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Couple Informed Consent Form-Client Information

Welcome to my practice. This document contains important information about 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 patient rights about the use and disclosure of your Protected Health Information (PHI) for the purposes of treatment, payment, and health care operations. Although these documents are long and sometimes complex, it is very important that you understand them. When you sign this document, it will also represent an agreement between us. We can discuss any questions you have when you sign them or at any time in the future.

PSYCHOLOGICAL SERVICES

Therapy is a relationship between people that works in part because of clearly defined rights and responsibilities held by each person. As a client in psychotherapy, you have certain rights and responsibilities that are important for you to understand. There are also legal limitations to those rights that you should be aware of. I, as your therapist, have corresponding responsibilities to you. These rights and responsibilities are described in the following sections.

Psychotherapy has both benefits and risks. Risks may include experiencing uncomfortable feelings, such as sadness, guilt, anxiety, anger, frustration, loneliness and helplessness, because the process of psychotherapy often requires discussing the unpleasant aspects of your life. However, psychotherapy has been shown to have benefits for individuals who undertake it. Therapy often leads to a significant reduction in feelings of distress, increased satisfaction in interpersonal relationships, greater personal awareness and insight, increased skills for managing stress and resolutions to specific problems. But there are no guarantees about what will happen. Psychotherapy requires a very active effort on your part. In order to be most successful, you will have to work on things we discuss outside of sessions.

The first 2-5 sessions will involve a comprehensive evaluation of your needs. By the end of the evaluation, I will be able to offer you some initial impressions of what our work might include. At that point, we will discuss your treatment goals and create an initial treatment plan. You should evaluate this information and make your own assessment about whether you feel comfortable working with me. If you have questions about my procedures, we should discuss them whenever they arise. If your doubts persist, I will be happy to help you set up a meeting with another mental health professional for a second opinion.

APPOINTMENTS

Appointments will ordinarily be 45 minutes in duration, (Intake is 1 hour) once per week at a

time we agree on, although some sessions may be more or less frequent as needed. If you need to cancel or reschedule a session, I ask that you provide me with 24 hours' notice. If you miss a session without canceling, or cancel with less than 24 hour notice, you are responsible for payment of this missed session. It is important to note that insurance companies do not provide reimbursement for cancelled sessions. If it is possible, I will try to find another time to reschedule the appointment. In addition, you are responsible for coming to your session on time; if you are late, your appointment will still end on time.

PROFESSIONAL FEES

My standard fee for is \$225. You are responsible for paying at the time of your session unless prior arrangements have been made. Payment must be made by check, Zelle (7032980631) or cash. Any checks returned to my office are subject to an additional fee of up to \$25.00 to cover the bank fee that I incur. If you refuse to pay your debt, I reserve the right to use an attorney or collection agency to secure payment.

In addition to weekly appointments, it is my practice to charge this amount on a prorated basis (I will break down the hourly cost) for other professional services that you may require such as report writing, telephone conversations that last longer than 15 minutes, attendance at meetings or consultations which you have requested, or the time required to perform any other service which you may request of me. If you anticipate becoming involved in a court case, I recommend that we discuss this fully before you waive your right to confidentiality. If your case requires my participation, you will be expected to pay for the professional time required even if another party compels me to testify.

INSURANCE

In order for us to set realistic treatment goals and priorities, it is important to evaluate what resources you have available to pay for your treatment. If you have health insurance that I am contracted with, I will file the claims, and you are responsible for knowing your coverage/co-pay and for letting me know if/when your coverage changes.

You should also be aware that most insurance companies require you to authorize me to provide them with a clinical diagnosis. Diagnoses are technical terms that describe the nature of your problems and whether they are short-term or long-term problems. All diagnoses come from a book entitled the DSM-5. Sometimes I have to provide additional clinical information such as treatment plans or summaries, or copies of the entire record (in rare cases). This information will become part of the insurance company files and will probably be stored in a computer. Though all insurance companies claim to keep such information confidential, I have no control over what they do with it once it is in their hands. In some cases, they may share the information with a national medical information databank. I will provide you with a copy of any report I submit, if you request it. By signing this Agreement, you agree that I can provide requested information to your carrier if you plan to pay or turn in your own claim to your insurance company.

If I am not a participating provider for your insurance plan, I will supply you with a receipt of payment for services (at the beginning of the month for the previous month) which you can

submit to your insurance company for reimbursement. Please note that not all insurance companies reimburse for out-of-network providers.

PROFESSIONAL RECORDS

I am required to keep appropriate records of the psychological services that I provide. Your records are maintained in a secure location in the office. I keep brief records noting that you were here, your reasons for seeking therapy, the goals and progress we set for treatment, your diagnosis, topics we discussed, your medical, social, and treatment history, records I receive from other providers, copies of records I send to others, and your billing records. Except in unusual circumstances that involve danger to yourself, you have the right to a copy of your file. Because these are professional records, they may be misinterpreted and / or upsetting to untrained readers. For this reason, I recommend that you initially review them with me or have them forwarded to another mental health professional to discuss the contents. If I refuse your request for access to your records, you have a right to have my decision reviewed by another mental health professional, which I will discuss with you upon your request. You also have the right to request that a copy of your file be made available to any other health care provider at your written request.

