Jayme Mahoney, LCMFT
Therapy Services
CA License LMFT 49992

CONFIDENTIALITY: All information disclosed within sessions and the written records pertaining to those sessions are confidential and may not be revealed to anyone without your (client's) written permission, except where disclosure is required by law.

________**When Disclosure Is Required by Law**: Some of the circumstances where disclosure is required by law are:

- where there is a reasonable suspicion of child, dependent or elder abuse or neglect;
- where a client presents a danger to self, others, to property, or is gravely disabled .

________**When Disclosure May Be Required**: Disclosure may be required pursuant to a legal proceeding. If you place mental status at issue in litigation initiated by you, the defendant may have the right to obtain the psycho-therapy records and/or testimony by this therapist. In couple and family therapy, or when different family members are seen individually, confidentiality and privilege do not apply between the couple or among family members. I will use my clinical judgment when revealing such information. I will not release records to any outside party unless I am authorized to do so by all adult family members who were part of treatment.

________**Emergencies:** If there is an emergency during our work together, or in the future after termination where I become concerned about your personal safety, the possibility of you injuring someone else, or about you receiving proper psychiatric care, I will do whatever I can within the limits of the law to prevent you from injuring yourself or others and to ensure that you receive the proper medical care.

________**Health Insurance & Confidentiality of Records**: Disclosure of confidential information may be required by your health insurance carrier or HMO/PPO/MCO/EAP in order to process the claims. If you instruct me, only the minimum necessary information will be communicated to the carrier. I have no control or knowledge over what insurance companies do with the information submitted or who has access to this information. You must be aware that submitting a mental health invoice for reimbursement carries a certain amount of risk of confidentiality, privacy or future capacity to obtain health or life insurance. The risk stems from the fact that mental health information is entered into large insurance companies' computers and soon will also be reported to Congress-approved National Medical Data Bank. Accessibility to companies' computers or to the National Medical Data Bank Data base is always in question as computers are inherently vulnerable to break-ins and unauthorized access. Medical data have been reported to be sold, stolen, or accessed by enforcement agencies, which puts you in a vulnerable position.

_____**Confidentiality of Email Communication** It is very important to be aware that email and cell phone communication can be relatively easily accessed by un-authorized people and hence can compromise the privacy and confidentiality of such communication. Emails, in particular, are vulnerable to such un-authorized access due to the fact that the server has unlimited and direct access to all emails that go through them. Faxes can easily be sent erroneously to the wrong address. Please notify me if you decide to avoid or limit in any way the use of any or all of the above mentioned communication devices.

________**Patient Litigation**: I will not voluntarily participate in any litigation, or custody dispute in which my client and another individual, or entity, are parties. I have the policy of not communicating with my client's attorney and will generally not write or sign letters, reports, declarations, or affidavits to be used in the client's legal matter. I will generally not provide records or testimony unless compelled to do so. Should I be subpoenaed, or ordered by a court of law to appear as a witness in an action involving the client, the client agrees to reimburse me for any time spent for preparation, travel, or other time in which I have made myself available for such an appearance at my usual and customary hourly rate.____$225/hour

Jayme Mahoney, LCMFT
Therapy Services
CA License LMFT 49992

________**Consultation:** I may consult with other professionals regarding my clients: however, the client's name or other identifying information is never mentioned. The client's identity remains completely anonymous, and confidentiality is fully maintained.

______**Records and Record Keeping**: I may take notes during session, and I will also produce other notes and records regarding my client's treatment. These notes constitute my clinical and business records, which by law, I am required to maintain. Such records are the sole property of the therapist. I will not alter my normal record keeping process at the request of the client. Should you request a copy of my records, such a request must be made in writing. I reserve the right, under Maryland law, to provide you with a treatment summary in lieu of actual records. I also reserve the right to refuse to produce a copy of the record under certain circumstances, but may, as requested, provide a copy of the record to another treating health care provider. I will maintain your records for ten years following termination of therapy. However, after ten years, your records will be destroyed in a manner that preserves your confidentiality.

______**TELEPHONE & EMERGENCY PROCEDURES**: If you need to contact me between sessions, please leave a message on my confidential voicemail (410.726.7709), and your call will be returned as soon as possible. I check my message a few times per day, unless I am out of town. I am unable to provide 24-hour crisis service. In the event that your child or teen feels unsafe or requires immediate medical or psychiatric assistance, you should call the Police at 911, or go to the nearest emergency room.

