GENERAL INFORMATION AND FEE STRUCTURE

The following is an overview of psychotherapy assessment services and clinical fee structure. This is used to provide a clear and mutual understanding of the professional and business aspects of my services. Please read this information carefully and feel free to ask me about anything that is unclear to you and/or to share concerns about those issues.

CONFIDENTIALITY: All client information is confidential and will be protected under the HIPAA Privacy Policy. A copy of my privacy policy will be made available to you.

In order to assist with insurance reimbursement, diagnosis, treatment plans, and progress, information may be requested by your insurance carrier. Be advised some insurance companies are requesting detailed information.

To enhance the quality of treatment services, other mental health professionals are periodically consulted regarding specific cases. They also provide coverage during my absence. These professionals are bound by ethical and legal standards regarding confidentiality, and information will not be used for any public or media purpose. If this arrangement raises concerns for you or violates your sense of privacy, please discuss this with me.

CLIENT RIGHTS: You have the right to end therapy at any time without moral, legal, or financial obligation beyond payment due for completed sessions or any missed appointments for which you are responsible. Therapy termination can sometimes be the result of misinterpretation, miscommunications, and the painfulness of the material being dealt with. Should you decide between sessions to withdraw from therapy, I ask that you attend one more session to discuss your reasons prior to making a final decision. If you decide to terminate, yet desire to continue therapy elsewhere, I will be able to provide you with names of other qualified therapists. You have the right to ask questions about philosophy of therapy, assessment findings and results, experience with your presented issues, treatment plans, and procedures used.

FEE STRUCTURE

(unless insurance restrictions apply)

INITIAL EVALUATIONS:	$160 per 60-75 minute session
INDIVIDUAL THERAPY:	$105 per 45-50 minute session $160 per 60 minute session
FAMILY THERAPY:	$105 per 45-50 minute session
COUPLES THERAPY:	$105 per 45-50 minute session
GROUP THERAPY:	$60 per 90 minute session
	$40 per 60 minute session

MISSED APPOINTMENTS: A $40 cancellation fee will be charged if the cancellation is not received within 24 hours of the scheduled appointment time. PLEASE NOTE: *Insurance companies do not pay for missed sessions.* If there are numerous missed or cancelled sessions, with notice or without, this will be discussed during the following therapy session for solutions.

PHONE CALLS: If it is necessary to provide frequent intervention by phone, calls will be billed at the usual hourly rate of $105 per 45 minute session. PLEASE NOTE: *Insurance companies do not pay for sessions conducted over the telephone.*

E-MAIL AND TEXT MESSAGING COMMUNICATIONS: These types of communications provide a great deal of convenience both to the patient/patient family and myself. Please be aware, however, non-encrypted e-mail and text messaging are not considered confidential or secure. Further, neither non-encrypted email nor text messaging meet HIPAA standards for confidentiality of protected healthcare information. Please decide the following:

I authorize New Day Counseling, LLC/Perette Halpin, LCSW-C to communicate by non-encrypted **e-mail** with me as necessary for my/patient's health care and treatment. I agree that non-encrypted **e-mail messages** may include protected healthcare information about me/patient whenever necessary.

*If *AGREE*, please identify preferred **E-Mail** address and initial below:
_____Initials:_____

If *DISAGREE*, please initial here: _____

I authorize New Day Counseling, LLC/Perette Halpin, LCSW-C to communicate by **text message** with me as necessary for my/patient's health care and treatment. I agree that **text messages** may include protected healthcare information about me/patient whenever necessary.

* If *AGREE*, please identify preferred phone number for **texting** and initial below:
_____Initials:_____

If *DISAGREE*, please initial here: _____

By signing below, I hereby release New Day Counseling, LLC/Perette Halpin, LCSW-C, representatives, and agents from any and all liability that may arise from the release of information as I have directed in the preceding two sections of this document. I understand I have the right to revoke any Authorization at any time. If I want to revoke any Authorization, I must do so in writing to New Day Counseling, LLC/Perette Halpin, LCSW-C. I understand that if I revoke any Authorizations, it will not apply to information released as a result of this Authorization. I understand I/patient cannot be denied or refused treatment if I refuse to sign for these authorizations.

*Signature of Authorization_____

INSURANCE/SCHOOL REPORTS: Billed at $160 per hour.

COURT FEES: $200 per hour (paid in advance). This includes preparation, travel and waiting times. There will be a cancellation fee of $200 for court appearances cancelled less than 48 hours prior to the scheduled time.

Special requests for letters to employers, attorneys, physicians, etc. will be billed at $160 per hour of preparation.

UNPAID BALANCES: All fees are payable at each session. Please notify me when financial circumstances make it difficult to pay your bill on a weekly basis. Large balances may result in straining our relationship and the work we do together. All balances due after 30 days will be subject to a 1.5% monthly charge (18% annually).

COLLECTIONS POLICY: In the event that therapy is ended and a bill is left unpaid, your name, address, and phone number will be given to a collection agency in order to collect payment. A collection fee of 50% will be added to the past due amount to cover the cost of the collection agency fee.

INSURANCE

Initial preauthorization for services is the client's responsibility. Each client is responsible to learn the details of your insurance policy and to comply accordingly. Failure to obtain authorization for services will result in client responsibility for the full fee. I will provide necessary information and statements for insurance reimbursement.

I am currently paneled with Aetna, APS Healthcare, BC/BS and Carefirst, InforMed, Cigna, Magellan, MH Net, Medicare, Medicaid, MultiPlan/PCHS, Quest, MHN and TRICARE, U.S. Family Healthcare, and the following EAPs: Cigna, Compsych, Deer Oaks, ENI, MH Net, Quest. If your company is not listed here, call Member Services to see if you have "out-of-network" benefits.

OFFICE INFORMATION

In order to keep costs to a minimum, a confidential voice mail is utilized which is routinely screened during the workday. Although my goal is to return calls as soon as possible, all calls will be returned within 48 hours.

This practice cannot provide 24-hour emergency service. If there is a crisis or emergency situation, please utilize your local hospital emergency room, psychiatrist, physician, etc. Hotline numbers are: 800-SUICIDE (784-2433); 800-273-TALK (8255); or 800-422-0009 (Maryland only). Persons who require frequent crisis intervention or hospitalization for major mental illness where symptoms include frequent suicide attempts or suicidal/homicidal ideation, and psychotic thought processes such as auditory or visual hallucinations will only be accepted if client is in active treatment with a psychiatrist. Otherwise, referral options will be discussed. Weekend and holiday coverage are provided on a very limited basis. Vacation coverage is arranged through an agreement with each individual client.

I have read and understand the terms listed in the General Information and Fee Structure form.

Printed Name of Client and/or Guardian

Signature

Date