

CLIENT INFORMATION AND SERVICE AGREEMENT (page 1 of 2)

Welcome to my practice!

I realize that starting counseling is a major decision and you may have many questions. This document is intended to inform you of my policies, State and Federal laws, and your rights. If you have any questions or concerns, please ask and I will try to give you all the information you need.

Counseling focuses on resources, strategies and solutions to help you with your presenting problem or situation. While we may discuss different areas of your life, the focus of counseling will be working on your specific goals. In order for our work to be effective, it is necessary for you to take an active role. Participation involves discussing your concerns openly and providing feedback about the progress of counseling.

Therapy also has potential emotional risks. Approaching feelings or thoughts that you have tried not to think about for a long time may be painful. Making changes in your beliefs or behaviors can be scary and sometimes disruptive to the relationships you already have. You may find your relationship with me to be a source of strong feelings. It is important that you consider carefully whether these risks are worth the benefits to you of changing. Most people who take these risks find that therapy is helpful.

Appointments: Standard appointments are 45 - 50 minutes long (the standard therapy hour), but extended sessions are available. Unless using insurance, telephone sessions can be scheduled if you are unable to come into the office. Sessions with an adolescent may only last 30-45 minutes, depending upon the adolescent's ability to tolerate the therapy process.

Telephone calls: My telephone is answered by voice mail that I check frequently. I return most calls within a few hours if you leave a message before 7 pm. If you are difficult to reach, please inform me of some times when you will be available. On rare occasions, my voice mail may fail to record messages. Therefore, if I haven't returned your call within 24 hours, please call again. In an emergency, call 911 or go to the nearest emergency room.

Confidentiality: Counseling often involves sharing sensitive, personal, and private information. All sessions are confidential to people outside of the therapy, with some exceptions. I cannot and will not tell anyone what you have told me without your prior written permission. You may direct me to share information with whomever you choose and you can change your mind and revoke that permission at any time. The following are *legal* exceptions to your right to confidentiality:

1. If I have credible reason to believe that you will harm another person, I must attempt to inform that person and warn them of your intentions. I must also contact the police and ask them to protect your intended victim;
2. If I have good reason to believe that you are abusing or neglecting a child, or vulnerable adult, or if you give me information about someone else who is doing this;
3. If I believe that you are in imminent danger of harming yourself, I may legally break confidentiality and call your family, the police and/or a local crisis team; or
4. In some legal proceedings, upon a court order, testimony and/or records may be rendered.

In addition, information may be shared for supervision or consultation reasons or to collect payments from your insurance company. Like anything on the internet, communication by email is able to be intercepted by 3rd parties, and is therefore, not considered a confidential means of communication.

In counseling adolescents, I prefer to keep confidentiality as much as possible in order for the therapeutic process to work. While you, as parent or guardian, may have a legal right to information, know that if you insist on knowing what is being said, your son or daughter may well lose confidence in the process, and in me, and the benefits of the therapy may be lost.

You acknowledge that you have received a copy of your privacy rights and have had the opportunity to discuss them with me.

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Other Rights

You have the right to ask questions about anything that happens in therapy. I'm always willing to discuss how and why I've decided to do what I'm doing, and to look at alternatives that might work better. You can feel free to ask me to try something that you think will be helpful. You can ask me about my training for working with your concerns, and can request that I refer you to someone else if you decide I'm not the right therapist for you. You are free to leave therapy at any time. If I am away, or unavailable, for an extended period of time, I will provide you with the name of a colleague to contact, if necessary.

Record-keeping.

I keep very brief records, noting only that you have been here, what interventions happened in session, and the topics we discussed. If you prefer that I keep no records, you must give me a written request to this effect for your file and I will only note that you attended therapy in the record.

Payment policy: You agree to make payment at the time of service. You are responsible for paying for your session weekly, unless we have made other arrangements, in advance. My fee for a session is \$110.00/individual and \$125.00/family or couple (except for the initial session, which is \$150.00) unless we have made other arrangements. Phone calls made on your, or your adolescent's, behalf, to collateral contacts (teachers, guidance counselors, physicians, probation officers, etc.), will be billed at a prorated session rate. All insurance information is taken as a courtesy. You agree your insurance company will pay me directly for services rendered. If the information proves to be invalid or inaccurate, you agree that you are responsible for any outstanding balance you may have accrued (balances carried for 30 days or more will be charged directly to your credit card on file). You authorize the release of any records, which may be necessary to process your or your child's insurance claims.

