**Joan Rockwell, LCSW**

**2915 Hunter Mill Road, Suite 14, Oakton, Virginia 22124**

Welcome to my practice. This document contains important information about my professional services and business practices. Please read it carefully and feel free to ask questions.

* **Client Data Form:**  Please complete the **Client** **Data Form** as this information is necessary for communicating. The information is also required for filing insurance company claims.
* **Notice of Privacy Practices:** Please read the **HIPAA** agreement carefully, sign it, and return the signature portion to me. In order for me to accept insurance, I **must** have a copy of this form on file.
* **Insurance Coverage:** Please complete and return the **Insurance Form**. **It is your responsibility to know exactly what services your insurance plan covers and if pre-authorization is required.** **Obtain pre-authorization if it is required by your plan. If a claim is rejected for failure to obtain pre-authorization you will be responsible for payment of the session.** I am a provider for Blue Cross Blue Shield, which includes CareFirst and Anthem, United Behavioral Health, an out-of-network provider for Tricare, and Aetna NAP. I will submit claims to your insurance company at your request even if I am not a provider.
* **Financial Agreement:** **My fee is $120.00 per 45-60 minute session, $180.00 per 90 minute session, and $240.00 for a double session of 100 minutes.** **Payment is due at the time services are rendered**. I accept co-pays and will file out-of-network claims for you, at your request. If your insurance is out-of-network I am also willing to file your insurance claim and will accept the difference between what the insurance pays and my fee of $120.00 once your deductable has been met. If your deductable has not been met, you will be expected to pay the full fee until it is. **You are responsible for any payments or partial payments that your insurance company will not cover.**

* **Session Length:** Unless otherwise agreed upon**, sessions are 45-60 minute hour.**  Some insurance companies will not pay for sessions that go beyond 52 minutes. Critical issues that come up at the end of the session will have to wait until our next session.
* **Missed Sessions:** **You will be charged your insurance rate for any cancellations made less than 24 hours in advance. Insurance does not cover missed sessions so you will be responsible for the entire contracted fee.** Please cancel sessions **48 hours in advance** **or earlier when possible**. More notice is greatly appreciated as it allows me to make adjustments to my schedule. Sessions cancelled less than 24 hours due to inclement weather or illness will be dealt with on a case by case basis.
* **Phone calls:** I will accept phone calls between sessions, but they are not meant to take the place of sessions. You will be charged for calls that exceed 10 minutes at the rate of $25.00 per 10 minutes or any part thereof after the initial 10 minutes.
* **Communication:** The most expedient way to reach me is by phone or text. Please use text and e-mail for scheduling issues or if you would like me to call you. Texting and e-mail are not confidential and potentially violate HIPAA. **If you do not hear from me within 24 hours, I did not get your message whether it is via phone, text or e-mail.**
* **Forensic and Litigate Services:** I do not participate in lawsuits of any type on a plaintiff’s behalf unless compelled to do so by subpoena or court order. Due to the complexity of legal involvement, if you become involved in legal proceedings that require my participation, deposition, telephone time, transportation costs, court appearances, report writing, consultation, and supervision, even if I am called to testify by another party you will be charged $250.00 per hour for preparation and attendance at any legal proceeding.
* **Confidentiality:** You have the right to confidentiality regarding any records, communications, or other information pertaining to you treatment or evaluation. Information may only be shared if you sign a release of information that specifies who is to receive the information and the nature of the information to be shared.
* I reserve the right to consult with professional colleagues regarding treatment and evaluation. Such discussions do not include the use of names or identifying information. Exceptions to confidentiality do exist in order to protect yourself and others. A list of such exceptions is given on my “Confidentiality of Protection Health Information.” However, below is a brief summary of exceptions.

***Exceptions to confidentiality:***

* **Danger to Self or Others:** The law requires that mental health professionals report information that indicates that an individual is in imminent danger of hurting himself or another person. I I believe that a client is a threat to himself/herself, I am obligated by law to take protective action. This action may include seeking hospitalization or contacting family members or others who can assist in providing protection. This action may include notifying the potential victim, contacting the police, or seeking hospitalization. I will make every effort to fully discuss this with you before taking any action.
* **Abuse of Children and/or Adults:** The law requires that all mental health providers report information believed or reasonably suspected to constitute abuse or neglect of children. The law also requires the report of suspected abuse of persons 65 or older or of another adults who may be in need of protective services due to disability.
* **Orders or The Court:** Certain records (which differ by jurisdiction) can be subpoenaed by legal process. This possibility also applies to reports and testimony. In addition, you may give up your confidentiality if you choose to make your mental status an issue as part of a court proceeding.
* **Social Service Referrals:** If you are referred for evaluation or treatment by a Social Service Agency as part of an evaluation or intervention, there may be a requirement to share information regarding attendance, findings, recommendations and/or progress in treatment. The details of the information to be shared in such instances will be discussed with you prior to my discussion with representative of such agencies.
* **Delinquent Accounts:** Collection agencies or attorneys may be given identifying information only in order to pursue delinquent accounts. If your bill is sent for collection you will be responsible for any fees incurred.

**Consent for Treatment**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, (name of client or guardian as applicable), agree and consent to the policies, procedures, fees, and payment arrangements as described above.

Your signature below indicates that you have read the information in this document and agree to abide by its terms during our professional relationship.

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Print Client Name

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Client Signature Date Signed

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Signature of Guardian or Legal Representative Date Signed

I have read, understood, and agree to the above: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_