Looking Glass Counseling LLC
402 Highland Ave. Suite G
Somerville, MA 02144

Information Sheet

Client Name: _____

Date of Birth: _____

Address: _____

_____

Phone: _____

E-mail (for scheduling purposes only): _____

☐When contacted, do not mention agency name
☐Do not contact by phone call
☐Do not contact by text messages
☐Do not contact by email

Parent/Guardian (for minors): _____

Address: _____

_____

Phone: _____

Emergency Contact (name, phone number & relationship): _____

_____

Current Medications: _____

_____

Prescribing Psychiatrist (name and phone number): _____

_____

Current medical diagnoses: _____

_____

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Confidentiality Statement

Confidence in client/therapist confidentiality is an essential component of psychotherapy. Both written records and verbal communication are confidential and protected by law. A written release of information is usually required for the transfer of information. In most circumstances, the information that you share in therapy is kept confidential. Please see the Notice of Privacy Practices that gives a full summary of the ways that we are required or may be asked to break confidentiality and share your Personal Health Information. There are some exceptions where information may be shared without an authorized release from a client. These exceptions include:

Duty to Warn and Protect: If you disclose a plan or threat to harm yourself, your therapist must attempt to notify your family and notify legal authorities. In addition, if you disclose a plan to threat or harm another person, your therapist is required to warn the possible victim and notify legal authorities.

Abuse of Children and Vulnerable Adults: If you disclose, or it is suspected, that there is abuse or harmful neglect of children or vulnerable adults (i.e. the elderly, disabled/incompetent), your therapist must report this information to the appropriate state agency and/or legal authorities.

Legal Proceedings: Client case notes and records may be subject to subpoena when a client is involved in civil or criminal legal proceedings.

Collection Agencies: Information will be disclosed if they are required to collect unpaid fees.

Team Meetings: Our staff meet in team meetings and will collaborate on clinical information. Your therapist will not disclose identifying information about you in those meetings, but will get consultation on cases.

Insurance
If you are choosing to use your health insurance to pay for therapy, they require a mental health diagnosis, and are allowed access to diagnostic and treatment information. They demand that your symptoms and diagnosis meet the criteria for medical necessity, and they can dictate how many sessions you will receive.

Working with Children & Adolescents
Minors have limited rights to confidentiality under the law. If you are a minor, your parents/legal guardian must consent to treatment and are allowed access to your record. However, because privacy in psychotherapy is often crucial to successful progress, it is sometimes our policy to request an agreement from parents that they consent to give up their access to their child's records. If they agree, during treatment, the therapist will provide them only with general information about the progress of the child's treatment, and his/her attendance at scheduled sessions. Any other communication will require the child's authorization, unless the therapist feels that the child is in danger or is a danger to someone else, in which case, he/she will notify the parents of the concern. Before giving parents any information, the therapist will discuss the matter with the child, if possible, and do his/her best to handle any objections the client might have.

I agree to the above limits of confidentiality and understand their meanings and ramifications.

_____ _____
Client signature Date

_____
Print name

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Office Policies

Emergencies: If you have a psychiatric emergency, you need to call 911 or go to your local emergency room. If your therapist determines in a session that you are at serious risk to hurt yourself or others, he/she will discuss this with you to make a plan. Sometimes that plan includes contracting for safety, contacting family members or friends with your consent, contacting the local crisis team for an evaluation, or getting an ambulance to the emergency room.

Medication: If you are on psychotropic medication, we will ask for a release to speak with your psychiatrist or medical doctor. It is important for your treatment team to be in communication with each other regarding your symptoms and treatment.

Fees:
Psychotherapy intake: $150
Psychotherapy session: $120
Group session: $40
Less than 48-hr cancellation fee: Full session amount
Returned check fee: $25

Insurance payments: If you choose to use your insurance to pay for therapy, you are responsible for co-pays, co-insurance, deductible payments, and other expenses not covered by your plan. This amount is due at the time of the session, paid by cash, check or credit card, unless other payment arrangements are explicitly made.

Scheduling/Cancellation policy: We will attempt to keep a consistent therapy time open for you. You will be notified as soon as possible if the time needs to change. If you need to cancel, please give 48 hrs notice, and we can reschedule. If you do not give 48 hrs notice, you will be charged the full session fee, since we have set aside that time for you and will not be able to fill it with short notice. If you are going to be over 10 minutes late, please contact your therapist. We reserve the right to leave the office if you are 15 minutes late, and the session will be considered a no-show. If you repeatedly cancel appointments, we reserve the right to terminate your treatment.

Contacting us: Work in psychotherapy is generally limited to time in sessions with your therapist. On the occasion that you need to speak with your therapist between sessions, you may call Looking Glass Counseling at (617) 401-7576. It could take 1-2 business days to get back to you. If you have an emergency that cannot wait for a call back, you should call 911 or go to the nearest hospital emergency room.

I understand the policies listed above and agree to follow these guidelines.

_____ _____
Client signature Date

_____
Print name

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NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. At Looking Glass Counseling, we are required by law to maintain the privacy of your Protected Health Information (PHI). This includes information that is collected during the course of your treatment, such as your symptoms, diagnoses, treatment and a plan for future care. Information about care that you have received from other providers may also be included in your record. PHI also includes demographic information and payment information. This Notice of Privacy Practices describes how we may use and disclose your PHI in accordance with applicable law. We are required to abide by the terms of this Notice of Privacy Practices. We reserve the right to change the terms of our Notice of Privacy Practices at any time. Any new Notice of Privacy Practices will be effective for all PHI that we maintain at that time, and we will provide you with a copy of the version.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

For Treatment: I may use your PHI to provide and manage your health care. If I refer you for other treatment, such as emergency psychiatric treatment, I will provide that health care provider with the necessary information to diagnose or treat you. In addition, I may share your PHI with other health care providers who may consult with me about your care. I believe this is critical to provide you the very best treatment and is necessary given the complexities of various mental illnesses and issues.

