be of help to you. As a solution-focused therapist my goal is to help you discover your strengths and to use these to have a fulfilling and meaningful life.

**Qualifications:**

I have a Master’s in Social Work from the University of New England, College of Health Professions and a Master’s in Health Services Administration from St. Joseph’s College. The focus of my practice is on past and present trauma, PTSD, anxiety, depression and interpersonal stressors and relationships. I work with adults and children from an integrative perspective and rely on a broad range of models and interventions including psychodynamic, narrative, cognitive-behavioral, relational, attachment-based, Adaptive Information Processing, ego-state strategies, hypnosis, mindfulness strategies and family systems. As a Licensed Clinical Social Worker, I bring a certain expertise to our collaboration while you bring self-knowledge, the ability to learn from your life experiences, and a vision of what you want your life to be. For more information please visit my website at [www.rhondahugheslcsw.com](http://www.rhondahugheslcsw.com) .

**What to Expect:**

During our first few sessions the focus will be on assessment, determining your goals and areas of focus, the development of a plan and treatment related education. It is also during this time that I will assess whether I can be of benefit to you based on the issues you present and your goals. I do not accept clients to whom I believe I cannot be helpful. If this is the case, I will refer you to others who may work well with your particular issues and goals. Following this period we will start working on the specific goals and strategies we discussed during the planning process. This is often the longest phase. If you would like an estimate on the number of sessions please ask. Deciding when to stop our work together is meant to be a mutual process and often we will discuss a plan for phasing out of therapy. If it is not possible to phase out of therapy, I recommend that we have closure on the therapy process with at least two closing sessions.

**The Benefits and Risks of Therapy**

The purposes of psychotherapy generally are used to help someone address, cope with and accept major life changes and stressors such as relationship conflict, traumatic events and stressors, workplace stress and substance abuse. As with any powerful treatment, there are some risks as well as many benefits. In therapy, there is a risk that clients will, for a time, have uncomfortable levels of strong emotions or negative feelings. These feelings could be disruptive in areas of your life and some people in the community may mistakenly view anyone in therapy as weak or dangerous. Even with our best efforts, there is a risk that therapy may not work out well for you.

While you consider these risks, you should also know that the benefits of therapy have been demonstrated in hundreds of well-designed research studies. In therapy, people have an opportunity to learn new strategies to manage and understand difficult feelings, experience an improved mood, solve challenging life problems and enjoy improved interpersonal relationships. I work with a number of evidence based treatment models. Please ask for more information.

**About Appointments**

The first time we meet, we will need to give each other a lot of basic information. For this reason, I usually schedule 1–1.5 hours for this first meeting. Following this, we will usually meet for a 50-minute session once or twice a week, then less often as treatment progresses. We can schedule meetings that are convenient for both of us. Except in illness and emergencies, I make every effort to provide advance notice of my vacations or any other times we cannot meet. Please ask about my schedule in making your own plans. Please try not to miss sessions. When you must cancel, please give me at least 48 hours. *Missed appointment* fee $60.00 for any canceled appointments with less than 24 hours-notice. In the case of previously scheduled double or extended appointments the fee is $120.00. This is not billable to insurance.

In the case of snow or inclement weather, I will call to cancel if I will not be in the office. I don’t have any expectation that anyone will walk or drive in unsafe weather conditions so please let me know if you will need to reschedule.

MaineCare will not allow me to bill for missed appointments. Therefore, if you are a MaineCare client and have 2 “no shows” or short notice cancellations (less than 24 hours) services may be terminated.

**If You Need to Contact Me:**

***If you have a behavioral or emotional crisis you or your family members should call the statewide crisis number at***

***1-888-568-1112, call 911, or go to the nearest emergency room.***

My telephone number is 207-553-0079. I make every effort to be available to you when needed. That said, I cannot promise that you will always be able to reach me. Please leave a message on my voicemail, and I will return your call as soon as possible during office hours. While this can change, these hours are typically 9-5 Monday through Thursday. I am not in the office the Christmas and New Year’s weeks each year, or the last weeks in March, June, and September.

In some cases I may be out of town or otherwise unable to be reached for an extended period of time. In this case I would arrange for professional coverage for my practice. I will let you know if this occurs and who will be providing this coverage.

**Email, Texting, and Social Media**

For confidentiality and other reasons I use these tools in a very limited way as a part of my practice. I do have a practice related Facebook page but it is only occasionally updated and I do not respond to comments. It is also not meant to replace treatment. With your permission, I may use email or text on occasion but tend to limit this to administrative communications such as appointments, scheduling and to forward educational materials. While I take steps to protect electronic information, anything going through the Internet is at risk. I may not read or respond to non-administrative emails or texts and will save these for discussion at our next session.

