Alex Klein, MS, LCSW
Psychotherapy, Consultation, and Collaborative Care

INFORMATION ON TREATMENT AND OFFICE POLICIES

The following information is intended to inform you of protocols concerning confidentiality, treatment, and the policies of my practice. Please read the information carefully. I encourage you to ask questions if you have any concerns before providing your consent to treatment.

Psychotherapist Responsibilities

The following information regarding confidentiality, including its limitations, will be discussed with you at the onset of therapy.

Information obtained during therapy is confidential. Therefore, information you share with me will not be disclosed to others without your knowledge, and in most cases, without your written consent. Nevertheless, there are some exceptions. If I believe your safety is in jeopardy, it is my responsibility to take the necessary steps to protect you. Even under these circumstances, to the extent possible, I will aim to inform you of exactly what my intentions are. If someone else is in danger because of your actions, I am obligated by law to warn them, even without your consent. If I receive a valid subpoena from a court, I may be obligated to release information without your consent.

If you are under 18 years old, your parents (or custodial parent if they are divorced) have a legal right to information about your treatment. However, in most instances, treatment is typically more effective when the same confidentiality rules that apply to adults, are put into practice with minors. Often times parental involvement (in the form of discussion or other communication) enhances therapy. If I feel this may be the case, I will seek your permission and we will make a mutual decision regarding what information should be shared.

OFFICE LOCATION

762 Boston Post Road, Madison, CT; second floor, suite two; left door (above Khaki and Black).

*If the door is closed it is because therapy is in session. Please have a seat in the waiting area and you will be met at your scheduled appointment time.

FEES AND FINANCIAL RESPONSIBILITY

Fees are due at the time that services are rendered and must be paid in full before another appointment can be scheduled. Please be advised that I accept payment in the form of cash, check, or card.

If you have an insurance provider, you will receive an invoice for payments made at the end of each month, which you may submit to your provider for direct reimbursement. You may be able to receive reimbursement from your insurance provider depending on the nature and extent of your benefits. Please contact your insurance company prior to scheduling your first appointment to determine information regarding your benefits.

PSYCHOTHERAPY SERVICES:

Initial Individual Psychotherapy Intake Session, *75-90 minutes*	$180
Individual Psychotherapy, *45-60 minutes*	$150
Initial Family Therapy Intake Session, *75-90*	$225
Family Therapy, *45-60 minutes*	$180

CRISIS CONSULTATION SERVICES:

Developing a Plan of Care, *45 – 60 minutes*	$225

The initial consultation (first visit) is approximately 1-2 hours in length and is billed at $225 per hour, with adjustments made for shorter or longer sessions.

At the initial session, we will collectively determine the amount of time required to conduct a comprehensive assessment; which includes, the client's current status, analysis of previous and collected data, and development of a specific and documented plan of care.

Beyond the initial consultation visit, the fee for consultation services is $3,000 billed over three installments. Services generally require approximately 20 hours of clinical work and treatment planning. Time that exceeds the originally contracted 20 hours will be billed at $225 per hour.

The above fees include the value of administrative and coordination tasks as a part of treatment (i.e. communication with other providers, record keeping, treatment plan completion, etc.). In the unusual event that more extensive written work or telephone consultation (exceeding 15 minutes) is required, a fee of $250 per hour will be charged.

CANCELLATION POLICY

When scheduling appointments, the time slot is reserved solely for you. I will operate under the assumption that you are to attend, until informed otherwise. It is essential that I am informed **of any cancellation at least 24 hours in advance of a scheduled appointment,** so that I may offer your time slot to another client. Please do so via phone call. Communication via email or text will **NOT** be accepted as valid cancellation. **Failure to give 24 hours of advanced notice of cancellation will result in a fee equal to that of the scheduled appointment,** unless your time slot can be filled. Charges will not be made due to cancellation for inclement weather, dangerous road conditions, and school closure.

CONSENT TO TREATMENT

I acknowledge that I have received, have read (or have had read to me), and understand the information about the therapy I am considering, and I have had all my questions answered fully.

I do hereby seek and consent to take part in the treatment by the therapist named below. I understand that developing a treatment plan with this therapist and regularly reviewing our work toward meeting the treatment goals are in my best interest. I agree to play an active role in this process.

I understand that no promises have been made to me as to the results of treatment or of any procedures provided by this therapist.

I am aware that I may discontinue my treatment with this therapist at any time. In this instance, I will be responsible for the payment of services already received. I also understand that in this instance, I may lose access to other services and/or may have to take responsibility for resulting consequences (e.g. the responsibility of answering to the court in the event that treatment has been court-ordered).

I know that I must call to cancel an appointment at least 24 hours prior to the time of the appointment. If I do not cancel and do not attend, I will be charged for that appointment.

I am aware that an agent of my insurance company or other third-party financier may be given information about the type(s), cost(s), date(s), and providers of any services or treatments I receive. I understand that my therapist has the right to discontinue treatment if services go un-paid for.

My signature below confirms that I understand and agree with all the aforementioned statements.

_____ _____

Signature of client (or person acting for client) Date

_____ _____

Printed name Relationship to client (if necessary)

I, the therapist, have discussed the aforementioned items with the client (and/or his or her parent, guardian, or other representative). My observations of this person's behavior and responses give me no reason to believe that this person is not fully competent to give informed and willing consent.

_____ _____

Signature of therapist Date

INSURANCE AND BILLING INFORMATION

Full Name (Printed)	
Mailing Address	
Date of Birth	
Insurance Company Name	
Insurance Identification Number	
Co-Pay	
If a minor, parents full name, and birth date (of policy holder)	
Phone Number	
Policy Holder Name and DOB (if not you)	
Email Address	
Emergency Contact Name/Number	

_____ _____

Client Signature Date

CREDIT CARD AUTHORIZATION

I _____ (name of card owner) authorize Alex Klein, MS, LCSW to charge my credit card for psychotherapy sessions at the agreed upon rate of $150.00/$225.00 per session (plus a 3% processing fee) in the year 2018. In addition, I authorize Alex Klein, MS, LCSW to charge my credit card for cancellation of sessions not honoring the 24-hour cancellation policy as well as missed sessions and I guarantee payment for any services rendered made with my credit card, including renewed cards.

_____

Authorized signature of cardholder Date

_____

Printed name of cardholder

Card Type: _____ American Express
_____ Master Card
_____ Visa
_____ Discover

Card Number: _____

Expiration Date: _____

Security Code _____

Name as it appears on card: _____

Address (where credit card bills are sent): _____

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