For Payment: We may use and disclose PHI so that we can receive payment for the treatment services provided to you. This will only be done with your authorization. Examples of payment related activities are: making a determination of eligibility or coverage for insurance benefits, processing claims with your insurance company, reviewing services provided to you to determine medical necessity, or undertaking utilization review activities. If it becomes necessary to use collection processes due to lack of payment for services, we will only disclose the minimum amount of PHI necessary for purposes of collection.

For Health Care Operations: We may use or disclose, as needed, your PHI in order to support out business activities including, but not limited to, quality assessment activities, employee review activities, licensing, and conducting or arranging for other business activities. For examples, we may share your PHI with third parties that perform various business activities (ie: billing or typing services) provided we have a written contract with the business that requires it to safeguard the privacy of your PHI. For training and teaching purposes, PHI will be disclosed only with your authorization.

Required by Law: Under the law, we must make disclosures of your PHI to you upon your request. In addition, we must make disclosures to the Secretary of the Department of Health and Human Services for the purpose of investigating and determining our compliance with the requirement of the Privacy Rule.

Without Authorization: Applicable law and ethical standards permit us to disclose information about you without our authorization only in a limited number of other situations, such as:

- Required by Law: In the case of a mandatory reporting of child abuse or neglect, or in the case of mandatory government agency audits or investigations such as by the counseling licensing board or the health department.
- Legal Proceedings: I may be required to disclose PHI in the course of any judicial or administrative proceeding in response to a legal order or other lawful process including a subpoena. I will consult an attorney or my professional organization to seek advice on ways to protect your confidential information.
- Threat to Health or Safety: If information is disclosed to prevent or lessen a serious threat it will be disclosed to a person(s) reasonably able to prevent or lessen the threat, including the target of the threat.

- Worker's Compensation: I may disclose your PHI to the extent necessary to comply with laws relating to worker's compensation or other similar programs established by law.

With Authorization: Uses and disclosures not specifically permitted by applicable law will be made only with your written authorization, which may be revoked.

YOUR RIGHTS REGARDING YOUR PROTECTED HEALTH INFORMATION

You have the following rights regarding PHI we maintain about you. To exercise any of these rights, please submit your request in writing to Looking Glass Counseling LLC, 402 Highland Ave. Suite G, Somerville, MA 02144.

Right of Access to Inspect and Copy: You have the right to inspect and copy PHI that may be used to make decisions about your care. Your right to inspect and copy PHI will be restricted only in those situations where compelling evidence that access would cause serious harm to you.

Right to Amend: If you feel that the PHI we have about you is incorrect or incomplete, you may ask us to amend the information although we are not required to agree to the amendment.

Right to an Accounting of Disclosures: You have the right to request an accounting of certain disclosures that we make of your PHI.

Right to Request Restrictions: You have the right to request a restriction or limitation on the use or disclosure of your PHI for treatment, payment, or health care operations. We are not required to agree to your request.

Right to Request Confidential Communication: You have the right to request that we communicate with you about medical matters in a certain way or at a certain location.

Right to a Copy of this Notice: You have the right to a copy of this notice.

If you have any questions regarding this Notice of Privacy Practices, please contact Looking Glass Counseling LLC, 402 Highland Ave. Suite G, Somerville, MA 02144.

I have read and received the Notice of Privacy Practices. I have been able to ask questions about how Looking Glass Counseling LLC will use and disclose my protected health information to carry out treatment, payment or health care operations for purposes that are permitted or required by law. I have also read and understand my rights with regard to my health information.

_____ _____

Signature of client or parent/guardian Date

_____

Print name of client and parent/guardian

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Insurance Information

Client's Name _____

Address _____

_____

Phone Number _____

Date of Birth _____

Client's relationship to insured: (circle one) self spouse child other _____

Insurance Carrier _____

Insurance Identification Number _____

Plan Name _____

Co-pay amount _____

Do you have a deductible? (circle one) yes no I don't know

Insured's Employer _____

Insured's Name (if other than client) _____

Insured's Address (if different than above) _____

_____

Insured's Phone Number _____

Insured's Date of Birth _____

I hereby authorize Looking Glass Counseling to share information with my insurance company and to bill them for services provided.

Client Signature _____

Date _____

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Credit Card Authorization

I, _____, authorize Looking Glass Counseling LLC to charge my credit or debit card for services provided. I certify that I am the authorized cardholder and that I have full authority to make purchases on behalf of the account provided.

I understand that these charges might include co-payments or deductible payments as dictated by my insurance company, self-pay fees as agreed upon by me and Looking Glass Counseling, and fees for not showing up to a scheduled appointment or not cancelling within 48 hours. The fee for not cancelling within 48 hours is the full session amount.

Charges may show up on your bank statement under the name LGCouns or TheraNest, which is the practice management & credit card billing system used by Looking Glass Counseling. You will receive a statement of the charge via email.

Please enter the email address you would like receipts to go to:

_____

For complete security, neither Looking Glass Counseling nor TheraNest will store your credit card information on file.

_____ _____
Client signature Date

_____
Print name