______**CANCELLATION POLICY**: Since scheduling of an appointment involves the reservation of time specifically for you, a minimum of 24 hours (1 day) notice is required for rescheduling or canceling an appointment. Unless we reach a different agreement, the full fee will be charged for sessions missed without such notification. Please be aware that most insurance companies do not reimburse for missed sessions.

______**PAYMENTS & INSURANCE REIMBURSEMENT**: The usual and customary fee for service is $225.00 per 60-minute session. Sessions longer than 60-minutes are charged for additional time pro rata. I reserve the right to periodically adjust this fee. You will be notified of any fee adjustment in advance. From time-to-time, I may engage in telephone contact with you for purposes other than scheduling sessions. You are responsible for payment of the agreed upon fee (on a pro rata basis) for any telephone calls longer than 10 minutes. In addition, from time-to-time, I may engage in telephone contact with third parties at your request and with your advance written authorization. You are responsible for payment of the agreed upon fee (on a pro rata basis) for any telephone calls longer than 10 minutes.

Clients or their parents are expected to pay for services at the close of each session. I accept checks, cash, and credit card payments. Please notify me if any problem arises during the course of therapy regarding your ability to make timely payments.

I am not a contracted provider with any insurance company, or managed care organization. Should you choose to use your insurance, I will provide you with a statement on a monthly basis, per your request, which you can then submit to your insurance company for reimbursement if you choose. As indicated in the section **Health Insurance & Confidentiality of Records**, you need to be aware that submitting a mental health invoice for reimbursement carries a certain amount of risk. Not all issues/conditions/problems, which are the focus of psychotherapy, are reimbursed by insurance companies. It is your responsibility to verify the specifics of your coverage.

______**THE PROCESS OF THERAPY/EVALUATION**: Participation in therapy can result in a number of benefits to you, including improving interpersonal relationships and resolution of the specific concerns that led you to seek therapy. Working towards these benefits, however, requires effort on your part.

Jayme Mahoney, LCMFT
Therapy Services
CA License LMFT 49992

Psychotherapy requires your very active involvement, honesty, and openness in order to change your thoughts, feelings, and/or behavior. Sometimes more than one approach can be helpful in dealing with a certain situation. During evaluation or therapy, remembering or talking about unpleasant events, feelings, or thoughts can result in you experiencing considerable discomfort or strong feelings of anger, sadness, worry, fear, etc. or experiencing anxiety, depression, insomnia, etc. I may challenge some of your assumptions or perceptions or propose different ways of looking at, thinking about, or handling situations that can cause strong feelings. During the course of therapy, I am likely to draw on various psychological approaches according, in part, to the problem that is being treated and my assessment of what will benefit you. These approaches include, but are not limited to, cognitive-behavioral, mindfulness, experiential, family systems, solution-focused, developmental, or psycho-educational.

______**TERMINATION**: As set forth above, after the first couple of meetings, I will assess if I can be of benefit to you. I do not accept clients who, in my opinion, I cannot help. In such a case, I will give you a number of referrals that you can contact. You have the right to terminate therapy at any time. If you choose to do so, I will offer to provide you with the names of other qualified professional whose services you might prefer.

Acknowledgment

By signing below, you acknowledge that you have reviewed and fully understand the terms and conditions of this Agreement. You have discussed such terms and conditions with me, and have had any questions with regard to its terms and conditions answered to your satisfaction. You agree to abide by the terms and conditions of this Agreement and consent to participate in psychotherapy with me. Moreover, you agree to hold me free and harmless from any claims, demands, or suits for damages from any injury or complications whatsoever, save negligence, that may result from such treatment.

Client name (print) Date Signature

Client name (print) Date Signature

Jayme Mahoney, LCMFT

Therapy Services

CA License LMFT 49992

Consent to Treat a Minor

I, ____, as____

(print name) (relationship to minor)

have the legal authority to consent for psychological treatment for

____

(print name of minor)

I hereby give my consent for treatment and maintenance of records.

____

(Signature of Parent/s or Legal Guardian/s Date (witnessed by)