Roberta Hammond and Associates LLC

Client Information and Office Policy Statement
Informed Consent

I. New Client: Welcome!
Thank you for choosing to enter treatment. This is an opportunity to acquaint you with information relevant to treatment, confidentiality and office policies. Your therapist will answer any questions you have regarding any of these policies.

II. Aims and Goals:
The major goal is improving your quality of life including identifying and coping more effectively with problems in daily living and to deal with inner conflicts which may disrupt your ability to function effectively. This purpose is accomplished by:

1. Increasing personal awareness.
2. Increasing personal responsibility and acceptance to make changes necessary to attain your goals.
3. Identifying personal treatment goals.

You are responsible for providing necessary information to facilitate effective treatment. You are expected to play an active role in your treatment, including working with your therapist to outline your treatment goals and assess your progress. There may also be negative consequences if you do not follow through with recommended treatment(s). Probabilities of these will be discussed as part of your treatment planning.

You may be asked to complete questionnaires or to do homework assignments. Your progress in therapy often depends much more on what you do between sessions than on what happens in the session.

III. Appointments:
Appointments are usually scheduled for 45 to 60 minutes. Clients are generally seen weekly or more/less frequently as acuity dictates and you and your therapist agree. You may discontinue treatment at any time, but please discuss any decisions with your therapist. In the event of an emergency, dial 911, call Crisis Care at (937) 224-4646, or go to the local emergency room.

IV. Confidentiality:
Issues discussed in therapy are important and are generally legally protected as both confidential and "privileged." However, there are limits to the privilege of confidentiality. These situations include: 1.) suspected abuse or neglect of a child, elderly person or a disabled person, 2.) when therapist believes you are in danger of harming yourself or another person or you are unable to care for yourself, 3.) if you report that you intend to physically injure someone the law requires your therapist to inform that person as well as the legal authorities, 4.) if your therapist is ordered by a court to release information as part of a legal involvement in company litigation, etc. 5.) when your insurance company is involved, e.g. in filing a claim, insurance audits, case review or appeals, etc., 6.) in natural disasters whereby protected records may become exposed or 7.) when otherwise required by law. You may be asked to sign a Release of Information so that your therapist may speak with other mental health professionals or to family members.

V. Record Keeping:
A clinical chart is maintained describing your condition and your treatment and progress in treatment, dates of and fees for sessions, and notes describing each therapy session. Your records will not be released without your or your guardian's written consent, unless in those situations as outlined in the Confidentiality section above. Medical records are locked and kept on site. Request for medical records will be subject to medical records copying fees in accordance with Ohio Revised Code 3701.741.

Client Information and Office Policy Statement – continued

VI. Fees:

Initial Assessment:	$145.00	Individual Session, 60 Minutes:	$125.00
Individual Session, 30 Minutes:	$65.00	Family Therapy with client present	$125.00
Individual Session, 45 Minutes:	$100.00	Family Therapy w/out client present	$125.00

VII. Document Review and Writing and Telephone/Email Services:

Document review and writing as well as services provide via the telephone are not covered by your insurance. Telephone calls and email correspondence lasting more than 8 minutes and document review/writing services will be billed directly to you at $125.00/hour. Services will be billed in 15 minute increments with a $50.00 minimum fee.

VIII. Court Appearance or Testimony

Court appearance or testimony is billed at an hourly rate of $125.00, portal to portal, plus mileage and expenses. Court preparation time as well as time spent consulting with attorneys will also be billed. A copying and file preparation charge will be billed for records or other materials subpoenaed. The individual requesting this activity will be billed separately from regular charges and payment is due in full upon receipt of statement. A prepaid deposit may be required before this service is rendered.

IX. Payments:

Payment is due at the time of the session unless other arrangements have been made. Your therapist will file your insurance claim, but you are responsible for deductibles, co-insurance, and co-payments. It is your responsibility to familiarize yourself with your insurance benefit.

X . Cancellations and Missed Appointments:

You will be billed for a session that you cancel with less than 24 hours notice. You may leave messages 24 hours per day. You will be billed **$50.00** --not just a co-payment. Insurance companies generally do not reimburse for missed appointments.

XI. Complaints:

You have a right to have your complaints heard and resolved in a timely manner. If you have a complaint about your treatment, your therapist, or any office policy please inform us immediately and discuss the situation. If you do not feel the complaint has been resolved, you may also inform your insurance carrier and file a complaint if you so choose.

XII. Consent for Treatment

By signing below, you are stating that you have read and understood this 2-page policy statement and you have had your questions answered to your satisfaction.

I accept, understand and agree to abide by the contents and terms of this agreement and further, consent to participate in evaluation and/or treatment. I understand that I may withdraw from treatment at any time.

Name of Client (please print)_____

Signature:_____

Date:_____

Therapist/Witness:_____