Cancellation policy: You agree to cancel appointments only in the event of extreme necessity. You understand you will be charged \$110.00 unless you provide 24 hours advance notice of a cancelation. You give your permission for me to charge this late cancel/no show fee to your credit card on record.

Permission to treat: You acknowledge that it is your choice to participate in psychotherapy (or have your adolescent participate). You will take responsibility for your psychotherapy and will come prepared and ready for each session. You will discuss termination prior to ending treatment.

Intake Date:	Email:	URGENT	DOB:
Last Name:	First Name, "nickname":		Sex:
Street:	Town:	Zip Code:	
Telephone (H):	2nd (work, cell, pager):		
Person Calling:	Who may I thank for referring you?:		
Insurance:	Insurance ID#:		
Subscriber:	Sub. DOB:	Benefits & Auth. (for Therapist use)	
Sub. Address/Phone:		Ded. Met?	
Insurance Co. Ph. #:	Employer:	Co-Pay	
Credit Card: MC Visa AmEx CC#:		CC Exp:	Benefit
Claims Address/Special Instructions (for therapist use)			Visits Used?

Your signature acknowledges your agreement and understanding of the above:

Client Signature

Date

Therapist Signature

Date

2 Columbia Road ~ Suite 11 ~ Pembroke, MA 02359 ~ 781/826-2270

Michelle Ruprecht, LICSW

CONSENT FOR COORDINATION OF CARE

Date: _____ Name of Client: _____ DOB: _____

I, _____ (client/guardian) give / refuse my consent for

Michelle Ruprecht, LICSW and _____ (Primary Care Physician or Care Provider)

to exchange information regarding my medical treatment and treatment for mental health issues. I understand that this consent will remain in effect for the duration of my care by my current psychotherapist, unless I request its termination.

Client/Guardian Signature

Name of Primary Care Provider

Address

Telephone/Fax

Dear Primary Care Provider:

As the treating mental health provider, I am requesting the following information:

**Report from most recent Physical Examination

Date Received: _____

**Current Medications and purpose

**Consultations as needed

Per Massachusetts Department of Public Health regulations, I advise my clients to obtain an annual physical exam. Please be assured of my commitment to work closely with Primary Care Providers to coordinate the best care possible.

Sincerely,

Psychotherapist Signature

Michelle Ruprecht, LICSW

AUTHORIZATION FOR RELEASE OF INFORMATION

FOR _____ DOB _____

I, _____ (client / guardian), give / deny permission for

Michelle Ruprecht, LICSW and

Person

Organization

Address

Phone Number

to discuss or furnish written information with regard to the above named client within the guidelines outlined below. This release of information excludes psychotherapy notes, which require a separate, specific release of information.

Express purpose of releasing information:

Specific information to be released:

This release of information expires on _____ or _____.
Date Event

I understand that I may revoke this permission at any time regardless of the expiration conditions above and have been given an opportunity to ask questions regarding this form.

Client/Guardian Signature

Date

Printed Name

Michelle Ruprecht, LICSW

PATIENT INFORMATION

NAME:

SEX:

DOB:

ADDRESS:

HOME PHONE:

ALTERNATE PHONE:

NOTE:

EMERGENCY CONTACT

NAME:

RELATIONSHIP:

ADDRESS:

HOME PHONE:

ALTERNATE PHONE:

NOTE:

MEDICATION ALLERGIES

Michelle Ruprecht, LICSW

Michelle Ruprecht, LICSW is part of a group of **independent practitioners** who share office space as a matter of convenience. As such, I acknowledge that under no circumstances will any independent practitioner that is associated with this group of independent practitioners, other than the individual practitioner from whom I receive services, be held liable for any actions or omissions committed by my individual therapist.

Client or Guardian Signature

Date

Please Print Client Name Here