

**Laura A. Zipris, PA**  
561 558-7815

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***Client Handbook of Policies and General Information***

Welcome to my practice. This document contains important information about my professional services and business policies. Please read it carefully and jot down any questions you might have so that we can discuss them at our next meeting. When you sign this document, it will represent an agreement between us.

**The Treatment Process**

Our first few sessions will involve an evaluation of your needs. By the end of the evaluation, I will be able to offer you some first impressions of what I think our work together should consist of. However, the specific goals of therapy are arrived by our mutual agreement. Therapy involves a large commitment of time, money, and energy so you should be careful about the therapist you select and make sure that you feel comfortable with me. The length of therapy can range from a couple of sessions to years. It is usually difficult to assess at the beginning how long therapy will take.

Participation in therapy can result in a number of benefits to you, including reduction of the intensity of the distress or unease that brought you to therapy, improved interpersonal relationships, and insight. However, there are no guarantees that therapy will result in positive or intended results.

There are also risks in undertaking therapy. Psychotherapy can involve recalling or reliving unpleasant aspects of your history. As a result, you may sometimes experience sadness, guilt, anxiety, anger, loneliness, and helplessness. At times, I may challenge some of your long-held perceptions and propose different ways of looking at or handling situations. These challenges may feel threatening.

If at any time you have any question about the process of therapy, I depend on you to bring them up for discussion. This may be difficult for you but I encourage you to communicate your concerns, as it will only benefit our work together. If you have doubts about our work together that persist beyond our discussion(s), I will be happy to help you set up a meeting with another mental health professional for a second opinion.

My orientation as a psychotherapist is eclectic, which means that I draw from a number of different methods including: behavioral therapy, cognitive-behavioral therapy, mindfulness, hypnosis, psychodrama, EMDR, and Imago Relationship Therapy. In addition, some of the work we will do will be psycho-educational in nature. Psychotherapy is not like a medical doctor visit. Instead, it calls for a very active effort on your part. In order for the therapy to be successful, you will have to work on the things we talk about both during our sessions and at home.

## Sessions

I normally conduct an evaluation that will last anywhere from 2 to 4 sessions. During this time we can both decide if I am the best person to provide the services you need in order to meet your treatment goals. If psychotherapy is begun, I will usually schedule one 50- minute session (one appointment hour of 50 minutes duration) per week, although some sessions may be longer or more frequent. Weekend hours are not typically available but exceptions are made on a case by case basis.

## Fees (due at time of service)

All agreed upon session fees are due at time of service in the form of a **personal check or cash**. Payment is expected at each visit. If special circumstances exist that render it difficult for you to make a payment as expected, please discuss it with me. I may be willing to negotiate a fee adjustment or payment installation plan. If any checks are returned due to insufficient funds, there will be a **\$35.00** charge.

I will charge my regular session rate for other professional services that you may need or request, though I will prorate the hourly cost if I work for periods of less than one hour. Other professional services include report writing, attendance at meetings with other professionals you have authorized, preparation of records or treatment summaries, etc. There is no charge for an occasional brief telephone contact (five minutes or so). Longer calls will be charged on a prorated basis. Sliding scale fees may be available under certain circumstances and will be discussed on an individual basis.

If you become involved in legal proceedings that require my participation, you will be expected to pay for my professional time even if I am called to testify by the other party. Because of the difficulty of legal involvement, I charge **\$300** per hour for preparation and attendance at any legal proceeding, including transportation to and from the proceedings. There is a four hour minimum per day for attendance at legal proceedings.

I will make every attempt to obtain any outstanding balances from you via verbal and written notice; however, if after these efforts there continues to be outstanding balances due to non-payment, I have the option of using legal means. This may involve hiring a collection agency (30% will automatically be added to the balance in this case) or going through small claims court. If such legal action is necessary, its costs will be included in the claim. In most collection situations, the only information I release regarding a client's treatment is his/her name, the nature of the services provided, and the amount due.

## Cancellations

The times set aside for you are not easily filled when cancelled with short notice (less than 24 hours). A twenty-four hour notice for cancellation is **required**. Late cancellations and missed appointments will be charged at the standard fee. Exceptions on a case-by-case basis may be made for emergencies; for example, sudden illness or hazardous driving conditions.

## Insurance

I am currently accepting very limited insurances. If I am a participating provider in your plan, I will

submit the necessary forms for reimbursement. Please be advised that most insurance companies require you to authorize me to provide them with a clinical diagnosis. 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.

If I am not an in-network provider within your particular insurance plan, please be advised that some plans may allow you to see me as an out-of-network provider and will reimburse you directly for a portion of my fee. You will still need to pay me in full at the time of service. I will then provide you with the necessary documentation **upon request, but it is your responsibility to submit the information, check your policy, and consult with your representative about your coverage.** I will do my best to release the minimal amount of information needed in order to help you obtain your benefits. Generally speaking, insurance does not cover marriage or family counseling unless it is related to the treatment of a specific diagnosable problem (i.e. depression or anxiety) for an individual within the couple or family.

### **Telephone Accessibility**

When you call 561-558-7815, you will usually reach voice mail accessed only by myself. I will return your call as soon as possible, almost always the same day if it is during the work week. If you call over the weekend, or a holiday, I may be unable to return your call until Monday or the next business day. Please call between 8:00 a.m. and 7:00 p.m. for non-emergency contacts. If an urgent situation develops, please indicate it clearly in your message. If you need to talk to someone immediately, call 911 or go to the nearest emergency room.

### **Confidentiality Policy and Exceptions**

Professional ethics and legal standards require that our conversations, and my records (even the fact that you are a client) be kept strictly confidential.