CONFIDENTIALITY

My policies about confidentiality, as well as other information about your privacy rights, are fully described in a separate document entitled Notice of Privacy Practices. You have been provided with a copy of that document, and we have discussed those issues. Please remember that you may reopen the conversation at any time during our work together.

I understand that it is Mimi Weisberg's role to provide therapeutic services so that I might feel better and/or improve my functioning, especially as it relates to my family. Mimi Weisberg's role is not intended to gather information for the courts or to make judgments related to my family.

We understand that couples therapy begins with an evaluation of our relationship, past and present. While Mimi Weisberg is deciding whether she is the appropriate therapist for us, we will decide whether we wish to begin couples therapy with her. We understand that because of the commitment of time and money, plus the potential impact on us and others, it is important to make an informed choice for a couples' therapist.

TERMINATION/ENDINGS

Therapy is a collaborative process and so is the ending of psychotherapy. In the service of all involved (when possible,) let us plan the termination of your treatment together. Endings can stimulate other changes, transitions, and losses. Discussing the process can help pull all the hard work you have been doing together and give you a solid position to move forward.

CONTACTING ME

I am often not immediately available by telephone. I do not answer my phone when I am with clients or otherwise unavailable. You may leave a message on my confidential voice mail, and

your call will be returned as soon as possible, but it may take a day or two for non-urgent matters. If, for any number of unseen reasons, you do not hear from me or I am unable to reach you, and you feel you cannot wait for a return call or if you feel unable to keep yourself safe, 1) go to your Local Hospital Emergency Room, or 2) call 911 and ask to speak to the mental health worker on call. I will make every attempt to inform you in advance of planned absences and provide you with the name and phone number of the mental health professional covering my practice on my voice mail message.

OTHER RIGHTS

If you are unhappy with what is happening in therapy, I hope you will talk with me so that I can respond to your concerns. Such comments will be taken seriously and handled with care and respect. You may also request that I refer you to another therapist and are free to end therapy at any time. You have the right to considerate, safe and respectful care, without discrimination as to race, ethnicity, color, gender, sexual orientation, age, religion, national origin, or source of payment. You have the right to ask questions about any aspects of therapy and about my specific training and experience.

We have read and understand the potential limits of confidentiality, including those imposed by Mimi Weisberg's policies and by state law, and we have received a copy to keep.

We understand that information discussed in couples' therapy is for therapeutic purposes and is not intended for use in any legal proceedings involving the partners. We agree not to subpoena Mimi Weisberg to testify for or against either party or to provide records in a court action.

We understand all policies as described on the CLIENT INFORMATION sheet and accept them as conditions for entering into couple' therapy with Mimi Weisberg. We understand the limits and benefits of using insurance to pay for couples' therapy. If we use insurance, we agree to provide all information needed to comply with insurance regulations. We understand that if we use insurance, Mimi Weisberg will not retain control over information provided to the insurance company.

We have been given the opportunity to ask questions and discuss confidentiality and disclosure policies with Mimi Weisberg. We understand that while working as a couple, anything either of us might say to Mimi Weisberg individually, whether by phone or in an individual session, *may not be held as confidential, and at Mimi Weisberg's discretion may be shared with the spouse/partner during a subsequent couple session.*

We agree to share responsibility with Mimi Weisberg for the therapy process, including goal setting and termination. By entering into couples therapy, we accept that we both understand that working toward change may involve experiencing difficult and intense feelings, some of which may be painful, in order to reach therapy goals. We understand that the changes one or both of us makes will have an impact on our partner and on others around us. We accept that such changes can have both positive and negative effects and agree to clarify and evaluate potential effects of changes before undertaking them.

We agree to pay for all services provided by Mimi Weisberg, including any charges not fully reimbursed by the insurance company. We understand that no insurance company will pay for missed sessions, and we agree to Mimi Weisberg's policy of charging if we fail to cancel appointments in advance.

By signing below, we agree to accept mental health services from Mimi Weisberg and accept full responsibility for payment for such services.

Patient _____ Date _____
Patient _____ Date _____

Confidentiality Contract for Marital or Couple Therapy Regarding Deposition/Court Usage

This contract is an agreement between the interested parties that neither party shall for any reason attempt to subpoena my testimony or my records to be presented in a deposition or court hearing of any kind for any reason, such as a divorce case.

Both parties acknowledge that the goal of psychotherapy, either individual or marital or couples' therapy, is for the sole purpose of the amelioration of psychological distress and that the process of psychotherapy depends on trust and openness during the therapy sessions.

Therefore, it is understood by both parties that if they request my services as a psychotherapist, they are expected not to use information given to me during the therapy process against the other party in a judicial setting of any kind, be it civil, criminal, or circuit.

The signatures below reflect that the parties agree to the terms set forth above.

