CLAIRE HUGHES

THERAPY

Private Practice Policies

The therapy process: Your therapist's priority is to provide you with services to help you reach your goals, but please remember that your therapist cannot guarantee any particular outcome. Your therapist will work with you to develop a treatment plan and will regularly collaborate with you in discussing treatment progress. You have the right to agree or disagree with your therapist's recommendations. However, due to the varying nature and severity of problems and the individuality of each patient, your therapist is unable to predict the length of your therapy or to guarantee a specific outcome or result.

I. Confidentiality

- All communications between you and your therapist will be held in strict confidence unless you provide written permission to release information about your treatment. If you participate in marital or family therapy, your therapist will not disclose confidential information about your treatment unless all person(s) who participated in the treatment with you provide their written authorization to release.

- There are exceptions to confidentiality. For example, therapists are required to report instances of suspected child, dependent adult or elder abuse. Therapists may also be required or permitted to break confidentiality when they have determined that a patient presents a serious danger of physical violence to another person or when a patient is dangerous to him or herself. Federal, state, or local laws and judicial or administrative proceedings may require disclosure of your public health information. I may also have to use or disclose your PHI in response to a subpoena.

If you participate in marital or family therapy, your therapist will not disclose confidential information about your treatment unless all person(s) who participated in the treatment with you provide their written authorization to release such information. ***However, it is important that you know that your therapist utilizes a "no-secrets" policy when conducting family or marital/couples therapy.*** *This means that if you participate in family, and/or marital/couples therapy, your therapist is permitted to use information obtained in an individual session that you may have had with him or her, when working with other members of your family. Please feel free to ask your therapist about his or her "no secrets" policy and how it may apply to you.*

II. Minors and confidentiality

- Communications between therapists and patients who are minors (under the age of 18) are confidential. However, parents and other guardians who provide authorization for their child's treatment are often involved in their treatment. Consequently, your therapist, in the exercise of his or her professional judgment, may discuss the treatment progress of a minor patient with the parent or caretaker. Patients who are minors and their parents are urged to discuss any questions or concerns that they have on this topic with their therapist.

III. Records and your right to view them

- Your therapist is required to keep treatment records for at least 7 years. As a client, you have the right to review or receive a summary of your records. However, your therapist must protect your health information and your wellbeing and will use her clinical judgement in responding to requests for records.

- When more than one client is involved in treatment, such as in cases of couple and family therapy, your therapist will release records only with signed authorizations from all the adults (or all those who legally can authorize such a release) involved in the treatment. Your therapist may request up to 10 days in order to provide requested information.

IV. Appointment scheduling and cancellation policies

- Your consistent attendance greatly contributes to a successful outcome of therapy. In order to cancel or reschedule an appointment, you must notify your therapist at least 24 hours in advance of your appointment. If you do not provide your therapist with at least 24 hours' notice in advance, you are responsible for full payment and an additional $8.00 fee for the missed session. Please understand that your insurance company will not pay for missed or cancelled sessions.

V. Therapist availability/emergencies

- You are welcome to phone your therapist in between sessions. However, as a general rule, important issues are better addressed within regularly scheduled sessions.

- You may leave a message for your therapist at any time on her confidential voicemail. If you wish your therapist to return your call, please be sure to leave your name and phone number(s), along with a brief message concerning the nature of your call. Non urgent phone calls are returned during the therapist's normal workdays within 24 hours. If you have an urgent need to speak with your therapist, please indicate that fact in your message and follow any instructions that are

provided by your therapist's voicemail. In the event of a medical or psychiatric emergency or an emergency involving a threat to your safety or the safety of others, please call 911 to request emergency assistance. In the event of a medical or psychiatric emergency or an emergency involving a threat to your safety or the safety of others, please call 911 to request emergency assistance.

VI. Termination of therapy

- The length of your treatment and the timing of the eventual termination of your treatment depend on the specifics of your treatment plan and the progress you achieve. It is a good idea to plan for your termination, in collaboration with your therapist. Your therapist will discuss a plan for termination with you as you approach the completion of your treatment goals.

- You may discontinue therapy at any time. If you or your therapist determines that you are not benefiting from treatment, either of you may elect to initiate a discussion of your treatment alternatives. Treatment alternatives may include, among other possibilities, referral, changing your treatment plan, or terminating your therapy.

Your signature indicates that you have read and understand the private practice policies and are consenting to treatment under the care of Claire Hughes, LCSW.

***Please ask your therapist to address any questions or concerns that you have about this information before you sign.**

Name of Client: _____

Date:_____

Signature:_____

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Financial Agreement

Payment is collected on the day of each session and is accepted in the form of cash, credit card, check, PayPal, Zelle, or Venmo. The "24 hour cancellation policy" is as follows: you must cancel within 24 hours prior to the session in order to avoid being charged the session cost. Upon request, you will be provided with a receipt for therapeutic services rendered. Clients will be responsible for the standard rates listed below. If you have insurance, you will be responsible to pay out of pocket direct to Claire Hughes and you may contact your medical/mental health insurance carrier directly about possible reimbursement for out-of-network benefits. Upon request, I will provide you with a superbill at the end of each month. *Please inform me if you would like a superbill.*

Fee Schedule:

- Intake Assessment (60 minutes) $250
- Individual therapy session (45 minutes) $185
- Couples/Family therapy session (60 minutes) $200
- Additional paperwork for insurance/employer or other specific reason $50 per page
- Court appearances $350 per hour ** I am not an expert witness and will only participate in court as required by a court order**
- Return check fee $35

Checks are made payable to: "Claire Hughes"
Venmo payments: @Claire-Hughes-1
PayPal and Zelle payments: claireehughes@gmail.com

I have read and understand this financial policy and agree to its guidelines. If another person is responsible for payment, please state the relationship to client and sign.

Preferred Method of Payment (please circle one): Venmo / Zelle / Credit/Debit Card / Cash / Check / Paypal

Client (or financially responsible party) Name: _____

Client (or financially responsible party) Signature: _____

Date: _____

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Credit Card Information is to be kept on file. This does not mean payment must be made by credit card. *Please note there is a 3.5% + $0.15 fee incurred on all credit card transactions.*

I authorize the use of this card to pay for my sessions, which will be charged on the day of my scheduled appointment: Yes / No

Credit Card Information:

Name on Card _____

Credit Card Number _____

Billing Zip Code _____

Exp Date ___/___/___ CVV Code _____ Circle One: Visa/MC/AMEX/Disc

I have read and understand this financial policy and agree to its guidelines.

Client Name: _____

Client Signature: _____

Date: _____

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Authorization to Exchange Confidential Information

I, [Name of Patient] _____ hereby authorize Claire Hughes to exchange confidential information regarding my treatment with [name and function of the person(s) or entities to which information is to be exchanged]

_____.

This Authorization permits the exchange of the following information:

___ Any and All Information Necessary
___ Diagnosis
___ Progress to Date
___ Patient Records
___ Treatment Plan
___ Prognosis
___ Clinical Test Results
___ Dates of Treatment
___ Summary of Treatment
___ Other

The recipient may use the information described above solely for the following purpose(s): I understand that I have a right to receive a copy of this authorization. I also understand that any cancellation or modification of this authorization must be in writing. This Authorization shall remain valid for the length of my treatment (or until expiration date if specified: ("Expiration Date") _____)

Client Name: _____ Date: _____

Client Signature: _____