**About Confidentiality and Clinical Records:**

All information between provider and client is held strictly confidential unless:

* The client authorizes release of information with his/her signature
* I am served with a subpoena (and subsequent court order) compelling me to testify or provide documentation from our sessions.
* The client presents an imminent physical danger to themselves OR others
* Child/elder/dependent adult abuse/neglect is suspected.

If your records need to be seen by another person/organization I will discuss it with you. If you agree to share these records, you will need to sign a release of information form. You can review, add to or correct your own records in my files at any pre-arranged time. You may also have copies of them. Requests for copies should be in writing and please allow for 30days.

I ask you to understand and agree that you may not examine records created by anyone else and then sent to me. If I believe that information in your record could be detrimental, I may remove it prior to your review but will discuss this with you. It is my office policy to destroy clients’ records 10 years after the end of our therapy or 10 years from the age of 18 if a child.

Insurance companies often require information on symptoms, diagnoses, and my treatment methods. Requests will become part of your permanent medical record. My policy is to provide only as much information as the insurance company will need to pay your benefits. I cannot be responsible for the integrity or safety of client records once they leave my office under any circumstances.

***If your address must remain private for safety reasons, please let me know so we can take extra safeguards. Please know that I cannot control where insurance companies mail benefit information. Please contact them if this is a concern.***

If there is an emergency during our work together I am required by law and by the rules of my profession to contact someone—perhaps a relative, spouse, or close friend. I am also required to contact this person, or the authorities, if I become concerned that you may harm yourself or someone else.

I have a hybrid medical records system and use an online Electronic Medical Record System called TherapyNotes for some aspects of documentation and billing. I have a business associate agreement with them and they are bound by confidentiality laws (including HIPAA) for protecting your Personal Health information. Please let me know if you would like more information. I also use Faxage which is an online fax service. I have a business associate agreement with them as well. Please let me know if you would like more information.

Confidentiality extends to community interactions. For example, if we meet socially I may not acknowledge you in order to maintain your privacy.

**Consultations**

If for some reason treatment isn’t going as expected or I think you could benefit from a treatment I cannot provide, I will help you find a new therapist or connect with other support resources. For example, I may recommend an evaluation for medication or medical assessment.

I regularly seek peer and/or consultative support for case review, education and problem solving. While your personally identifying information is not disclosed, clinical information would be disclosed. Please let me know if you disagree with this potential as it may be more appropriate for me to refer you to another clinician who may be able to honor this request.

**Client Rights: Please see separate document.**

**I do not discriminate** against clients because of any of these factors: age, sex, marital/family status, race, color, religious beliefs, ethnic origin, place of residence, veteran status, physical disability, health status, sexual orientation, or criminal record unrelated to present dangerousness. If you believe you have been discriminated against, please bring this matter to my attention immediately.

**Dual Relationships:**

Therapy should never involve sexual, business, or any other dual relationships that could impair my objectivity, clinical judgment, therapeutic effectiveness or could be exploitative in nature. It is possible that during the course of your treatment, I may become aware of other preexisting relationships that may affect our work together. In that case, I will do my best to resolve these situations responsibly and ethically, but this may entail our needing to stop working together. Please discuss this with me if you have questions or concerns. Also, because I am your therapist, ***I cannot accept gifts of any kind nor have any other role in your life such as a personal relationship or other business relationship***.

**Minor Children:-see addendum for more information.**

When working with children and adolescents, communication with parents/guardians is vital. In the case of separated or divorced parents both parents must consent to treatment unless there is a specific court order stating otherwise. Parents have the right to know how treatment is progressing so that decisions can be made about the minor’s care; however, the minor child has the right to a certain level of confidentiality to facilitate development of the therapeutic relationship and effective intervention. A child’s assent/consent, in keeping with his/her developmental level, will be sought when information is shared, unless urgency precludes same.

**Safety:**

My office is intended to be a safe place for clients, families, visitors and myself. If you or an invited guest commit violence to, verbally or physically threaten, or harass me, yourself, other clients, the office, or my family, I reserve the right to terminate your treatment unilaterally and immediately. I will also press legal charges when possible. I know this sounds extreme but I have, unfortunately, discovered it as a necessary statement.

**Complaints:**

Just as in any other relationship. If you are not satisfied with any area of our work, please raise your concerns with me immediately. Our work together will be slower and harder if your concerns are not addressed. I will make every effort to hear any complaints or concerns you have and to seek solutions. If you feel that I have treated you unfairly or have even broken a professional rule, please tell me. You may also contact the Maine Board of Social Work Licensure. For more information please ask for a copy of the NASW standards or go to [www.naswdc.org](http://www.naswdc.org) .

