Sarah Faehnle Mast, LCSW
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Contract of Policies and Expectations

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.

TREATMENT PHILOSOPHY

Therapy is a process with which I engage wholeheartedly as a therapist; I work from an evidence-based practice, utilizing interventions which have been found in scientific studies to be most beneficial. I work from my integrity and value system, and with my heart, honoring what you have the courage to bring to session. Therapy will also involve a good deal of work on your part, both in the session and in your life. You will find the greatest amount of benefit if you work to practice the skills and insights you gain in our sessions. Therapy can also be a difficult or painful process, as you practice tolerating painful emotions or look at aspects of your life which you find important to change. It is often hard work to make changes in thoughts, behaviors, or relationships. There is no absolute guarantee of therapeutic benefits. However, people taking an active stance in their therapeutic process may find increased self-respect, increased skills for managing difficult emotions, and more fulfilling or connected relationships, among other benefits.

The first one to two sessions will involve an 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, you are welcome to discuss them whenever they arise.

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. I am contracted with Blue Cross/Blue Shield PPO. If you have a health insurance policy with Blue Cross/Blue Shield PPO, it will usually provide some coverage for mental health treatment. With your permission, I will assist you to the extent possible in filing claims and ascertaining information about your coverage, but you are responsible for knowing your coverage and for letting me know if/when your coverage changes.

Due to the rising costs of health care, insurance benefits have increasingly become more complex. It is sometimes difficult to determine exactly how much mental health coverage is available. Managed Health Care plans such as HMOs and PPOs often require advance authorization, without which they may refuse to provide reimbursement for mental health services. These plans are often limited to short-term treatment approaches designed to work out specific problems that interfere with a person's usual level of functioning. It may be necessary to seek approval for more therapy after a certain number of sessions. While a lot can be accomplished in short-term therapy, some patients feel that they need more services after insurance

benefits end. Some managed-care plans will not allow me to provide services to you once your benefits end. If this is the case, I will do my best to find another provider who will help you continue your psychotherapy.

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. There is a copy in my office and I will be glad to let you see it to learn more about your diagnosis, if applicable.). 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 with insurance.

In addition, if you plan to use your insurance, authorization from the insurance company may be required before they will cover therapy fees. If you did not obtain authorization and it is required, you may be responsible for full payment of the fee. Many policies leave a percentage of the fee (which is called co-insurance) or a flat dollar amount (referred to as a co-payment) to be covered by the patient. Either amount is to be paid at the time of the visit by check or cash. In addition, some insurance companies also have a deductible, which is an out-of-pocket amount that must be paid by the patient before the insurance companies are willing to begin paying any amount for services. This will typically mean that you will be responsible to pay for initial sessions with me until your deductible has been met; the deductible amount may also need to be met at the start of each calendar year. Once we have all of the information about your insurance coverage, we will discuss what we can reasonably expect to accomplish with the benefits that are available and what will happen if coverage ends before you feel ready to end your sessions. It is important to remember that you always have the right to pay for my services yourself to avoid the problems described above, unless prohibited by my provider contract.

If I am not a participating provider for your insurance plan, I will supply you with a receipt of payment for services, which you can submit to your insurance company for reimbursement. Please note that not all insurance companies reimburse for out-of-network providers. If you prefer to use a participating provider, I will refer you to a colleague.

INDIVIDUAL AND FAMILY APPOINTMENTS

Individual therapy appointments will ordinarily be 50-55 minutes in duration, once per week at a time we agree on, although some sessions may be more or less frequent as needed. Family therapy can be 50-55 minutes or 90 minutes, and scheduled as needed. The time scheduled for your individual or family appointment is assigned to you and you alone. 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, my policy is to collect a $50 fee. 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 need to end on time.

PROFESSIONAL FEES

The standard fee for each individual session lasting 50-55 minutes is $120.00. You are responsible for paying at the time of your session unless prior arrangements have been made. Payment must be made by

check, cash, credit or debit cards. 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 do not 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 (at $120 per hour) 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.

PROFESSIONAL RECORDS

I am required to keep appropriate records of the psychological services that I provide. Your records are maintained in a secure location. 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.

PARENTS & MINORS

While privacy in therapy is crucial to successful progress, parental involvement can also be essential. For adolescents, I request an agreement between the client and the parents allowing me to share general information about treatment progress and attendance, as well as a treatment summary upon completion of therapy. All other communication will require the adolescent's agreement, unless I feel there is a safety concern (see also above section on Confidentiality for exceptions), in which case I will make every effort to notify the child of my intention to disclose information ahead of time and make every effort to handle any objections that are raised.

CONTACTING ME

Though I do provide coaching calls to clients needing assistance using skills between sessions, I am often not immediately available by telephone. At these times, 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. My expectations for coaching calls are that they will last no more than 15 minutes and that you will be willing to take an active stance in your skill use.

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, call Psychiatric Emergency Services (472-HELP), go to your local hospital Emergency Room, or 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.

If you choose to e-mail or text me, know that these are not HIPAA-compliant means of communication, meaning it is not within my power to guarantee confidentiality of these means of communication. I will, with your permission, use email for scheduling and other routine business interactions.

PROFESSIONAL CONSULTATION

In efforts of being the most effective clinician I can be, and as a crucial part of the evidence-based treatment I provide (dialectical behavior therapy), I meet on a biweekly professional consultation team with other therapists to consult about cases when necessary. When consulting with other professionals, I will not disclose any of your personal identifying information, and use consultation only in your best interest.

TERMINATION

Ideally, you and I will plan together when your therapy with me will end. You may request to end therapy at any time. When possible, it is best to use at least one to two sessions to reflect on the work that has been done, and to prepare for our ending together and for your next steps. At your request, I will provide referrals to other treatment providers. I have the right to terminate services for reasons including, but not limited to: treatment goals being met, concerns arising that are outside the scope of my practice, nonpayment, conflict of interest, or failure to comply with treatment recommendations. If I initiate termination, I will still provide referrals to other treatment providers if requested.

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 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 expect that I will not have social relationships with clients or with former clients. You have the right to ask questions about any aspects of therapy and about my specific training and experience.

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AGREEMENT

I hereby grant my permission for any counseling that may be deemed necessary by my therapist. I understand that therapy is a joint effort between the therapist and client, the results of which cannot be guaranteed. I agree that I will be responsible for the payment of all professional fees. I know that I can end therapy at any time I wish and that I can refuse any requests or suggestions made by my therapist. I have been provided a copy of Sarah Faehnle Mast, LCSW's Notice of Privacy Practices. We have discussed these policies, and I understand that I may ask questions about them at any time in the future.

I consent to accept these policies as a condition of receiving mental health services.

Patient Signature: _____

Printed Name:_____

Date: _____

I consent to the policies above, and am the legal guardian or custodial parent of above minor, with legal right to consent to psychological treatment

Parent/Guardian: _____

Printed Name:_____

Date: _____

Therapist Signature: _____

Date: _____