Laurie Nickel Supkoff, LCSW
1329 Howe Avenue, Suite 201
Sacramento, CA 95825
(916) 743-1605

Office Policies & General Information Agreement for Psychotherapy 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.

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.

Your Right to Review Records: Both the law and the standards of my profession require that I keep appropriate treatment records. As a client, you have the right to review or receive a summary of your records at any time, except in limited legal or emergency circumstances or when I assess that releasing such information might be harmful in any way. In such a case I will

Initials _____

provide the records to an appropriate and legitimate mental health professional of your choice. Considering these exclusions, if it is still appropriate, upon your request, I will release information to any agency/person you specify unless I assess that releasing such information might be harmful in any way.

TELEPHONE & EMERGENCY PROCEDURES: If you need to contact me between sessions, please leave a voicemail message at (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 & 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

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.

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.

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.

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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