Lenée N. Essig, LCSW 2201 Mount Vernon Ave, Alexandria, VA 22301
(Phone) 703.749.4818 (E-mail) lenee@leneenessiglcsw.com (Web) www.leneenessiglcsw.com

Consent, Financial Fee Agreement, Authorization to Contact & Notice of Privacy Practices

Consent To Treatment

I, and or we, the undersigned, give my, and or our, consent and authorize Lenée N. Essig, LCSW, to provide me, and or us, with psychotherapy services. I, and or we, understand that these services may include individual and family clinical interviews, assessments, consultations and treatments. Services may also include discussions with other individuals in my life by my therapist, but I, and or we, understand that she will contact no individual without my, and or our, prior written consent.

I, and or we, understand that I, and or we, have the right to refuse treatment or terminate counseling services should I, and or we, choose.

Confidentiality

Confidentiality is a high value and every effort is made to ensure that client information is kept confidential. However, the state of Virginia and the National Association of Social Workers specify certain conditions in which it may be necessary for information about a client's treatment be discussed with other professionals. The situations in which confidentiality is to be broken are:

1. If a therapist believes there is imminent danger that a client may harm him/herself or others.
2. If a therapist becomes aware of a client's involvement in abuse of children, elderly or disabled persons.
3. If a therapist is ordered by the court to release client records.
4. If a client signs an authorization for release form that allows a therapist to discuss a client case with another person; eg: doctor, psychiatrist, relative.

Financial Fee Policy & Agreement

The following is a clarification of the financial/fee policies and agreement. I ask that you read this document and sign your name(s) indicating that you have read, and agree to the following information. Should you have any questions please feel free to discuss them with me.

- Your fee, applies to each ninety-minute, fifty to sixty-minute individual and/or couples session, and/or seventy-five minute group session. You are responsible for this fee and I ask that you make payment at the beginning of each appointment. Checks returned due to insufficient funds will incur a charge of $30.00.

- As the time scheduled for your appointment is reserved for you, I ask that you give 48 hours notice if it is necessary to cancel an appointment. If notice is given in less than 48-hours, you will be charged for that session. Rescheduling of cancelled appointments may be made within the same week of the cancelled session, and only as my schedule allows. All missed visits without cancellation will be charged accordingly.

- If you terminate therapy with an outstanding balance of fees you will still be responsible for paying said fees, and if necessary all costs of collection, including attorney's fees if collected by or through an Attorney-at-law. You are ultimately responsible for full payment of your account, including claims denied by your insurance company for any reason.

- From time to time the fees may change. I will notify you in advance if there is a change in the fee schedule.

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- You are responsible for any applicable co-pays and/or out of network expenses, which results from failure of notifying me of any changes in insurance coverage (e.g. change in policy). In such:

  1. If claims are denied or payment is reduced because of non-notification of change in insurance coverage my fee-for-service applies to those claims.
  2. I am not financially responsible for previous billed sessions prior to notification or due to non-notification of change in insurance coverage.

- Fees for other services, such preparation of special reports or telephone consultations are billed at $140.00 per hour.

- I am not a Medicare or TriCare provider. If your carrier is either Medicare (Part B) or TriCare you agree not to submit a claim (or to request that I submit a claim) to the Medicare or TriCare program with respect to services rendered. If applicable, please refer to signed agreement for additional information.

  ☐ I am a Medicare B or TriCare recpient ☐ I am not a Medicare B or TriCare recpient

I, and or we, _____, agree to pay $_____ per session, for services rendered by Lenée N. Essig, LCSW, LLC.

In addition, I and or we, authorize the release of any medical or other information to the named insurance company(s) and/or their designated agent(s) necessary to approve and/or pay any claims, if applicable. I hereby assign and authorize payment of all medical benefits payable pursuant to any claims to Lenée N. Essig, LCSW, LLC, for services rendered.

I, and or we, understand that Lenée N. Essig, LCSW, LLC, uses a third party billing software for filing with insurance companies, and give(s) permission for this.

Payment is expected at the time services are rendered, unless otherwise noted above, or prior arrangements have been made.

Notice of Privacy Practices

I have been provided with access & copy of the *Privacy Practices* (updated 2013) in accordance of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), as well as a copy of the *Practice Policies*.

Authorization to Contact by Telephone/Verbally in Event of Breach of PHI

I, _____ [Name of Client], authorize Lenée N. Essig, LCSW, LLC, to provide notice to me by telephone or verbally in the event of a breach of my protected health information (PHI) by Lenée N. Essig, LCSW, LLC. Such conversation shall be documented by Lenée N. Essig, LCSW, LLC.

Pursuant to the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Final Rule modifying the HIPAA Privacy, Security, Enforcement and Breach Notification Rules, the verbal or telephonic notice provided to me pursuant to this authorization shall not be simply for the administrative convenience of Lenée N. Essig, LCSW, LLC.

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AGREEMENT

I, and or we, have read, understand and agree to the above consent, policies and financial agreement.

_____ _____
Client/Guardian Signature Therapist Signature

_____ _____
Client/Guardian Signature Date

_____
Date