

Amy M. Rosenthal
Licensed Clinical Social Worker
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Informed Consent Statement

I am a clinical social worker in private practice. I have a master's degree in social work and am fully licensed in New York State. I adhere to the National Association of Social Workers Code of Ethics.

The following information answers some important and frequently asked questions concerning my practice. Please read this form carefully and let me know if you need more information about policies or treatment.

Confidentiality/Client Rights:

I abide by the laws and ethical principles that govern privilege and confidentiality. I will not discuss any information about you with anyone without your written permission by way of a signed Authorization to Disclose Medical Records. There are some exceptions to this standard which are noted in the Notice of Privacy Practices:

- I am legally required to act so as to prevent physical harm to yourself or others when there is “clear and imminent” danger of that happening.
- I am legally required to report cases of ongoing child, elder and disabled person abuse.
- I may have to release clinical information regarding you to your insurance carrier as required for authorization, payment of your claim, or quality assurance review.
- I may have to release your records when ordered to do so by court subpoena. However, I will discuss this with you beforehand and request a written release of information from you, if I judge this to be in your best interest.
- I may release information, upon request, to the non-custodial parent of children under the age of 18.
- I may release information to parents if the client is a minor under the age of 14.
- I may consult with a supervisor about my work. This is kept confidential, without using your name or identifying information.

It is important that you discuss any question or concerns that you may have now or in the future regarding exceptions to confidentiality. The laws governing confidentiality can be quite complex, and I am not an attorney. In situations where specific advice is required, formal legal advice may be needed.

Appointments and Fees:

I provide psychotherapy to adults, adolescents, children, and caregiver-child dyads. The agreed upon fee for our sessions is \$_____. Subsequent sessions are \$_____ and are 45-53 minutes in length. Frequent or extended telephone calls and reports or letters are billed at my usual therapy rate, with a 15 minute minimum charge. Phone calls and letters/reports are not billable to insurance.

If our sessions are covered by your in-network insurance, your co-payment is due at the time of service unless other arrangements are made in advance (or full payment, if insurance is not used or your deductible is not satisfied).

My fee may be raised on a yearly basis at a fair rate. This will be discussed in advance with the client.

Late Policy:

I offer a grace period of 15 minutes to accommodate for delays in beginning our session. After that, I will not be able to hold the time unless there is an emergency, and you will be charged for the full appointment. See below for cancellation policy.

Cancellation Policy:

There is a 50% charge for the first appointment canceled less than 48 hours in advance. If you are ill or have an unavoidable emergency and cancel prior to your appointment, there is no charge. Thereafter, missed appointments are charged in full. Insurance does not cover late canceled or missed appointments. Payment for late canceled or missed appointments will be due at the next appointment.

Out-of-Network Insurance Practices:

For clients who do not have insurance coverage or will be using out of network benefits, a monthly bill may be supplied to you, upon request, for submission to your insurance, taxes, and/or other record keeping purposes.

In-Network Insurance Practices:

For clients who have insurance coverage, claims are submitted on a regular basis unless you request otherwise. In the event your insurance does not pay for your treatment, you will be responsible for payment. Insurance benefits have become increasingly complex. It is sometimes difficult to determine exactly how much mental health coverage is available. In addition, managed health care plans such as HMOs and PPOs often require prior authorization in order to reimburse for services.

I will send you a monthly statement if there is an outstanding balance which your insurance is not expected to pay. Payment of any outstanding client balance is due within two weeks.

Legal/Court Involvement:

If you enter into treatment with me, you are agreeing not to involve me in legal/court proceedings or to attempt to obtain records of treatment for legal proceedings. This prevents misuse of your treatment for legal objectives. My goal is to support you in achieving therapy goals, not to address legal issues that require an adversarial approach. If you are involved in or anticipate being involved in legal or court proceedings, please notify me as soon as possible. It is important for me to understand how, if at all, your legal involvement might affect our work together.

It is important for you to recognize that treatment is not an appropriate way to obtain evaluative results. If you need a formal psychological evaluation, I will be happy to assist you to find a provider who offers this service.

Treatment Philosophy:

Psychotherapy has both benefits and risks. It requires an investment of your time and energy in order to make the process of therapy most successful. Occasionally individuals may go through periods in therapy which result in emotional discomfort, changes in relationships or temporary worsening of their symptoms. This should subside as the work progresses. You will always retain the right to request changes in treatment or to refuse treatment at any time.

Contacting Me:

I am often not immediately available by telephone. When I am unavailable, my telephone is answered by a confidential voicemail that I monitor frequently. Please inform me of some times that may be best to reach you.

Emergencies:

Because I am not readily available by phone, I am not the best person to call in an emergency. Please contact 911, or go to the nearest emergency room.

Grievance Procedure:

If at any time you are dissatisfied with your treatment, please discuss your concerns with me directly so we can work together to resolve them. If, after doing so, you would like a referral to a different therapist, I would be happy to assist you.

Consent to Treatment:

Signature(s) below indicate that I/we have read and understand the above consent to treatment with Amy M. Rosenthal, LCSW, under the conditions specified above. I may specifically authorize the release of my clinical record information for coordination with my insurance company for the purpose of payment, health care credentialing, utilization review and quality assurance review.

In the event that treatment is for a minor child, I hereby give my consent to treatment and affirm that I am their legal guardian with authority to authorize mental health treatment.

Client Name (Please Print)_____

Signature (Client or Legal Guardian)_____ Date_____

Acceptance of Financial Responsibility

I assume financial responsibility for any balance on my account. I will make co-payments and pay amounts owed toward my deductible at the time of each session unless alternative arrangements have been made. I understand and agree to pay 50% of the session fee for the first appointment canceled less than 48 hours in advance and 100% for missed appointments thereafter.

Client Name (Please Print)_____

Signature_____ Date_____