Diane E. Masullo, MS, LPC, LMFT

Confidentiality and Informed Consent Agreement

Confidentiality and Limits to Confidentiality:

I am required by law to protect your Protected Health Information (PHI.) Everything you discuss in therapy sessions remains confidential with only a few exceptions. You must give signed permission before I can share your PHI.

Limits to confidentiality include:

- Disclosure of harm to children, elderly, or persons with disabilities. Reports will be made to the appropriate authority. I am a mandated reporter.
- Threat of harm to self or others. Medical professional and/or law enforcement will be contacted
- Insurance companies (TRICARE, etc) requires a diagnosis- they do not receive your records
- Criminal or other Court case if subpoenaed, or court order(s) by judge
- Active duty- case manager will be contacted if authorization for continued services are required. They do not receive mental health information other than need for more services and accountability for sessions attended
- Client Initials:____________

Emergencies:

I have been informed that Ms. Masullo maintains regular office hours that are designated for regular appointments, and that she is not available for emergencies. We have discussed the procedure of calling 911 or going to the nearest emergency room for assistance. I acknowledge that I understand this limitation in services and agree to it as a condition of therapy. Client Initials:_______

Payment Fee and Insurance Payment

The fee is agreed upon prior to beginning counseling. The standard rate is 95.00 per hour, with the initial session requiring 90 minutes ($150). I have been informed that Ms. Masullo may not be a current provider on my insurance plan and agree to pay any Payment Fee not covered by my insurance company. Client Initials:_________

Computer Communications:

Email:
I acknowledge that any email communication is not secure, and that by using email privileged communication and confidentiality may be compromised. I Do / Do Not agree to use email as a means of communication with my therapist.

Friending:

I do not accept friend requests from current or former clients on any social media sites such as Facebook or Linkedin. Friending clients as friends compromises confidentiality and treatment boundaries.

Following:

I do not follow former or current clients on any social media sites such as Twitter or Pinterest. I am concerned with your privacy, therefore following you would compromise your confidentiality.

By signing/initialing I verify understanding of computer use restrictions and limitations. Client Initials:___________

Tricare Clients:

Tricare reimburses full payment for Active Duty Soldiers and their family members. Active duty require a physician referral and contact with case manager for authorization of counseling services. Retired Tricare Recipients are responsible for their $12 co-pay , due at date of service; if payment is not received at time of service you will be billed for your co-pay requirement. By signing this form you agree to pay all required co-pay fees. Client Initials:___________

Time:

Sessions are 50 minutes long, starting on the hour and ending 10 minutes to the next hour. Longer sessions can be scheduled if we agree that it will be helpful. I will let you know when there are 5 minutes left in the session. We need to end on time because other clients are scheduled. Client Initials:___________________

Contacting Provider:

I am available by office phone (254) 547-3040 on office days Tuesday, Thursday, and Friday. However, my answering machine is available to take calls 24 hours a day. If you need to contact me outside of our scheduled appointment, please call and leave a message, including your phone number and I will call you back on my office days. Client Initials:______________

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Therapy Records:

All records will be kept five years from date of first session, according to licensing requirements and guidelines. Client Initials:______________

Cancellation policy:

I will be reserving the time for you, so please give me as much notice as possible if you will not be able to make your appointment. My voice mail is available 24 hours a day to receive messages. If you do not provide at least 24 hours notice of a cancellation, unless due to an emergency or illness, you agree to pay a $25.00 fee for a missed session. This fee must be paid prior to scheduling another session. Client Initials:___________

Ending therapy:

Your participation in therapy is voluntary and you have the right to end therapy whenever you want. However, if you decide to exercise this option, I encourage you to talk with me about the reason for your decision in a counseling session. I ask that you allow for one final session for us to have an ending together, to review what we've done, and to offer feedback to each other.

In adherence with ethical guidelines, I am required to end our therapy work together when there is evidence that progress is not being made or, (in my clinical judgement) that another provider is better able to help you reach your therapeutic goals. In such cases I will provide you with names of providers and their contact information. It will be your responsibility to secure the necessary authorization and/or referral with your insurance carrier and primary care provider. It will also be necessary for you to schedule all appointments with the new provider. Other reasons for termination and referral include, failure to participate in therapy, inconsistent attendance to scheduled appointments, frequent no-show or cancellations, conflicts of interest, untimely payment of fees, or my belief that I may not be the best person for your needs. Client Initials:_____________

I, ______________________________, have been informed of my rights of privacy and confidentiality according to HIPPA. I have read the Informed Consent, Notice of Privacy, and Limits of Confidentiality provided by my therapist, Diane E. Masullo, MS, LPC, LMFT. I understand that my signature at the bottom of this page provides for the release of necessary information for third party billing. I agree to pay any fees not covered by my insurance provider. I understand that I am under no obligation to continue counseling and that I may quit at any time. I further understand that there are no guarantees of a resolution to my presenting problem, but that success is dependent upon a number of variables including motivation, level of participation, honesty, insight, and the relationship between my therapist/counselor and myself.

Diane E. Masullo, MS, LPC, LMFT

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I/we have read, understand and agree to the information and policies described in the Informed Consent Form. Client Initials:_____________

I/we have read, understand and agree to the cancellation policy.

I/we understand that if I/we miss a scheduled session and I/we do not provide at least 24 hours' notice or if the absence is not due to an emergency or illness, I/we agree that I will pay the $25 fee prior to scheduling another session. Client Initials:_______________

If you have any questions, please feel free to discuss them with me prior to signing this consent form.

Client's Signature

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Printed Name

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Client Initials:__________________ Date:________________