

Laurie Nickel Supkoff, LCSW
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**Office Policies & General Information Agreement
for Reconnection Counseling Services**

CONFIDENTIALITY: All information disclosed within sessions and the written records pertaining to those sessions are privileged and confidential and may not be revealed to anyone without your (client's) written permission, except where disclosure is required by law. A report may be required for the courts at the conclusion of reunification therapy.

When Disclosure Is Required By Law: Some of the circumstances where disclosure is required by the law are: where there is a reasonable suspicion of child, dependent or elder abuse or neglect; where a client presents a danger to self, to others, to property, or is gravely disabled.

When Disclosure May Be Required: Disclosure may be required pursuant to a legal proceeding. If you place your mental status at issue in litigation initiated by you, the defendant may have the right to obtain the psychotherapy records and/or testimony by me, Laurie Nickel Supkoff, LCSW. In couple and family therapy, or when different family members are seen individually, confidentiality and privilege do not apply between the couple or among family members. I will use my clinical judgment when revealing such information. I will not release records to any outside party unless I am authorized to do so by all adult family members who were part of the treatment.

Health Insurance & Confidentiality of Records: I do not contract with insurance companies as a network provider, so I am only responsible and accountable to you. My loyalties are not divided and there is no conflict of interest. Your health insurance policy is a contract between you and your insurance company. Since I am not a party to that contract, I would be considered an out of network provider. I will provide an invoice you can submit to your insurance company for reimbursement. Please specify that you intend to submit an insurance claim. The insurance claim form I supply will be filled out in such a way the client will receive direct reimbursement.

_____ Yes, I will need an insurance claim form

Consultation: I consult regularly with other professionals regarding my clients; however, neither clients' names, nor any other identifying information, are ever mentioned. My client's identity remains completely anonymous and confidentiality is fully maintained.

Initials _____

TELEPHONE & EMERGENCY PROCEDURES: If you need to contact me between sessions, please leave a message on my voice mail (916) 743-1605 and your call will be returned

as soon as possible. I check my messages several times each day unless I am out of town. If an emergency arises, please indicate it clearly in your message. If you need to talk to someone right away you may consider calling your family physician.

PAYMENTS, RETAINER & INSURANCE REIMBURSEMENT: My practice is currently online via Thera-link due to Covid-19 concerns. Payment is due upon logging in for the appointment unless other arrangements have been made. Each 50-minute session is billed at \$185.00 due at the time of the meeting. If your insurance will cover this type of counseling, I will supply you with an insurance billing form that you can submit to your insurance provider for direct reimbursement.

_____ Yes, I will need an insurance bill for reimbursement

Clients also agree to pay and maintain a retainer in the amount of \$370.00. Retainers can be used to cover costs described in the pertinent sections below. Unused retainers will be refunded to clients at the end of reconnection counseling.

PHONE, EMAILS AND LETTERS: Phone calls requiring more than five (5) minutes and emails including any information other than scheduling an appointment shall cost the same hourly rate as a counseling session for the time required to print and read the emails.

THE PROCESS OF RECONNECTION COUNSELING: Reconnection counseling begins with the therapist meeting with both parents separately for at least one session and usually with each child separately for at least one session. Children may also be seen together for at least one session. The parent desiring reconnection and the child(ren) will then be brought together if possible. More individual work with parents and/or children may be required before conjoint sessions are possible. Pursuing reconnection in no way guarantees a specific result, there are times when the issues related to the case impair the accomplishment of reconnecting a parent with child(ren).

Referrals: If in the course of our working together I determine that I cannot assist you to the full degree you are in need of, I will refer you to another professional(s) who would likely be more able to assist you in your efforts to produce change and growth in your life.

Dual Relationships: Therapy never involves sexual or business relationships or any other dual relationship that impairs the therapist's objectivity, clinical judgment, therapeutic effectiveness or can be exploitative in nature.

Reports and Consultation: A minimum fee of two hours is charged for all reports based on my hourly rate. Telephone calls and professional consultations, with colleagues, attorneys or others as needed related to your treatment or your child's treatment will be prorated and billed at the hourly rate. I will discuss this with you prior to making these contacts. Please notify me immediately if you think you will need a psychotherapist for court testimony. Court rates are

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\$200 per hour and are to be paid in full prior to the court date based upon the number of hours needed to clear my schedule.

CANCELLATION: Appointments are arranged so that we share a consistent, ongoing weekly or biweekly scheduled time together. If your appointment must be canceled, a minimum of **24 hours** prior notice is expected to avoid being charged for that session. You will also be charged if you “No Show” for your scheduled time.

My Agreement to You: I agree to assist you in gaining awareness and understanding of the obstacles you face, and to help you gain new skills to make healthy choices in your life, however, this in no way guarantees that the changes you would like to have happen will occur.

I have read the above Office Policies and General Information Agreement carefully; I understand them and agree to comply with them.

Client Name (print)

Date

Signature

Laurie Nickel Supkoff, LCSW

Therapist

Date

Signature