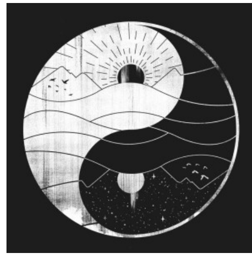


The Peace Practice Liz Eanniello, LICSW

THERAPIST - CLIENT RESPONSIBILITIES

Name: ____

I am committed to using my professional expertise to help you with whatever concerns you bring to counseling or those that come up during sessions. We will together establish your counseling/therapy goals and will clarify these from time to time.

Please read the following carefully and discuss with me any questions you have before signing. You will receive a duplicate copy.

APPOINTMENTS:

► Your appointment time is being reserved for you and is scheduled according to your counseling/therapy needs and appointment availability. Standard appointments are 50 minutes long and can be pro-rated to up to 75 minutes. Appointments can take place virtually via Zoom, in-person at The Meeting Point in Jamaica Plain, or within the community. **Please see financial agreement for service costs.**

CANCELLATIONS & NO SHOWS:

► You will be charged **the total of your session fee** for a session you have failed to cancel within **24 hours or that you missed without notice**.

**I will reach out via email 7-10 minutes after the start of our appointment time if you have not arrived for our meeting. If you have not responded or arrived 15-18 minutes after the session has started, I will end the meeting, and this is considered a No Show.

_______ Initial Please

► Exceptions apply for emergencies, illness, weather. These fees are not reimbursed by insurance.

FINANCIAL AGREEMENT:

I acknowledge that The Peace Practice and Liz Eanniello, LICSW does not accept or work directly with insurance companies. **All services are self-pay**. **Payment is due 24 hours after the date of service, if payment is not received within 24 hours Liz Eanniello, LICSW will charge my card on file with Stripe.** An invoice or superbill of services is available upon request as some insurance carriers offer partial reimbursement for out of network providers. Please check with your specific insurance provider.

► **My fee structure is as follows:**

CPT Code: 90834
Individual Therapy 50 minutes

Weekly sessions	$140
Bi-Weekly sessions	$150

***I am able to offer some fee adjustments/sliding scale spots, so please ask!**

Please note that as of 9/1/21 there will be an additional fee for community/home-based sessions based on distance from my office space at The Meeting Point in Jamaica Plain:

3 miles and under - $5, 4-6 miles -$10, 7- 10 miles $15

Payments accepted: Cash/check (in-person only),
Credit card via Stripe

____
Initial Please

STATEMENT REGARDING CONFIDENTIALITY:

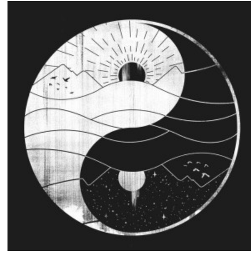
Name: ____

► All information shared in this office is confidential unless a specific release of information is signed by you with the following exceptions:

- You express your planned intention of harming yourself or your emotional/mental state is observed by me to put you at risk.
- You express that you intend to do bodily harm to another person. (In that event, I am obligated by law to take reasonable precautions to ensure others' safety.)
- You share that you have in the past and/or present emotionally, physically or sexually abusing a child, an elderly or a disabled person.
- You are under 18 and you share that you are currently or have been physically or sexually abused, or I determine that you are at significant risk.
- Your insurance company requests information relative to payment of your claim, or another process is required to collect unpaid fees, or any legal defense is required by your therapist.
- I receive a signed order by a judge to testify in court, or to provide records.
- I am required to share information under Federal or state law or regulation
- I am required to share information by the Board of Registration of Social Workers or the Office of the Attorney General during the course of an investigation.
- You are a defendant in a criminal proceeding and you need me to speak on your behalf.
- You are currently receiving Mental Health Services and/or are taking medication for a mental health condition, or if you need psychiatric care while receiving therapy, or if you have had previous Mental Health Services. You will be requested to permit me to speak with your prescribing physician, therapist or clinic.

► In the above instances, I will take appropriate action to ensure your safety. Otherwise, I may not reveal any information about you without your written permission. I have no control over the confidentiality of any information once it is disclosed outside this office. If you have any questions about who has access to your information, please contact others to whom you have authorized information to be released.

______
Initial Please

The Peace Practice  Liz Eanniello, LICSW

<u>STATEMENT REGARDING PRIVATE HEALTH INFORMATION:</u>

Name: ___________________________ Date: _____________________

It is the intent of this office to be in compliance with the Privacy Standards for Private Health Information (PHI) covered under Health Insurance Portability and Accountability Act (HIPAA).

► I understand that I have the <u>right</u> to <u>request</u> that certain information be excluded from my record unless the information is related to my diagnosis or is related to one of the exceptions listed on page 3 of the **Therapist – Client Responsibilities**.

► I understand that I have the right to <u>amend</u> information but not expunge (“erase”) information from my record.

► I understand that I have the right to inspect and/or receive a copy of my Private Health Information (PHI) i.e. Record unless it is legally determined that it would adversely affect my well-being or I am a minor. My request must be fulfilled by this office within 60 days of my written request. There will be a charge for copies.

► As additional HIPAA regulations are mandated and clarified, this office will be altering its policies and procedures to be in compliance.

► If this office is found to be in violation of the Primary Standards put forth in HIPAA, I am urged to speak with my therapist and if not resolved, I have a right to file a formal compliant with the Office of Civil Liberties.

I have read and received a copy of the above Privacy Standards for Private Health Information covered under HIPAA.

Signed: ___________________________________ Date: _________________

STATEMENT REGARDING RELEASE OF INFORMATION:

Name: _______________________________

► I understand that I may be asked to sign a Release of Information to permit **Liz Eanniello, LICSW** to speak with my physician(s), and/or provide pertinent medical records. I understand that I have the right to refuse to sign a Release of Information.

Please Initial: __________

► I understand that, when applicable, I will be asked to sign a Release of Information to permit __**Liz Eanniello, LICSW** to speak with current or previous therapist(s), and/or provide Mental Health Records. I understand that I have the right to refuse to sign a Release of Information.

Please Initial: __________

► I understand that if, at any time, **Liz Eanniello, LICSW** determines that I need a different type of psychotherapy care, he/she/they will discuss my needs with me and transfer me to another provider.

Please Initial

► I give permission to **Liz Eanniello, LICSW** to contact the person who referred me to her/him/they, as a courtesy.

☐☐
Yes No Please Initial: _________

I have read and understand the above statements on this page and the preceding pages and agree to the conditions stated.

Signed: ___________________________________

Therapist: ______________________________ Dated: ___________________________________