**Our Agreement**

**I, the client (or his or her parent or guardian),** understand I have the right not to sign this form. My signature below indicates that I have read and discussed this agreement; it does not indicate that I am waiving any of my rights. I understand that any of the points mentioned above can be discussed and may be open to change. If at any time during treatment I have questions about any of the subjects discussed in this document, I can talk with you about them, and you will do your best to answer them. I understand that after therapy begins I have the right to withdraw my consent to therapy at any time, for any reason. However, I will make every effort to discuss my concerns about my progress with you before ending therapy with you.

I understand that no specific promises have been made to me by this therapist about the results of treatment, the effectiveness of the procedures used by this therapist, or the number of sessions necessary for therapy to be effective.

I have read, or have had read to me, the issues and points in this agreement. I have discussed those points I did not understand, and have had my questions, if any, fully answered. I agree to act according to the points covered in this agreement including payment for services. I hereby agree to enter into therapy with this therapist (or to have the client/child enter therapy), and to cooperate fully and to the best of my ability, as shown by my signature here.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_

Name of client Date of Birth

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of client (or person acting for client) Date Printed Name

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of client (or person acting for client) Date Printed Name

**I, Rhonda Hughes**, have met with this client (and/or his or her parent or guardian) for a suitable period of time, and have informed him or her of the issues and points raised in this brochure. I have responded to all of his or her questions. I believe this person fully understands the issues, and I find no reason to believe this person is not fully competent to give informed consent to treatment. I agree to enter into therapy with the client, as shown by my signature here.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Therapist Date Printed Name

I truly appreciate the chance you have given me to be of professional service to you, and look forward to a successful relationship with you. If you are satisfied with my services as we proceed, I (like any professional) would appreciate your referring other people to me who might also be able to make use of my services.

**Financial Agreement**

As a courtesy, I (or my billing support person) will submit documentation to your insurance company for payment. There is no guarantee that insurance will pay for any or all fees. They may also recoup fees already paid but at a later date. To the best of my knowledge, I will discuss with you what I believe insurance will/will not pay. Ultimately you are responsible for the full payment of services. It is your responsibility to verify the specifics of your coverage.

While I participate with many insurance companies, this tends to shift and change over time. In the event that I discontinue the contractual relationship I may have with your insurance provider, I will provide you with a written 100 days-notice.

Please pay known fees and copayments at each session. A lapse in payment may cause a lapse in services or cancellation of future appointments until the balance is paid or payment arrangements can be made. If this is the case I will provide you with other therapist/agency names and contact information.

*Some of the more common fees include:* $175.00 Initial evaluation, $135.00 per session up to 50 mins; $100.00 per hour for sessions exceeding 60 minutes-prorated, $35.00 per 15 mins telephone communication (brief conversations are expected and no fee is charged).

*Missed appointment* fee $60.00 for any canceled appointments with less than 24 hours-notice. In the case of previously scheduled double or extended appointments the fee is $120.00. This is not billable to insurance.

*Reports and copies of records*: Copies are $0.50 per page. Postage varies. $135.00 per hour for non-court related document/report preparation.

*Other Fees*: If you become involved in legal proceedings that require my participation, you will be expected to pay for my professional time and services even if I have been called to testify by another party. Because of the difficulty of legal involvement and the interruption to my regular practice, I charge $200 per hour for preparation (including note/report writing) and attendance at any legal proceeding. A $1000.00 advance payment will be requested at the time I learn of a scheduled court event date and is due two weeks before the scheduled court date.

*Please feel free to request a full copy of my fee schedule.*If any financially related issues come up, please bring it to my attention so they may be worked out openly and quickly.

I authorize Rhonda Hughes, LCSW to release any information necessary for third party claim submission and/or payment of services. Third party Payments are authorized to be made directly to Rhonda Hughes, LCSW for services rendered. I authorize use of this signature on all insurance submissions.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_

Name of client Date of Birth

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of client (or person acting for client) Date Printed Name

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of client (or person acting for client) Date Printed Name

**I, Rhonda Hughes**, have met with this client (and/or his or her parent or guardian) for a suitable period of time, and have informed him or her of the issues and points raised as related to this financial agreement. I have responded to all of his or her questions. I believe this person fully understands the issues, and I find no reason to believe this person is not fully competent to give financial consent.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Therapist Date Printed Name

**Addendum**

**Agreement for Parents & Caregivers**

Addendum to *Information for New Clients and Treatment Consent Form*

The process of therapy is often more complicated for children as there are many people who are interested in the welfare of a child. It becomes even more complicated when a child comes from a family where the parents are divorced or separated. This agreement is an effort to clarify some of the complexities from the beginning to avoid surprises later.

