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## **MOLLY MILGROM PSYCHOTHERAPY**

1555 Connecticut Ave NW  
Washington, DC 20036  
molly@mollymilgrom.com  
(202) 207-6203

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### **Informed Consent Agreement for Psychotherapy Services**

Welcome to my practice, I look forward to working with you. This document (the Agreement) contains important information about my professional services and business policies. Please read this document carefully and ask me about anything you do not fully understand. This Agreement 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 for the purpose of treatment, payment, and health care operations. HIPAA requires that I provide you with a Notice of Privacy Practices (the Notice) for use and disclosure of PHI for treatment, payment and health care operations. The Notice, which is provided with your initial packet, 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 by the end of the first session. Although these documents are long and sometimes complex, it is very important that you read them carefully. Again, we can discuss any questions you have about the procedures.

When you sign this document, it will 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 in reliance 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.

### **BENEFITS AND EMOTIONAL RISKS OF PSYCHOTHERAPY**

The majority of people who participate in therapy benefit from the process. The therapeutic process is generally quite helpful, but some risks do exist. Risks include sometimes experiencing uncomfortable feelings such as sadness, anger, guilt, or frustration. Also, psychotherapy often involves discussing unpleasant aspects of your life. However, most people find that therapy ultimately leads to a significant reduction in feelings of distress, better relationships, and resolutions of specific problems. Still, there are no guarantees about what will happen in any one individual's therapeutic process. You are an active participant in the therapy and share the responsibility for the treatment process by discussing your concerns openly and honestly. As therapy progresses, I strongly encourage you to raise any questions you have about treatment goals, procedures, or your impression of the services you are receiving.

### **CONTACTING ME**

I am often not immediately available by telephone because I do not answer my telephone if I am working with a client. When I am unavailable, my telephone will be answered by voice mail. I will return any messages left on my voice mail as soon as possible, usually within 24 hours of receiving your call. Outside of serious emergencies, I will return evening and weekend calls on the next business day. You may also contact me via e-mail at molly@mollymilgrom.com, but since electronic communication (ie. email, fax) is not a confidential method of communication, any information you sent electronically cannot be guaranteed as confidential. Therefore, I ask that you limit email communications to routine administrative matters such as scheduling appointments. Email communication will be included in therapy records. If you need to contact me about any time-sensitive matter, such as a late arrival, any

cancellation of sessions, or an urgent mental health matter, or if I have not promptly responded to an e-mail you have sent me, please contact me by telephone at (202) 207-6203.

### **EMERGENCIES**

As I do not provide after-hours availability, **in cases of a life threatening emergency or psychiatric emergency (such as serious suicidal or homicidal feelings or an attempt), please call 911 or go to the nearest hospital emergency room. If you are in crisis and in need of immediate support, please call the following community hotline resources: CrisisLink Local Hotline: 703-527-4077; DC Access Helpline: 888-793-4357; National Lifeline: 800-273-TALK (8255).**

### **LICENSURE**

I am both a Licensed Independent Clinical Social Worker (LICSW; License Number: #LC50080408) in the District of Columbia and a Licensed Clinical Social Worker (LCSW; License Number: #0904008829) in Virginia. I hold a master's degree in Clinical Social Work from The Catholic University of America.

### **OTHER THERAPISTS AND DOCTORS**

It is very helpful to know all other clinicians and doctors who are caring for you. If another clinician has referred you or if you are working with another clinician for medication management, that clinician and I will need to have contact to coordinate treatment. I will ask you to sign a release of information form, allowing us to communicate. Similarly, if you have had significant therapeutic treatment in the past or currently have a significant medical condition that affects your cognitive functioning or emotional wellbeing, contact with those treating clinicians may also be requested.

### **CONFIDENTIALITY**

The ethical codes of my profession, state and DC laws, and the federal HIPAA all protect the privacy of all communications between client and psychotherapist. In most situations, I can only release information about your treatment to others if you sign a written authorization. This Authorization will remain in effect for a length of time you determine. You may revoke the authorization at any time, unless I have taken action in reliance on it.