Signed &
Dated _____

Signed &
Dated _____

NOTICE OF PRIVACY PRACTICES (NPP)

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

My practice is dedicated to maintaining the privacy of your personal health information as part of providing professional care. I am required by law to keep your information private. These laws are complicated, but I must give you this important information. This form is a shorter version of the full legally required NPP. Please feel free to discuss with me any questions or problems.

I will use the information about your health which I get from you or from others mainly to provide you with treatment, to arrange payment for our services, and for some other business activities which are called, in the law, health care operations. After you have read the NPP I will ask you to sign a Consent Form to let me use and share your information. If you do not consent and sign this form, I cannot treat you.

If you or I want to use or disclose (send, share, release) your information for any other purposes I will discuss this with you and ask you to sign an Authorization form to allow this.

Though I will keep your health information private there are times when the law requires mental health professionals to disclose information. For example:

- When there is a serious threat to your health and safety or the health and safety of another individual or the public. I will only share information with a person or organization which is able to help prevent or reduce the threat.
- Suspected child abuse or neglect must be reported to the proper authorities.
- If you are a party to a lawsuit or other legal proceedings and I am served with a subpoena, I may have to release some of your health information. I will try and make certain that you have been made aware of the subpoena, so that you may take appropriate action to protect your privacy.
- If a law enforcement official requires me to do so.
- For Workers Compensation and similar benefit programs.

There are some other situations like these which don't happen very often. They are described in the longer version of the NPP.

Your Rights Regarding Your Health Information

- You can ask me to communicate with you about your health and related issues in a particular way or at a certain place which is more private for you. For example, you can ask me to call you at home, and not at work to schedule or cancel an appointment. I will try my best to do as you ask.
- You have the right to ask me to limit what I tell people involved in your care or the payment for your care, such as family members and friends. While I don't have to agree to your request, if I do agree, I will keep our agreement except if it is against the law, or in an emergency, or when the information is necessary to treat you.
- You have the right to look at the health information I have about you such as your medical and billing records. With your request in writing, you can get a copy of these records but there may be a charge.
- If you believe the information in your records is incorrect or missing important information, you can ask me to make some kinds of changes to your health information. You have to make this request in writing including the reasons you want to make the changes.
- You have the right to a copy of this notice. If I change this NPP I will post a new version in the waiting area, and you can always request a new copy for yourself.
- You have the right to file a complaint if you believe your privacy rights have been violated. You can file a complaint with the Secretary of the Department of Health and Human Services. All complaints must be in writing. Filing a complaint will not change the health care I provide to you in any way.

If you have any questions regarding this notice or my health information privacy policies, please speak with me about your concerns.

The effective date of this notice is April 14, 2003.

Mimi Weisberg, LCSW

McLean Professional Park
1499 Chain Bridge Rd., Suite 200
McLean, VA 22101
703-298-0631

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

By my signature below, I/We _____,

_____ ,
I acknowledge that I received a copy of the Notice of Privacy Practices for the clinical practice of Mimi Weisberg, LCSW. I understand that if I have any questions regarding the Notice or my privacy rights, I can contact Ms. Weisberg.

Signature

Date

Signature

If this acknowledgment is signed by a personal representative on behalf of the client, complete the following:

Personal Representative's Name: _____

Relationship to Client: _____

For Office Use Only

I attempted to obtain written acknowledgment of receipt of our Notice of Privacy Practices, but acknowledgment could not be obtained because:

_____ Individual refused to sign.

_____ Communications barriers prohibited obtaining the acknowledgment.

_____ An emergency situation prevented us from obtaining acknowledgment.

_____ Other (please specify) _____

Mimi Weisberg, LCSW

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Tele-Mental Health Services - Informed Consent

Tele-mental health is best summarized as the provision of mental health services with the provider and recipient of services being in separate locations and the services being delivered over electronic media, primarily - internet based technology tools.

In appropriate cases and conditions, it becomes necessary for treatment to occur via interactive video conferences or by phone. Currently, the video platform that I use is doxy.me/mimilcsw. I also use Zoom when we agree to do so, especially when seeing more than one person in a session.

This provider will use tools that adhere to security best practices for purposes of protecting your privacy. As with all things in technology you also have a role to play in maintaining your security. Please use reasonable security protocols to protect the privacy of your own health care information, such as using devices and service accounts that are protected by unique passwords that only you know. Do not record video sessions without this provider's consent; this provider will not record sessions.

Risks associated with using tele-mental health services may possibly include but are not limited to reduced reimbursement rates for video sessions, the session being interrupted or delayed by dropped internet connections or breach of information beyond our control. It is recommended that you create a safe and confidential space during sessions. In addition, you will need to make a plan for mental health crisis and medical emergencies by contacting 911 or going to your local emergency room.

Please indicate that you have read this document and the opportunity to ask questions, understand the procedures, risks, and benefits of video sessions. You also have the right to terminate this consent at any time. Sign and return (photo or scan) or reply to this email with your consent with a date indicated.

Signature(s) and Date: _____