My work with children, is guided by the ethics and foundational knowledge of my profession, licensing regulations, peer consultation and education as well as my experience and additional training. I believe in supporting children in achieving and maintaining safety, security and the primary attachment relationships in their lives. I am also concerned with helping children find ways to deal with difficult and confusing thoughts and feelings and finding ways for them to express feelings and needs in a safe and appropriate way.

**Therapist Responsibilities:**

* Establishing a therapeutic alliance with the child client
* Facilitating open and appropriate expression of the strong feelings which routinely accompany major stressors.
* Providing an emotionally neutral setting in which children can explore these feelings.
* Helping children understand and accept changes in their life
* Contacting your child’s caregivers and community professionals (as needed) to gather information relevant to understanding your child’s welfare and circumstances and/or to coordinate treatment efforts. (e.g., pediatrician, teachers, other psychologists, social workers, etc.).
* Offering feedback and recommendations to a child’s primary or other caregivers based on knowledge of the child’s specific emotional needs and developmental capacities.
* NOT to take a side, except perhaps the child’s point of view, especially when that point of view may not be clear to others.
* NOT to serve as a mediator or make recommendations verbally or in writing about physical custody, child residence, visitation, parenting capacity or in any other area of parental dispute.

**Parent/Caregiver Responsibilities:**

* Each of the child’s caregivers (e.g., parents, stepparents, daycare workers, guardian ad litem [GAL], etc.) mutually accepts and implements the recommendations for and related to the child’s participation in therapy.
* Refraining from bringing the parental/caregiver conflict into the therapy room as the usefulness of therapy is extremely limited when the therapy itself becomes simply another matter of dispute between caregivers or others.
* NOT to discuss family/adult issues in front of the child
* Recognizing and, as necessary, reaffirming to the child, that the therapist is the child’s helper and not allied with one parent or the other.
* Remaining in frequent communication regarding this child’s welfare and emotional well­being. Open communication about his or her emotional state and behavior is critical. In this regard, I invite each of you to initiate frequent and open exchange with me as your child’s therapist and to attend any scheduled family sessions.
* Caregivers involved choose to participate in co-parenting or other related group in which separating and divorced parents learn basic co-parenting strategies focused on the best interests of the child.

**Confidentiality:**

Children should have a reasonable expectation that their work with me will be kept confidential except in limited circumstances such as those described in the “Information for New Clients and Treatment Consent Form”. While parents have access and a right to review the record and have knowledge of the content of sessions (some limitations apply as the child grows older), I ask that parents make a commitment not to engage the child in content conversations about sessions or read the record. This supports the development and maintenance of a therapeutic and trusting relationship between the therapist and the child.

I will encourage and assist children in sharing information with parents when appropriate. Information shared without your child’s consent can serve to seriously erode the relationship we have built and negatively impact your child’s ability to benefit from treatment.

I keep records of all contacts relevant to your child’s well-being including written communications, emails, and phone messages. Clinical records are subject to court order and may be disclosed to the court and, under some circumstances and with your permission, may be disclosed to parties to your divorce, including your attorneys.

Any matter brought to my attention by either parent regarding the child may be revealed to the other parent/caregiver. While I use great discretion, I don’t typically keep secrets. Obviously there will be some exceptions.

**Financial:**

The parent/guardian who initially registers the child for services is responsible for payment of the account. Typically this is the person who brings the child to the first session. It is the responsibility of this person to collect reimbursement from the other parent if sharing expenses and for payment of missed appointment fees. Receipts available upon request. The missed appointment fee will apply if an appointment is missed regardless of which parent/guardian scheduled the appointment.

**Court Involvement:**

In order to protect the therapeutic relationship, child’s confidentiality and the effectiveness of treatment, I ask that I not be called as a witness in a court proceeding by either party. Revealing information discussed between the child and the therapist can have potentially emotionally damaging effects on the child, the family, and be detrimental to the entire treatment process. Even the appearance of such has a negative effect, such as a child knowing or seeing me in court. Depending on proceedings, I may not be able to continue as your child’s therapist.

If I am ordered to appear in court for testimony, parents will be billed at $200 per hour for any court related activities. This must be paid in advance according to the attorney’s estimate of the time required. See “*Information for New Clients and Treatment Consent Form*”.

If I am required to appear as a witness, the party responsible for my participation agrees to reimburse me at the rates noted in the “*Information for New Clients and Treatment Consent Form*” for time spent.

By signing below, I am acknowledging that I have read, understand, and have had opportunity to ask questions and/or clarify terms and consent to the terms of this agreement.

Name of client: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of client (or person acting for client) Date Printed Name

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of client (or person acting for client) Date Printed Name

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Rhonda Hughes, LCSW Date Printed Name