CYNTHIA SHINABERRY, LCSW

1600 W. Eau Gallie Blvd, Suite 201-L Melbourne, FL 32936

OFFICE POLICIES & GENERAL INFORMATION AGREEMENT TO PROVIDE PSYCHOTHERAPY SERVICES

Confidentiality:

All information disclosed within our sessions and the records pertaining to those sessions are confidential and may not be revealed to anyone except when disclosure is required by law. There are state and federal laws that protect your therapy records. The information about you cannot be released without your expressed written consent. However, there are mandated reporting laws, which are exceptions to this confidentiality. These exceptions include certain domestic violence events, threats of harm to self or others, child abuse/neglect situations, elder or vulnerable adult abuse/neglect, and court orders from a judge to release information. Insurance carriers often request and require oral or written case summaries as a condition of reimbursement. If you were referred to me by another professional, I would like to notify them of your contact with me, with your signed consent.

Litigation Limitation:

Due to the sensitive nature of the therapeutic process and the fact that it often involves making a full disclosure with regard to many matters which are of a confidential nature, it is agreed that should there be legal proceedings (such as, but not limited to, divorce and custody disputes, injuries, lawsuits, etc.), you (client) your attorney, or anyone else acting on your behalf will call on me, your therapist, to testify in court or at any other proceeding, nor will there be a request for a disclosure of you psychotherapy records. This will help preserve the safety and trust you have in the therapy process.

Consultation:

I consult occasionally with other professionals and work with students and registered interns regarding both my and their caseloads; however, the client's name or other identifying information are never mentioned. The client's identity remains completely anonymous, and confidentiality is fully maintained.

Your Right to Review Records:

As a client, you have the right to review or receive a summary of your records at any time, except in limited legal or emergency circumstances or when I as your therapist assess that releasing such information might be harmful in any way. In such a case, I will provide the records to an appropriate and legitimate mental health professional of your choice.

Fees and Billing Policy:

All fees are due at the time services are provided. Co-pays are due for each service on a given day. You may pay by cash, check, or charge. If you pay by charge, the bank and credit card companies are charging a fee of 2.35% automatically. This fee is imposed by the credit/banking industry and is not kept by me. This fee is subject to change.

The initial session fee is $160, and the session can last between one to one and a half hours. In general, all sessions are billed at $150 per 45-50-minute ("clinical hour") session. Different fee schedules exist for longer evaluations, expert witness fees, and consultations. You may pay by cash, check, credit card, cashier's check, or money order. Upon payment of cash, if you request I will give you a receipt to keep for your own records. At the end of the calendar year, I will send you an itemized list of payments. In the event that a check should be returned, you will be responsible for paying any fees that are charged to

me by my banking company, in addition to the original amount owed. (This payment may be made by cash or cashier's check only.) Account balances that exceed $300 will need to be reviewed with me before scheduling further appointments. In the event that your account is overdue (unpaid) and there is no agreement on a payment plan, I can use legal means (court, collection agency, etc.) to obtain payment. If you are a cash paying client, you may incur other charges for your appointments for increased complexity of care or if you are in crisis. You will be informed of this at the time of your appointment.

Occasionally, you may need to speak to me over the phone for an extended period. These calls are not to be considered treatment alone but would be an adjunct to your treatment. These calls are not covered by insurance. The fees for these calls are your responsibility and a valid credit card must be kept on file for these charges if they occur, for billing purposes. The charge for these calls will be as follows:

20 minutes - $20

30 minutes -$30

45 minutes - $45

Insurance Billing Policy:

If you choose to use your insurance plan, you will be required to pay for your portion of services rendered at the time of service. If you are unable to pay the full amount, please review your financial concerns with me. Please be aware that if you do elect to use your health benefits, your insurance company will require that I submit diagnostic and clinical information. Disclosure of confidential information may be required by your health insurance carrier or HMO/PPO/MCO/EAP in order to process the claims. Only the minimum necessary information will be communicated to the carrier. This information is very sensitive and generally treated as such by insurance carriers, however; I cannot guarantee how any insurance carrier or employer will respect the information. There may be times that your insurance company will seek more information before giving further authorizations for reimbursement. Then it will become necessary to use the information from part of your clinical sessions to complete the necessary paperwork and provide the insurance company with the requested information.

If your insurance plan changes, it is your responsibility to notify me. Failure to notify me does not alleviate your responsibility for full payment of services.

I, Cynthia Shinaberry, LCSW have the right to discontinue contracting with providers at any time but will try to give you a 30-day advanced notice. There are some services that are provided that insurance does not covered, and should you require these services fees will be discussed beforehand.

If your case has been closed, you will need to bring your account up to date prior to being seen. Your case may be closed if you have failed to pay for services, failed to be seen for more than three months, or request discharge from treatment.

Authorization to Release Information and to Pay Benefits:

By signing below, I am agreeing to authorize Cynthia Shinaberry, LCSW to release any of my mental/behavioral health information, including any drug and alcohol history, to my insurance company,

as needed to process my insurance claim. I authorize my insurance company to make payments directly to Cynthia Shinaberry, LCSW for covered mental/behavioral health services.

Appointments

My services are provided by appointment and I will work with you as much as possible to provide convenient appointment times. The length of the appointment is generally schedules for 45-50 minutes, allowing 10-15 minutes of the hourly charge for preparation and record keeping.