However, there are some disclosures that *do not* require your Authorization, as follows:

- If you are involved in a court proceeding and a request is made for information concerning your diagnosis and treatment, such information is protected by the therapist-client privilege law. I cannot provide any information without your (or your legal representative's) written authorization, or a court order. If you are involved in or contemplating litigation, you should consult with your attorney to determine whether a court would be likely to order me to disclose information.
- If a client files a complaint or lawsuit against me, I may disclose relevant information regarding that client in order to defend myself.
- If a client files a worker's compensation claim, I must, upon appropriate request, provide a copy of the client's record to the D.C. Office of Hearings and Adjudications, the client's employer or insurer.
- If you have an unpaid balance, and when given notification that you must make arrangements to pay the balance you do not contact me to make such arrangements, I may submit the information necessary to a collection agency to collect unpaid fees.
- I may periodically consult with other mental health professionals in order to provide you with optimum care. In these cases, I will not share your name or identifying information about you. These professionals

must also abide by confidentiality and ethics laws. There are some situations in which I am legally obligated to take actions in order to attempt to protect you or other individuals from harm, and I may have to reveal some information about a client's treatment, specifically:

- If I know or have reason to suspect that a child has been or is in immediate danger of being a mentally or physically abused or neglected child, the law requires that I file a report with the appropriate governmental agency, usually the Child Protective Services Division of the Department of Human Services. Once such a report is filed, I may be required to provide additional information.
- If I have substantial cause to believe that a vulnerable adult is in need of protective services because of abuse, neglect or exploitation, even if by someone other than my client, the law requires that I file a report with the appropriate governmental agency, usually the Department of Human Services. Once such a report is filed, I may be required to provide additional information.
- **In an emergency, if I believe that a client presents a substantial risk of imminent and serious injury to him/herself, I may be required to take protective actions, including notifying individuals who can protect the client and/or initiating emergency hospitalization.**
- **If I believe that a client presents a substantial risk of imminent and serious injury to another individual, I may be required to take protective actions. These actions may include notifying the potential victim, contacting the police, or seeking hospitalization for the client.** If such a situation arises, I will make every effort to fully discuss it with you before taking any action and I will limit my disclosure to what is necessary, unless discussing it with you would jeopardize my or another person's safety.

In all other situations, I will ask you for an advance authorization before disclosing any information about you. While this written summary of exceptions to confidentiality should prove helpful in informing you about potential problems, it is important that we discuss any questions or concerns that you may have now or in the future. The laws governing confidentiality can be quite complex, and I am not an attorney. In situations where specific advice is required, formal legal advice may be needed.

If we see each other accidentally outside of the therapy office, I will not acknowledge you first. Your right to confidentiality is of the utmost importance to me, and I do not wish to jeopardize your privacy. However, if you wish to acknowledge me first, I will be more than happy to speak briefly with you, but feel it appropriate not to engage in any lengthy discussions in public or outside of the therapy office.

### **CONFIDENTIALITY & TECHNOLOGY**

Some clients may choose to use technology in their counseling sessions. This includes but is not limited to online counseling via video, telephone, email, or text. It is important to be aware that these modes of communication can be relatively easily accessed by unauthorized people and hence can compromise the privacy and confidentiality of such communication. These modes of communication are not considered HIPPA compliant forms of communication. If you communicate confidential or private information via video, email, texts, fax or phone it assumes that you have made an informed decision, and will be seen as your agreement to take the risk associated with such communication. Clients who engage in video therapy do so with full informed-consent of the limitation of privacy and confidentiality during video sessions. Sensitive information should be conveyed off-line or in-person.

### **CONFIDENTIALITY & GROUP THERAPY**

The nature of group counseling makes it difficult to maintain confidentiality. If you choose to participate in group therapy, be aware that your therapist cannot guarantee that other group members will maintain

your confidentiality. However, your therapist will make every effort to maintain your confidentiality by reminding group members frequently of the importance of keeping what is said in the group confidential. Your therapist also has the right to remove any group member from the group should she discover that a group member has violated the confidentiality rule.

