Diane Haley, LCSW, OSW-C

Lauren Myler, LCSW, OSW-C

Lisa Picciuti, LCSW, OSW-C, CTTS

261 James St, Suite 1C

Morristown, NJ 07960

This document contains information about the professional services and office policies which are an integral part of our work together. Please feel free to discuss any questions you may have now or develop later.

**Sessions:** Sessions are 45 minutes in length and are generally scheduled on a weekly basis. It is important to come consistently and on time in order to have adequate structure and space for the process to unfold. Additional or less frequent sessions can sometimes be arranged.

**Initial** \_\_\_\_\_\_

**Benefits and Risks of Therapy:** Participating in therapy can result in a number of benefits for you, including a better understanding of yourself, alleviation of painful feelings, improved interpersonal relationships, better physical and mental health, and, hopefully, the resolution of the specific concerns that led you to seek therapy. However, it is also true that therapy can be uncomfortable, especially when painful feelings arise or when unpleasant aspects of your history or your present situation come up. For therapy to be effective, you will need to be an active participant, both in and outside of the therapy sessions. Between sessions, notice what comes up for you regarding what we discussed and what it means to you. Come to each session prepared to talk about your thoughts and especially your feelings on prior or new issues, because it is the client who determines the goals of therapy. There are no guarantees about what therapy will do for you. At times, participating in psychotherapy results in changes that you may not expect or that you did not originally intend.

**Initial** \_\_\_\_\_\_

**Fees:** Payment in full is expected at the time of the session. You will receive a receipt for your personal and/or insurance needs, if requested. Though I do not participate on any insurance panels, you may have coverage under your Out-of-Network Mental Health benefits. It is your responsibility to check this prior to scheduling an appointment. If special payment arrangement is needed, please discuss this with me at the beginning of your session. There will be a $50 service fee for returned checks in addition to any bank fees incurred. Form of payment may be accepted in a variety of ways. Should you choose to utilize digital technology (i.e. via a payment app), you understand your potential risk for your private health information to be identified.

**Initial** ­­­\_\_\_\_\_\_

**Cancellations:** Once we decide to work together, we reserve a time specifically for you. If you must cancel a session, please call at least 24 hours in advance. If you do not call to cancel at least 24 hours prior to your appointment or you do not show for your scheduled session, payment for the full cost of the session will be your responsibility and you will be billed for it. Please note that most insurance companies do not reimburse for missed sessions.

**Initial** \_\_\_\_\_\_

**Contacting me and Emergency Procedures:** Though I am available to receive and return telephone calls from 8:30 a.m. until 9:00 p.m. Monday through Saturday, I do not answer calls when I am in session with other clients. You may leave confidential phone messages at any time. I will do my best to return your call on the same day or the day after. There is no charge for phone conversations of 10 minutes or less.

The charge for calls of longer than 10 minutes is prorated based on the fee for a 45-minute session. If I will be unavailable for an extended time, I will provide you with the name of a colleague for you to contact if necessary. In an EMERGENCY or an IMMEDIATE crisis, contact the police (911) or go to the nearest emergency room or hospital. You may also call Morristown Medical Center 24-hour Crisis Hotline at 973-540-0100.

**Initial** \_\_\_\_\_\_

**Confidentiality:** Your privacy is extremely important to me and for our work together. What you disclose to me is generally protected by law and by the National Association of Social Worker’s Code of Ethics. I need your permission before I may release any information concerning your treatment, except under the following circumstances: (1) if there is a reasonable suspicion of abuse/neglect of a child, elderly, dependent or disabled person, (2) if you may be in danger of harming yourself or another person, (3) as required by a third-party to obtain reimbursement, and (4) as otherwise ordered or required by law (for example, as a result of a court order). This form does not cover every possible exception. Please refer to the HIPAA Notice of Privacy Practices form.

There are two situations where I may share some information about our work together. I may discuss your treatment in consultation with other therapists or I may share aspects of my work in teaching, presentations, or publications. In each case, I will make sure to disguise personal identities and I will not use identifying information, reveal your name or things about you that could lead someone to know whom I am discussing. If you are receiving clinical services from other health care professionals, I may need to confer with them about your treatment plan and progress for the purpose of coordinating our treatment. You will be asked to sign a release of information form in order for this communication to occur.

**Initial** \_\_\_\_\_\_

**Conclusion of Therapy:** Termination is an important aspect of the therapeutic process and should be based on a careful discussion. In some circumstances, people feel that they want to end therapy when they are about to face something that is uncomfortable, yet potentially very fruitful. For these reasons, I recommend at least one session for termination under all circumstances. The longer we have worked together, the more sessions we should have to bring our work to a close, so that you may gain the most benefit from therapy.

**Initial** \_\_\_\_\_\_

**Please initial this page and sign and return the next page at your initial session.**

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**I have read the office policies and information pertaining to the professional services to be rendered by the above-named practitioner. I accept, understand, and consent to participate in treatment. I also give \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, LCSW, OSW-C permission to thank the individual who referred me to her.**

**Print Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**