Ellen H. Theodores, LCSW, LLC

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Licensed Clinical Social Worker
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PROFESSIONAL DISCLOSURE STATEMENT

Welcome to my practice. I would like to acquaint you with several important policies and answer questions you may have. Please read the information carefully and once we review and I answer your questions, I will ask for your acknowledgement by signing below.

PSYCHOLOGICAL SERVICES

Psychotherapy is not easily described in general statements. Counseling provides the opportunity for growth and self-discovery in the context of a safe and supportive therapeutic relationship. What I am describing is a process in which we will work together to better understand how to help you feel better. Although my approach to therapy pulls from many different theories, my foundation is guided by a Strengths/Resilience approach, Psychodynamic, Dialectical Behavior Therapy (DBT), Wellness Recovery Action Plan (WRAP), and Mindfulness-Based Cognitive Behavioral Therapy (CBT). Cognitive Behavioral Therapy identifies how your cognitions (thoughts and beliefs) affect your feelings and behaviors. Dialectical Behavioral Therapy (DBT) offers a combination of the cognitive approach along with offering some distress tolerance skills. My education, ongoing training, and life experience provide different approaches that I may incorporate to assist you with the issues you wish to address. It will take some time and it will take some courage. We will work together.

Psychotherapy is somewhat like a medical doctor visit in which it calls for an active effort on your part. In order for the therapy to be most successful, you will have to work on the issues we talk about during our sessions and on your own between sessions. Psychotherapy can have benefits and risks, and there are no guarantees of what you will experience. Psychotherapy has been shown to have many benefits. Therapy often leads to better relationships, solutions to specific problems, and significant reductions in feelings of distress. On the other hand, since therapy often involves discussing unpleasant aspects of your life, you may also experience uncomfortable feelings like anxiety, sadness, guilt, anger, frustration, loneliness, and helplessness.

Our first few sessions will involve an evaluation of your needs. By the end of the evaluation, I will be able to offer you my impressions of what our work should include and a treatment plan to follow. You will decide whether to continue with therapy. You should evaluate this information along with your own opinions of whether you feel comfortable working with me. If you have questions about my procedures, we should discuss them whenever they arise. If doubts persist, I will be happy to help you set up a meeting with another mental health professional for a second opinion.

Social Justice is an important value. In my practice, there is no discrimination due to age, sex, relational/marital/family status, race, color, religious beliefs, ethnicity, place of residence, veteran status, physical disability, health status, sexual orientation, or criminal record unrelated to present dangerousness. I will strive to advance and support the value of human dignity.

AGREEMENT FOR THERAPY AND TREATMENT

This Agreement contains important information regarding my professional services and business policies. It also contains summary information about the Health Insurance Portability and Accountability Act (HIPAA), a federal law that provides privacy protections and client rights with regard to the use and disclosure of your Protected Health Information (PHI) used to the purpose of treatment, payment, and health care operations. HIPAA requires that I provide you with a Notice of Privacy Practices for us e and disclosure of PHI for treatment, payment, and health care operations. The Notice, which is attached to this Agreement, explains HIPAA and its application to your personal health information in greater detail. The law requires that I obtain your signature acknowledging that I have provided you with this information. Although these documents are long and sometimes complex, it is very important that you read them carefully. We can discuss any questions you have about the procedures. When you sign this document, it will also represent an agreement between us. You may revoke this Agreement in writing at any time. That revocation will be binding on me, unless I have taken action already relying on it, if there are obligations imposed on me by your health insurer in order to process or substantiate claims made under your policy, or if you have not satisfied any financial obligations you have incurred.

PROFESSIONAL FEES

My practice operates by appointment only. My **fee for a 45-minute session is $85.00.** Fees and insurance are discussed individually when you call for your appointment. **All co-payments are due and payable at the time of your appointments. Credit Cards,** checks and cash are accepted. I cannot guarantee that your insurance policy will reimburse you and what percentage of my fees they might cover. Please contact your insurance company in order to have proper expectations for reimbursement. Additionally, please be aware that insurance companies require that I give you a *diagnosis* from the diagnostic manual in order to cover your services. This information may be used in future evaluation of *pre-existing conditions*. It is important that you know how your insurance company uses this information and although I am trained to make proper diagnosis of mental and emotional disorders, I cannot guarantee how this information is used after it is submitted in insurance claim forms.

If you become involved in legal proceedings that require my participation, you will be expected to pay for my professional time, including preparation and transportation costs, even if I am called to testify by another party. Because of the difficulty of legal involvement, I charge a separate fee per hour for preparation and attendance at any legal proceeding.