### **SOCIAL MEDIA POLICIES**

**Friending:** I do not accept friend or contact requests from current or former clients on any social networking site (Facebook, LinkedIn, Google+, etc). I believe that adding clients as friends or contacts on these sites can compromise your confidentiality and our respective privacy. It may also blur the boundaries of our therapeutic relationship. If you have questions about this, please bring them up when we meet and we can talk more about it.

**Interacting:** Please do not use messaging on social networking sites such as Twitter, Facebook, or LinkedIn to contact me. These sites are not secure and I may not read these messages in a timely manner. Please do not use wall postings, @replies, or other means of engaging with me in public online if we have already established a therapeutic relationship. Engaging in this way could compromise your confidentiality. It may also create the possibility that these exchanges become part of your legal record and will need to be documented and archived in your chart.

**Internet Searches:** While my present or potential clients might conduct online searches about my practice and/or me, I do not search my clients with Google, Facebook, or other search engines unless there is a clinical need to do so, as in the case of a crisis or to assure your physical wellbeing. If clients ask me to conduct such searches or review their websites or profiles and I deem that it might be helpful, I will consider it on a case by case basis and only after discussing possible impacts to our professional relationship and your privacy.

**Business Sites:** You may find my practice on sites such as Yelp, Healthgrades or any other places that list businesses. Some of these sites include forums in which users rate their providers and add reviews. I have not added my practice to these sites intentionally; many of these sites comb search engines for business listings and automatically add listings regardless of the business has added itself to the site. If you should find my practice listed on any of these sites, please know that this listing is not a request for a testimonial, rating or endorsement from you. Of course, you have the right to express yourself on any site you wish. But due to confidentiality, I cannot respond on any of these sites. I urge you to take your privacy as seriously as I take my commitment of confidentiality to you. You should also be aware that if you are using these sites to communicate indirectly with me about our work, there is a possibility I may never see it. If we are working together, I hope you that you will bring your feelings and reactions to our work directly into the therapy process as this can be an important part of therapy.

**Location-Based Services:** If you have used location-based services on your mobile phone, you may wish to be aware of privacy issues related to these services. I do not place my practice as a check-in location on various sites such as Foursquare. However, if you have GPS tracking enabled on your device, it is possible that others may surmise that you are a therapy client due to regular check-ins at my office on a weekly basis. Please be aware of this risk if you are intentionally “checking in,” from my office or if you have a passive LBS app enabled.

### **COMPLAINTS**

You have the right to voice grievances and request changes in your therapy plan without restraint, interference, coercion, discrimination or reprisal. I encourage you to share any concerns you may have with me directly, including if you believe your privacy rights have been violated. If you believe I have violated your privacy rights, you have the right to file a complaint in writing to me or with the Secretary

of Health and Human Services at 200 Independence Avenue, S.W., Washington, D.C. 20201 or by calling (202) 619-0257. I will not retaliate against you for filing a complaint.

### **MINORS**

If you are under 18 years of age but over 14 and your parents have consented to treatment, you should be aware that District of Columbia law states that your parents can only review your records with your consent. If you agree, and sign a release of information form stating so, I will provide them with general information about the progress of treatment and attendance. The exception to this confidentiality is if I feel there is a high risk that you will seriously harm yourself or someone else. In this case, I will notify your parents of my concern. Before giving them any information, I will discuss the matter with you, if possible, and do my best to respond to any objections you may have regarding what I am prepared to discuss. Parents may also contact me about any matters of particular concern that have arisen, and I will usually address these in therapy. However, parents should be aware that therapy is not effective if the content of what is discussed with your teen is regularly shared with you. Therefore, while I will regularly update you about general progress of the treatment, and may request parent meetings from time to time, the content of what is disclosed will be discussed with teenagers ahead of the meeting, and the general themes of the meeting with you will be discussed afterwards, in order to provide a safe and confidential space for your teen. You can be assured that whenever a teen's safety or life may be in jeopardy, I will discuss these issues with you promptly and will alert your teen that I plan to do so. However, experimentation with risky behaviors is common in adolescents and may not always be disclosed, as addressing these behaviors may be part of the work of the treatment. By your signature below you agree to allow me to exercise my best professional judgment in disclosing information about your teen's treatment to you.