However, there are circumstances under which I am legally and ethically obligated to breach confidentiality:

- If you present a serious imminent danger to yourself or others
- In cases of apparent abuse or neglect of a child, an elderly person, or a disabled person
- When you report that you intend to physically injure someone the law requires me to inform that person as well as legal authorities
- When a judge orders the release of information

These events have rarely occurred in my practice. If it does happen, I will make an effort to fully discuss it with you before taking any action. And if I must breach confidentiality, the minimum amount of information will be revealed—only enough to protect you or others.

All insurance companies require information about you that includes, at a minimum, a psychiatric diagnosis and dates and types of services provided. I cannot control the confidentiality of any information once you have submitted information to your insurance companies or their agents. I will not be able to tell you whether employers have access to information about you or if such information is distributed to national data banks.

Please refer to the [Notice of Privacy Practices](#) for additional information about confidentiality.

### **Records**

As required by law and professional ethics, I maintain confidential records of our sessions together, and any other contacts with me. These records (written or verbal) are available to others only at your written request. You are entitled to receive a copy of these records, unless there is reason to believe that releasing them might be harmful. In that case, I will provide them to an appropriate and legitimate mental health professional of your choice.

### **Consultation**

In order to serve you best, I may consult with other professionals when appropriate. Your name and identifying details will not be disclosed.

### **Child and Adolescent Treatment**

Both parents have the right to be informed about their child's treatment. I will, however, respect the confidences of your child or adolescent, when, in my opinion, it is in their best interest to do so. Without such a guarantee of confidentiality, your child or adolescent may not trust me enough to establish a therapeutic relationship and treatment may be less effective.

Child and adolescent therapy frequently requires the active involvement of significant individuals in the child's life. If necessary, you agree to participate in your child or adolescent's treatment and agree to assist in getting other significant individuals in the child's life to participate as well.

### **Ending Therapy**

If at any point during psychotherapy, it becomes evident that our work together is not effective, I will discuss this with you, and if appropriate, terminate treatment and suggest alternatives. I will do my best to support the conclusion of our work together, no matter the reason. When you decide you are ready to leave, I would like to help you leave in the best possible way. Please give at least one week's notice so that we can review our work together, and plan for the future. Even if you are unable to give advance notice, I will still do my best to help you leave in a positive manner and provide closure.

**PLEASE READ CAREFULLY AND SIGN EACH:**

**CANCELLATION POLICY:**

If you fail to cancel a scheduled appointment, I cannot use this time for another client and you will be billed for the entire cost of your missed appointment.

A full session fee is charged for missed appointments or cancellations with less than a 24-hour notice. My voicemail service is available 24 hours a day to receive your call. If you have an emergency that arises on the day of your session, please notify the office as soon as possible. Payment for the missed session will be determined on a case by case basis.

**Sign Here** \_\_\_\_\_ **Date** \_\_\_\_\_

**Sign Here** \_\_\_\_\_ **Date** \_\_\_\_\_

**LEGAL MATTERS:**

In the event you are involved in divorce, child custody, or other legal matters you agree you will not subpoena me to provide testimony or to provide any written documentation.

**Sign Here** \_\_\_\_\_ **Date** \_\_\_\_\_

**Sign Here** \_\_\_\_\_ **Date** \_\_\_\_\_

**SOCIAL NETWORKING WEBSITES:**

It is my policy not to socialize or communicate with clients via social networking websites (i.e. Facebook, etc.) Any attempts by clients to contact me in this manner will kindly not be responded to.

**Sign Here** \_\_\_\_\_ **Date** \_\_\_\_\_

**Sign Here** \_\_\_\_\_ **Date** \_\_\_\_\_

**EMAIL COMMUNICATION/TEXT:**

I understand that any such communication with my therapist will be for the purpose of scheduling appointments or communicating information to my therapist and not for the purpose of receiving internet psychotherapy. I also understand that my therapist has taken reasonable steps to protect my confidentiality with the use of firewall and password protection and other safety measures. However, I know that there are risks to my privacy using this method of communication and I accept that. Legal guardians must sign for underage minors.

**Sign Here** \_\_\_\_\_ **Date** \_\_\_\_\_

**Sign Here** \_\_\_\_\_ **Date** \_\_\_\_\_

**SKYPE COMMUNICATION:**

I understand that my therapist has taken steps to protect my privacy but that there are risks to confidentiality as a result of this method of communication and I accept that.

**Sign Here** \_\_\_\_\_ **Date** \_\_\_\_\_

**Sign Here** \_\_\_\_\_ **Date** \_\_\_\_\_

**NOTICE OF PRIVACY POLICIES AND CLIENT RIGHTS:**

I have read and received a copy of the Notice of Privacy Practices and Client Rights Document.

**Sign Here** \_\_\_\_\_ **Date** \_\_\_\_\_

**Sign Here** \_\_\_\_\_ **Date** \_\_\_\_\_

**CONSENT FOR TREATMENT:**

By signing below, you are stating that you have read and understood this policy statement and have had your questions answered to your satisfaction. I accept, understand and agree to abide by the contents and terms of this agreement and further consent to participate in evaluation and/or treatment. I understand that I can withdraw from treatment at any time.

**Sign Here** \_\_\_\_\_ **Date** \_\_\_\_\_

**Client Printed Name** \_\_\_\_\_

**Sign Here** \_\_\_\_\_ **Date** \_\_\_\_\_

**Client Printed Name** \_\_\_\_\_

**Legal Guardian Printed Name** \_\_\_\_\_

**If you would like a copy of this document, please ask!**