In the case of divorced parents, each parent needs to give consent for treatment of their children. The parent with legal custody or medical decision-making who brings the child to therapy will be responsible for all charges unless otherwise determined by the co-parents.

CANCELLATIONS

Once an appointment is scheduled, you will be expected to pay for it unless you **provide 24 hours advance notice of cancellation**. I am not able to attempt to use time slots reserved for you unless I know in advance that you will be unable to attend a session. It is important to note that insurance companies do not provide reimbursement for cancelled sessions. Likewise, if I am unable to keep an appointment with you within the 24-hour cancellation period, you will not be charged for that session, and I will make efforts to accommodate your schedule and reschedule you for my earliest opening. To cancel, please leave a message on my voicemail (207) 245-5087.

TELEPHONE CONTACT

Due to my work schedule, I am often not immediately available by telephone. When I am unavailable, my telephone is answered by voicemail and I will make every effort to return your call within 24 hours. This may not always include weekends or holidays.

In the unlikely event of an emergency, you may leave a message with my voicemail and indicate that it is urgent. Every effort will be made to return urgent calls as soon as possible. You should always feel comfortable using the MAINE STATE CRISIS LINE as a backup in emergencies.

The **Maine State Crisis Line** number is **888-568-1112** or **207-282-6136**.

In the case of a serious **emergency** at any time, go to a hospital emergency room for evaluation. A Psychiatrist is always on call at Mid Coast Hospital, Maine Medical, Mercy, or other local hospital.

CONFIDENTIALITY and YOUR RECORDS

Your medical records are confidential and therefore can only be released with your written authorization except for the purposes of treatment, payment, and health care operations. Enclosed please find the Notice of Privacy Practices that I am required to give you by law. When you come in for your first session, you will be asked to confirm that you received it.

I may occasionally find it helpful to consult other medical and mental health Professionals about a case. During a consultation, I make every effort to avoid revealing the identity of my client. The other professionals are also legally bound to keep the information confidential. I will not tell you about these consultations unless I feel that it is important to our work together. I will make note of these consultations in your clinical record. **Your signature on this Agreement provides consent for this activity.**

With few exceptions, everything discussed in sessions is confidential and cannot be disclosed to others without your verbal or written permission. I am required by law to break confidentiality when I have received evidence that you might plan to hurt yourself, others, damage property, or when I suspect physical or sexual abuse of a child or dependent person. In the context of working with couples or families, statements made by one party to the therapist are not protected if at a later date records are demanded by the court, a situation that could arise during a custody dispute. In the context of working with adolescents, there may be circumstances in which I might feel it important to relay information to parents (if I believe an adolescent is engaging in behaviors that might harm them). Nevertheless, I will carefully consider any such disclosure with each party's best interest in mind. If such a situation arises, I will make an effort to discuss it with you before taking any action and will limit my disclosure to what is necessary

I keep a record of the health care services that I provide to you. You may ask to see a copy of that record. You may also ask me to correct that record. I will not disclose your record to others unless you direct me to do so, or unless the law authorizes or compels me to do so. You may request to read and discuss the written information contained in your file at any time. A copy can be made available to you at your duplicating expense.

Informed Consent:

I have read and understand the preceding statements.

Ellen H. Theodores, LCSW has reviewed with me the nature and purpose of her proposed course of treatment, alternative treatments, and risks and benefits in addition to answering my questions. I understand that I have the right to refuse treatment at any point and that requested information will be provided to my carrier. I understand the limitations of confidentiality and how my records will be handled. I have also read and understand that full payment or co-payment is due at time of service.

YOUR SIGNATURE BELOW INDICATES THAT YOU HAVE READ THIS AGREEMENT AND AGREE TO ITS TERMS. YOUR SIGNATURE ALSO SERVES AS AN ACKNOWLEDGEMENT THAT YOU HAVE RECEIVED A COPY OF THE NOTICE OF PRIVACY PRACTICES DESCRIBED ABOVE.

_____ _____

Signature of Client Date

_____ _____

Signature of Legal Guardian or Representative Date

Please indicate the nature of your relationship to the client _____

PROFESSIONAL TRAINING and LICENSURE

I received my Bachelor of Arts 1986 from Ripon College in Ripon, WI with major in English and in Elementary Teaching. I received my Master of Social Work degree from the University of New England in 2010. I am a Maine Licensed Clinical Social Worker and additionally, I am a member of the NASW (National Association of Social Workers). My licensure (LCSW) insures that I have a master's degree from an accredited university and that a complaint procedure is available to you regarding my services. If you have a complaint that you wish to report, please contact myself or the Department of Professional and Financial Regulation in Augusta, Maine at (207) 624-8660.