Please be aware that in cases where separation or divorce has occurred or is in process, the signatures and consent of BOTH parents are required for treatment when Joint Legal Custody is in place, regardless of which parent has physical custody of the child. Also, please note that utilizing therapy to support custody petitions is generally not in the best interest of you or your child, and I am not a qualified expert in custody evaluations.

### **COURT APPEARANCES**

I do not voluntarily provide evaluations for attorneys, the courts, or for any forensic purposes. If I am required to testify for these purposes, you will agree to pay the fee for my time when billed. This includes preparing for testimony, reports, travel, court time, and other time that is needed (5 hour minimum) with a 14-day notice of cancellation required to avoid charge.

### **PROFESSIONAL RECORDS**

The laws and standards of my profession require that I keep treatment records. In conformance with HIPAA, I keep Protected Health Information about you in your Clinical Record. It includes information about your reasons for seeking therapy, a description of the ways in which your problem impacts on your life, your diagnosis (if applicable), the goals that we set for treatment, your progress towards those goals, your medical and social history, your treatment history, any past treatment records that I receive from other providers, reports of any professional consultations, your billing records, and any reports that have been sent to anyone, including reports to your insurance carrier. I use a secure cloud-based program to document and store this information.

Except in unusual circumstances that involve a substantial risk of imminent psychological impairment or imminent serious physical danger to yourself and others, you may examine and/or receive a copy of your Clinical Record, if you request it in writing. Because these are professional records, untrained readers may

misinterpret them. For this reason, I recommend that you initially review them in my presence, or request a summary that we can review together.

### **CLIENT RIGHTS**

You have certain rights with regard to your Clinical Record and disclosures of protected health information. These rights include requesting that I amend your record; requesting restrictions on what information from your Clinical Record is disclosed to others; requesting an accounting of most disclosures of protected health information that you have neither consented to nor authorized; determining the location to which protected information disclosures are sent; having any complaints you make about my policies and procedures recorded in your records; and the right to a paper copy of this Agreement, the attached Notice form, and my privacy policies and procedures. I am willing to discuss any of these rights with you.

### **TERMINATION**

How long you remain in therapy is a matter best discussed and decided upon by us together within the context of the accomplishment of your goals. Regardless of the reason(s), ending relationships can be difficult. Therefore, it is important to have a termination process in order to achieve some closure. The appropriate length of the termination depends on the length and intensity of the treatment. I may terminate treatment after appropriate discussion with you and a termination process if I determine that the psychotherapy is not being effectively used, or if you are in default on payment. I will not terminate the therapeutic relationship without first discussing and exploring the reasons and purpose of terminating. While it is your right to end therapy when you decide that termination is in your best interest, ending therapy is an important part of the treatment process, and is most productive when discussed in the context of your therapy. **I will usually request a minimum of one wrap-up session after you have decided to terminate treatment to bring your therapy to an appropriate closure.** I will remain willing to discuss your thoughts about terminating therapy with you during any session. If therapy is terminated for any reason, or you request another therapist, I will provide you with a list of qualified psychotherapists to treat you. You may also choose someone on your own, or from another referral source.

Should you fail to schedule an appointment for three consecutive weeks, unless other arrangements have been made in advance, for legal and ethical reasons, I must consider the professional relationship discontinued.

### **FEES**

Initial individual psychotherapy evaluation meetings are \$\_\_\_\_\_. Each session is 45 minutes in length. If either of us believes that for any reason you would be best served by another clinician or by another treatment modality, I will be happy to provide you with appropriate referrals on a no-fee basis, even if this should require additional time and research on my part. Should we both agree to continue, subsequent 45 minute weekly sessions are \$\_\_\_\_\_ by cash or check or \$\_\_\_\_\_ by credit card. Group therapy meetings are \$\_\_\_\_\_. Each session is 75 minutes in length. Payment is due at time of service. Reduced fee services are available on a limited basis in unusual situations.

Additionally, while it is expected that there will be brief telephone contacts regarding scheduling appointments and other matters, extended phone consultations with clients, family members, or other providers will incur charges at the rate of \$\_\_\_\_\_/\_\_\_\_\_ (depending on method of payment), billed in 15-minute increments. Please be aware that insurance does not reimburse for phone consultations.

