Laurie L. Rosen, LCSW
Licensed Clinical Social Worker
703-239-2600 • LaurieLRosenLCSW@gmail.com
www.LaurieLRosenLCSW.com

CONTRACT FOR PSYCHOTHERAPY SERVICES

Permission to file your claim to health insurance carrier… ***(please initial)***

_____ /_____I authorize the release of any medical and other information necessary to process my health insurance claims.
_____ /_____I authorize the payment of medical benefits to Laurie L. Rosen, LCSW for services provided.

Health Insurance Information ONLY COMPLETE THE FOLLOWING INFORMATION IF PATIENT IS NOT RESPONSIBLE PARTY FOR PAYMENT OF SERVICES:

POLICY HOLDER INFO IF NOT PATIENT: Name_____ Relationship to patient_____
Policyholder Home Address, City, State, Zip_____ DOB_____
Policyholder Home Phone_____ Work Phone_____ Cell Phone_____
Policy Holder Email_____

Payment Contract

This Payment Contract between Laurie L. Rosen, LCSW & _____(name of "Responsible Party") establishes that the above "Responsible Party" agrees to make all payments in full by **cash or check**, payable to Laurie L. Rosen, LCSW, due at the time session. If patient misses or cancels a session with less than 24 hours advance notice, "Responsible Party" agrees to pay half the session fee ($75) for that missed session, which is not to be submitted to health insurance carrier for reimbursement. "Responsible Party" agrees to submit claims for which provider is out-of-network. "Responsible Party" agrees to pay any amounts not covered by health insurance carrier, including the deductible, and any amounts charged in an attempt to collect fees via attorney or collection agency, which may be utilized for a balance delinquent past 30 days. "Responsible Party" agrees that treatment may be terminated until such time that all delinquent fees have been paid. **Fee for psychotherapy session** (TBD w/ therapist)_____

_____ _____
Signature ***Date***

_____ _____
Signature ***Date***

Notice of Privacy Practices & Informed Consent (If couple, both parties initial below)

_____ /_____I have received a copy of or have been instructed as to where I can access the Notice of Privacy Practices (NPP), informing me about how my Protected Health Information (PHI) may be used and disclosed, and how I can get access to this information. It is my responsibility to request a copy if I so desire. NPP IS AVAILABLE ON WEBSITE.

_____ /_____I understand that much of the work of therapy will be to resolve issues, and will depend on my honesty and willingness to do the things I need to do to move forward, even if it is painful and difficult. I understand that "homework" such as reading, written exercises, and changing behaviors may be prescribed as part of my treatment. I understand that I am entirely responsible for my own actions and I will always make my own final decisions regarding counseling.

_____ /_____I understand that 30 days from my last session without any follow-up appointment or communication, my case will be considered closed and the therapeutic relationship terminated. However, I may call for an appointment to resume therapy anytime contingent upon scheduling availability.

_____ /_____I understand that whatever I say in a session is strictly confidential and will not be released to anyone without my consent EXCEPT in cases of: abuse, being at risk for harming myself or others, couples therapy, utilizing collection agencies for unpaid balances, and obtaining payment from health insurance companies. I agree to the above statements and hereby agree to enter into a therapeutic relationship with Laurie L. Rosen, LCSW.

_____ /_____ I understand there may be additional fees to be paid should I request documentation about my treatment that may include correspondence, summary, dates of service, or forms.

_____ _____ _____
Signature ***Printed Name*** ***Date***

_____ _____ _____
Signature ***Printed Name*** ***Date***

As your therapist, I will bring the best that I know from my study and experience, insight and wisdom. I will keep a holistic perspective in our work together because I believe that the mind, body, and spirit all work together to form the wholly healthy person. You can expect truth from me even when you may not want to hear it. I will provide a safe place where you will experience compassion and empathy on your journey. Thank you for the privilege to share in your life, learning, and growth.

Laurie

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CONTRACT FOR COURT PROCEEDINGS

Psychotherapy records are kept confidential and protected under the law. Once these records are in the hands of attorneys and the court, the information gleaned from them can be quite damaging to all parties involved. Please respect the protection your ex's and your records are afforded.

Each party is required to initial all statements below, indicating you understand the policies and protections around mental health records in my care and agree to abide by fees that may incur.

_____ _____I agree NOT to petition this therapist to appear in court as a witness for custody hearings, trials, or other domestic issues.

_____ _____I agree NOT to petition this therapist to share confidential therapeutic records about myself or anyone else (ex: my spouse/partner or ex-spouse/ex-partner).

_____ _____I understand any attempt to petition this therapist to court or for records would nullify the confidentiality of my records and may be more damaging to my case.

_____ _____I understand records cannot be released until a Release of Information is completed, signed and returned to my therapist.

_____ _____In the event this therapist is served with a subpoena to provide documentation that includes: records, dates of service, correspondence, reports, or forms, I agree to pay a fee of $300.00, cash or check prior to release of requested documents.

_____ _____Appearance in court requires a minimum retainer of 4 hours ($1200) for my services. This includes but is not limited to: waiting, meals, transportation, testifying, depositions).

_____ _____I understand compensation for ANY of these matters are to be paid in full to my therapist on a set due date, prior to court appearance or receiving subpoenaed records. Failure to compensate this therapist as agreed will result in additional fees for collections and legal action.

_____ _____I understand these policies and this document is in place in order to protect both myself, my partner/spouse, ex-partner/ex-spouse, my child(ren), and anyone else -- all who deserve the right to privacy and confidentiality through the therapeutic relationship.

_____ _____
Signature Printed Name

_____ _____
Signature Printed Name

_____ _____
Date Date