Marni Millet, LCSW, CASAC
4309 East Genesee Street, Ste. 4
Syracuse, NY 13214
marnimillet@marnimillet.com
315.480.7160

Psychotherapy Agreement

Welcome to my practice-I am happy you made this huge decision for yourself! Please read the following, as this will be our agreement throughout our time together, which begins today.

Psychotherapy is a very engaged activity and not a passive stance by the therapist. I will be engaged and collaborate with you, working through a holistic perspective. This therapy can be transformational, if you let it. I am versed in many theories, and use an eclectic approach to being. This is a collaborative partnership, so please ask questions, as this is a courageous step you are taking with me. Please know that our first session will involve an evaluation of your needs. By the end of the evaluation, I will be able to offer you some 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, I will inform you if I believe that I am not the right therapist for you and, if so, I will give you referrals to other practitioners whom I believe are better suited to help you. Please know that my practice is not affiliated with Paul Cohen, PhD., but share our professions in a co-located suite.

Confidentiality

In general, the privacy of all communications between a patient and a psychotherapist is protected by law, and I can only release information about our work to others with your written permission. But there are a few exceptions.

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.

There are some situations in which I am legally obligated to take action to protect others from harm, even if I have to reveal some information about a patient's treatment. For example, if I believe that a child [elderly person or disabled person] is being abused or has been abused, I must [may be required to] make a report to the appropriate state agency.

If I believe that a patient is threatening serious bodily harm to another, I am [may be] required to take protective actions. These actions may include notifying the potential victim, contacting the police, or

seeking hospitalization for the patient. If the patient threatens to harm himself/herself, I may be obligated to seek hospitalization for him/her or to contact family members or others who can help provide protection. If a similar situation occurs in the course of our work together, I will attempt to fully discuss it with you before taking any action.

I may occasionally find it helpful to consult other professionals about a case. During a consultation, I make every effort to avoid revealing the identity of my patient. The consultant is also legally bound to keep the information confidential. Ordinarily, I will not tell you about these consultations unless I believe that it is important to our work together. These practitioners are Patricia Coughlin, PhD; Jon Frederickson, MSW; and other colleagues in the various peer supervision groups. We will discuss video-recordings and you will consent before showing these recordings.

Sessions

Practice days/hours are Monday-Thursday: 9am-3pm. Any sessions scheduled outside these times are at my discretion and are appointments for ISTDP/Self Pay sessions only. I ask that once attending the initial assessment, you make a commitment to meet for the next six sessions, if we agree to move forward with our partnership after the first visit. This gives us an opportunity to build our collaborative alliance, as our work together in therapy is important to reach your goals.

If you are requesting ISTDP, including video-recording, this method is self-pay only.

Payments

ISTDP Video-recorded treatment

$375 ISTDP Psychotherapy Assessment: (2.5 hours)

$225 Individual Sessions (60 Minutes)

Treatment (NON-ISTDP, no video recording)

Couple Counseling is self pay only, $250 (60 min)

Assessment Individual $225 (60 min)

Individual sessions $175 (60 min)

Payments for Self-Pay sessions are made 48 hours before the appointment. Payment via check is my preferred method for payment. If it's best for you to use credit card, I'm happy to accept them, as well. HSA/Flex payment available through Square.

You will be charged the total fee for any session that is cancelled with less than a 48 hour notice, or the day of session. This fee is payable before scheduling the following session. I am unable to charge your insurance for a missed appointment, or late cancel. Appointments scheduled for a Monday will need to be

cancelled by you no later than 12pm on the Friday prior to your Monday appointment. Otherwise, you will be charged the late cancel fee with weekend or Monday cancellations. I appreciate the early notification in order to keep my small practice operating successfully.