### **PAYMENT**

Once a commitment to treatment is made, payment for services is expected at the time of each session by cash, check, or credit card, unless special arrangements are made and agreed upon in writing. Please

prepare your payment ahead of time to provide us the opportunity to make the best use of our time together. **If you do not pay your balance for services rendered within the agreed upon time frame, you will be notified and your credit card will be charged for the balance.**

My practice is a fee-for-service business and you, the client, are responsible for payment although I will provide you with a detailed statement at the end of each month that you may choose to submit to your insurance company to seek reimbursement if you wish. Rate increases may occur annually and will take effect on January 1<sup>st</sup>.

### **INSURANCE**

I do not participate in managed care plans nor do accept assignment of benefits, which means that I do not accept insurance for counseling or therapy sessions. However, you may wish to submit to your insurance company for reimbursement. Please be aware that if you choose to utilize your insurance benefits by requesting reimbursement, the insurance company may require me to provide them with a mental health diagnosis, information about your symptoms and to provide a “treatment plan” in order for you to receive reimbursement. In addition, they may request other information about your treatment, such as substance abuse history or suicidal/homicidal gestures or risk, progress and prognosis in order for treatment to be reimbursed. Although insurance companies have confidentiality procedures, once the information leaves my office I have no control over who it is shared with or how the data is stored. There have been rare occasions when persons have been denied future health, life or disability insurance applications based on even a seemingly benign diagnosis. In addition, companies may decide that your diagnosis, the number of sessions, or the fee amount will not be covered, in which case your therapy sessions will have been at your full expense. A copy of documents sent to your insurance company on your behalf will be kept in your medical record for your reference. Please take these matters into consideration when choosing to seek reimbursement from your health insurance plan.

### **CANCELLATION POLICY**

Therapy is a commitment, and its progress and effectiveness depend on consistent participation. Together, we agree to meet here and to be on time. Once a commitment to treatment is made, payment for services is expected at the time of your session by cash, check, or credit card. **Clients will be charged for any session missed without prior notice. In a calendar year, a client may cancel 2 sessions without being charged. The client will be charged for any cancellations after the 2 allowed, including those resulting from work responsibilities and vacations. However, if a client can reschedule a cancelled session within two weeks, it will not count toward the annual limit.**

As a member of group therapy, you are responsible for paying for all sessions until you formally terminate with the group, whether you are in attendance or not. This is because participating in a group is similar to renting a spot that I am unable to fill with anyone else when you are absent.

**Please note: charges for missed or canceled sessions may not be insurance reimbursable.**

In the case of inclement weather, I will make my best effort to be in the office. In extenuating circumstances, I will contact you if I am unable to make it to the office and we will do a phone session. Unless we are in contact about canceling an appointment, I will assume that you plan to attend, and the late cancellation policy will apply if you do not attend. If you feel it would be dangerous for you to come to our appointment, please let me know as soon as possible and we will do our session by phone. Due to the nature of psychotherapeutic work, the consistency of our appointments is very important.

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**CONSENT TO TREATMENT**

**Signing below signifies that you have read this psychotherapy services agreement, agree to its terms, and have had it explained to you if you requested it. You freely and voluntarily choose to participate in treatment. This agreement will be valid until you discontinue therapy. You understand that you are free to discontinue therapy at any time. If you choose to withdraw your consent and to discontinue therapy, you hereby release me from all claims of liability for any ill effects that may result from the withdrawal of consent and discontinuation of participation in therapy.**

Name of Client (please print): \_\_\_\_\_

Signature of Client: \_\_\_\_\_ Date: \_\_\_\_\_

Signature of Witness: \_\_\_\_\_ Date: \_\_\_\_\_



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I acknowledge that I have been provided the **Notice of Privacy Practices** of Molly Milgrom Psychotherapy.

Name of Client (please print): \_\_\_\_\_

Signature of Client: \_\_\_\_\_ Date: \_\_\_\_\_

Signature of Witness: \_\_\_\_\_ Date: \_\_\_\_\_