I require a 24-hour notice for cancellations, otherwise you will be charged $50. I understand that emergences come up and will work with you on which cancelations you will not be charged. Please be aware that insurance carriers do not reimburse for missed appointments. If you know that you will need to cancel an appointment, please call and we will work together on rescheduling your session at a more convenient time and date. If you arrive late, I will do my best to accommodate you, but we may only be able to utilize the remainder your appointment time or may need to reschedule.

Messages

It is rare that I accept calls while I am in session with you or while I am with other clients as my focus is on you. During those times, or if I am otherwise unavailable, messages can be left on my voicemail. I will make every effort to return your call as soon as possible. If you leave me a text message I will get back to you as soon as possible. If you choose, during the course of treatment, to communicate by text message (e.g. “SMS”) be informed that this method, in its typical form, is not a confidential means of communication. Please note, that I will not send clinical information over text, but I will respond briefly or confirm appointments. I do not use email at all with my patient’s as I do not check or respond to my email frequently. If an emergency situation arises, please indicate it clearly in your message. If the emergency is life-threatening, please call 911, call the Suicide crisis hotline at 1-800-273-8255, The Crisis Hotline of Central Florida 407-425-2624 or go to your local emergency room. *Please inform the emergency department that I am your therapist and have them contact me at 410-961-5917.

THE PROCESS OF THERAPY/EVALUATION:

Participation in therapy may result in benefits to you, including improving interpersonal relationships and resolution of the specific concerns that led you to seek therapy. Working toward these benefits requires effort on your part. Psychotherapy requires you to take an involved, active, honest, and open approach towards your sessions and any homework to change your thoughts, feelings and/or behavior. During your therapy, you may find that remembering or talking about unpleasant events, feelings, or thoughts may result in you experiencing discomfort or strong feelings, insomnia or increased symptoms. I may challenge some of your assumptions or perceptions or propose different ways of looking, thinking, or handling situations that might cause you to feel very upset, angry, depressed, challenged or disappointed.

It is the desire to resolve these issues that brought you to therapy in the first place and therapy may result in these changes plus other positive changes that were not originally intended. Psychotherapy may result in decisions about changing behaviors, and sometimes a decision that is positive for one family member is viewed quite negatively by another family member. Change is sometimes easy and swift and sometimes slow and frustrating. There is no guarantee that psychotherapy will yield positive or intended results. During the course of therapy, I will likely draw on various psychological approaches according, in part, to the problem that is being treated and my assessment of what will best benefit you. These approaches include behavioral, cognitive-behavioral, psychodynamic, existential, system/family, developmental (adult, child, family), or psycho-educational.

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Dual Relationships:

Therapy never involves sexual or business relationships or any other dual relationship that impairs my objectivity, clinical judgment, therapeutic effectiveness or can be exploitative in nature.

Patient Bill of Rights:

By signing this, you acknowledge that you have had access to Cynthia Shinaberry, LCSW'S Patient Bill of Rights. If you have any questions about the Patient Bill of Rights, please don't hesitate to ask.

DISCUSSION OF TREATMENT PLAN

After initiating treatment, we will discuss my understanding of the problem, the treatment plan, objectives, and possible outcome of treatment. If you have any questions about any of the procedures used in the course of your therapy, their possible risks, my expertise in employing them, or about the treatment plan, please ask and you will be answered fully. You also have the right to ask about other treatments for your condition and their risks and benefits. If you could benefit from any treatment that I do not provide, I have an ethical obligation to assist you in obtaining those treatments.

Termination:

After the first couple of meetings, I will assess if I can be of benefit to you and if not, I will give you a number of referrals of those whom you can contact. If at any point during psychotherapy, I believe that I am not effective in helping you reach the therapeutic goals, I am obligated to discuss it with you and, if appropriate, to terminate treatment. In such a case, I will refer you a number of providers, which may be of help to you. If you request it and authorize it in writing, I will talk to the new therapist in order to help with the transition. You have the right to terminate therapy at any time. If you choose to do so, I ask that you speak with me so that we may close out your treatment together.

I HAVE READ THE ABOVE OFFICE POLICIES AND GENERAL INFORMATION AGREEMENT CAREFULLY, I UNDERSTAND THEM AND AGREE TO COMPLY WITH THEM:

Confirmation of Appointments

By signing below, I agree to allow Cynthia Shinaberry, LCSW or her appointment reminder service to contact me at the following number(s) to confirm, make, or change appointments:

Phone #'s: _____ Alternate phone #: _____

I also agree/ don't agree (please check one) to allow Cynthia Shinaberry, LCSW or her appointment reminder service to leave a message regarding our appointment, if I am not available at the time of the call.

******* THIS FOLLOWING SECTION WILL BE FILLED OUT IN PERSON *******

Monthly Statements

By signing below, I agree to authorize Cynthia Shinaberry, LCSW to send monthly statements to my provided home address, in the event that I have a balance owed.

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Consent for Treatment

By signing below, I acknowledge that I have read the Notice of Private Practice as part of the HIPPA Policy requirements. If you have any questions or concerns regarding any of this material, please do not sign until we have discussed it and I have answered all of your questions.

_____ _____

Patient Signature Printed Name of Patient

_____ _____

Responsible Party's Signature (if patient is under 18) Printed Name of Responsible Party

_____ _____

Clinician's signature Printed name of clinician

(For office use only) Date _____

FOR OFFICE USE ONLY: If unable to obtain written acknowledgement of receipt of our Notice of Private Practice please note why:

____Individual refused to sign

____Communication barriers prohibited obtaining the acknowledgement

____An emergency situation prevented us from obtaining acknowledgement

_____Other (Please specify):

P (410) 961-5917 **F** (321) 241-4687