Please let me know if you have had a change in your insurance coverage. You will need to supply insurance information to my billing service(O'Brien's Billing, 437-1451) before your first appointment and at any time your insurance coverage changes. In order to bill your insurance company, I have to supply a clinical diagnosis that justifies the service as medically necessary. If we are not billing your insurance directly and you would like to submit a claim to your insurance company for reimbursement of costs associated with my services, I will supply you with a Superbill with all required information. In order for you to get reimbursement from your insurance company, I have to supply a clinical diagnosis to your insurance company that justifies the service as medically necessary.

Other Fees

My hourly individual fee is $175. In addition to weekly appointments, I charge this amount for other professional services you may need, though I will break down the hourly cost if I work for periods of less than one hour. Other services include report writing, telephone conversations lasting longer than 15 minutes, attendance at meetings with other professionals you have authorized, preparation of records or 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 my professional time even if I am called to testify by another party. Because of the difficulty of legal involvement, I charge $400 per hour for preparation, travel, and attendance at any legal proceeding.

Contacting me

I am not always immediately available by telephone. You may leave a message on my cell phone (315.480.7160). You may text this phone number and please be aware that if you do text personal information to this phone, you are authorizing me to text back and this info is not secure and at your own risk. You may email me for non-emergency reasons at marnimillet@marnimillet.com. I will do my best to return your call/email on the same day. If you are in a medical or psychiatric crisis (symptoms feeling out of control/ suicidal or homicidal), you should call 911 or proceed immediately to the ER or Comprehensive Psychiatric Emergency Program (located at St. Joseph's Hospital) for emergency evaluation/ intervention. Please call me at 315-480-7160 for immediate assistance, as well. Please do not contact me on weekends or Holidays, or outside the hours of 7am-9pm weekdays, unless it is an emergency. Remember that emergencies supersede any policy here and you will need to reach out to me in the event of an emergency, and I welcome it.

Client consent to psychotherapy

I have read this statement, had sufficient time to be sure that I considered it carefully, asked any questions that I needed to, and understand it. I understand the limits to confidentiality required by law. I consent to the use of a diagnosis in billing, and to release that information and other information necessary to complete the billing process. I agree to pay the fees listed above. I understand my rights and responsibilities as a client, and my therapist's responsibilities to me. I agree to billing/clinical use through KAREO electronic medical records. I agree to undertake therapy with Marni Millet, LCSW, CASAC. I know I can end therapy at any time I wish and that I can refuse any requests or suggestions made by Marni Millet. I am over the age of thirteen.

I have read the policies and understand and agree with them. I hereby agree to be treated by Marni Millet, LCSW, CASAC. I agree that I am personally responsible for ensuring that all charges for services rendered are paid by myself. I authorize Marni Millet to provide information concerning my treatment to any physician or therapist who referred me. Patients are under no obligation to continue services should they decide to terminate at anytime.

NOTICE OF PRIVACY PRACTICES and CONFIDENTIALITY AGREEMENT:
Initial _____ and circle Y/N I acknowledge that I have read, been offered a copy, signed the Notice of Privacy Practices.

Initial _____ and circle Y/N I may be contacted through Text, Email, Phone, and message may be left on my Voicemail. I realize that PHI may be identified through these communications, but mostly confirmation for scheduled appointments. PHI discussions are only through your request and agreement for supportive texts between sessions, after our discussing first. Please know that dual relationships, current, or after discharge, are unethical, and no social media will be shared (FB, Instagram, Twitter, LinkedIn, or other forms of social media)between therapist and client, out of respect for client confidentiality.

Initial _____ and circle Y/N If you reach out with personal information via texting(which I highly advise you do not, as it could be breached d/t internet) you give permission for me to text personal information including information protected by Federal Regulations Article 42 CFR Part 2, when I respond to your texting for additional support between session. I highly advise against this and typically will not text through this method.

I, the undersigned, agree that I am financially responsible for all services provided by Marni Millet, LCSW, CASAC. I am aware that the office policy requires payment at time of service. If paying with insurance, I will complete the insurance form and pay Co-pay or Co-Insurance at the time of the session.

PATIENT NAME_____DATE_____

SIGNATURE_____DATE_____

MARNI MILLET, LCSW,CASAC _____DATE _____