Danielle Roginski, LCSW
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(561) 779-6711

INFORMED CONSENT FOR PSYCHOTHERAPY

THE PROCESS OF THERAPY AND SCOPE OF PRACTICE:
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 requires effort on your part, including active involvement, honesty, and openness. During therapy, remembering and talking about unpleasant events, thoughts, or feelings can result in experiencing considerable discomfort or strong feelings of anger, sadness, fear, etc. Attempting to resolve issues that brought you to therapy may result in changes that were not originally intended. Sometimes a decision that is positive for one family member may be viewed negatively by another family member. No particular outcome can be guaranteed. As with any healing process, you may temporarily feel worse before feeling better. Be assured that psychotherapy has been found helpful in a long tradition of scientific research.

In general, sessions are initially scheduled on a weekly basis. You have the right to be informed about my credentials, treatment approaches, anticipated duration of therapy, and fee structure, as well as where to file complaints about professional conduct. Please ask if you would like to receive this information. You also have the right to review with this therapist or receive a summary of your records, except in limited legal or emergency circumstances or when I assess that releasing such information might be harmful in any way. When more than one client is involved in treatment, such as in cases of couple and family therapy, I will release records only with signed authorizations from all the adults (or all those who legally can authorize such a release) involved in the treatment.

Within a reasonable time after the initiation of treatment, I will discuss with you a working understanding of the presenting problem(s), treatment plan, therapeutic objectives, and your view of the possible outcomes of treatment.

Please be advised the following services do not fall within the scope of my practice: medication recommendation or prescription, legal advice, or custody evaluation recommendation.

TERMINATION PROCESS:
During the initial phase of treatment, I will assess if I can be of benefit to you. If I determine that you have needs that surpass my practice expertise or scope of services, I will provide you several referrals whom you can contact. I believe that goodness of fit between therapist and client is essential to the therapeutic process. You have the right to seek a second opinion from a different therapist and to terminate therapy at any time. If you decide to end therapy, I ask that you discuss your intentions with me first. If appropriate, I will provide you with names of other qualified professionals, and with written consent, will provide them with the essential information for continuity of care at your request. **If you decide to stop therapy without discussion, after 90 days your file will be closed.**

In certain circumstances, I may decide to terminate therapy after discussing the reasons for my decision with you. If I determine that I am not effective in helping you reach your therapeutic goals, if you are non-compliant with the treatment plan or chronically cancel or miss appointments, if a conflict of interest or dual relationship develops, or if you harm or threaten to harm this practitioner or those close to this practitioner, therapy may be terminated involuntarily.

It is my intention that termination of therapy will be mutually agreed upon based on the satisfactory completion of the treatment plan and attainment of your stated goals of therapy.

CONFIDENTIALITY AND PRIVILEGED COMMUNICATIONS:
All information disclosed within sessions and the written records pertaining to those sessions are confidential and may not be revealed to anyone without your written permission except where disclosure is required by law.

According to FS 490.0147, FS 491.0147, FS 39.201, FS 39.202, FS 39.204, this privilege may be waived under the following circumstances:

1. When there is a reasonable cause to suspect that a child, dependent, or elderly person is abused, abandoned, or neglected by a parent, legal custodian, caregiver, or other person responsible for their welfare.
2. When there is a clear and immediate probability of physical harm to the client, to other individuals, or to society and the therapist communicates the information only to the potential victim, appropriate family member, or law enforcement or other appropriate authorities.
3. When the therapist is a party defendant to a civil, criminal, or disciplinary action arising from a complaint filed by the client, in which case the waiver shall be limited to that action.
4. When the client agrees to the waiver, in writing, or when more than one person in a family is receiving therapy, when each family member agrees to the waiver, in writing.

Disclosure may also be required pursuant to a legal proceeding by or against you. If you place your mental status at issue in litigation initiated by you, the defendant may have the right to obtain the psychotherapy records. Your health insurance or managed care plan will require that I waive confidentiality and that general information about your treatment is provided. When I am on vacation or unavailable, I will inform you that another therapist will be answering calls and may need to have general information about your treatment. Only the least amount of information that is necessary will be disclosed.

EMERGENCY SITUATIONS:
If there is an emergency during therapy, where I become concerned about your personal safety, the possibility of you injuring yourself or 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. For this purpose, I may contact the person whose name you have provided on the Client Intake Form.

TELEPHONE AND EMERGENCY PROCEDURES:
If you need to contact this therapist between sessions, please leave a voicemail message at (561)779-6711 and your call will be returned as soon as possible. I check messages during regular work hours only, unless I am out of town. If an emergency situation arises, please call 911 or go to the nearest hospital emergency room. In a psychiatric emergency, you may also contact JFK South Behavioral Health Medical Center (561) 965-7300, JFK North Behavioral Health Medical Center (561) 881-2671, St. Mary's Institute for Mental Health (561) 844-6300, or Mobile Crisis Team (561) 383-5777 available 24/7.

LITIGATION LIMITATION:
Due to the nature of the therapeutic process and the fact that it often involves making a full disclosure with regard to many matters which may be 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.), **neither you nor your attorney(s), nor anyone else acting on your behalf will call on this therapist to give a deposition, testify in court or at any other proceeding, nor will a disclosure of the psychotherapy records be requested unless otherwise agreed upon.**

CONSENT FOR TREATMENT:
I voluntarily consent to psychotherapy services with Danielle Roginski, LCSW of Transition Counseling, Inc.

I voluntarily consent to psychotherapy services for my minor child, _____, with Danielle Roginski, LCSW of Transition Counseling, Inc.

FINANCIAL AGREEMENT

STANDARD SERVICE FEES:
The rates listed below are based on a 45-50 minute clinical hour.

- Individual Session: $125
- Couple or Family Session: $150
- Professional Consultation: $150

If a report, letter or consultation with an outside party is requested, I understand I will be billed for any time required to prepare documentation, or to conduct an in-person or phone consultation. The standard service fee listed above will apply.

FORMS OF PAYMENT AND PAYMENT POLICIES:
The following forms of payment are accepted: cash, check, Visa, MasterCard and Discover. Clients will be responsible for payment at the time services are rendered.

Checks returned for insufficient funds will be charged $25 in addition to the amount of the check. An invoice may be sent to your home for any outstanding balance.

CANCELLATION POLICY:
If you need to cancel an appointment, 24 hour advanced notification is required. This allows your session time to be offered to another client. If you do not give sufficient notice or no notice is given at all, you will be charged a $50 fee. This no-show or late cancellation fee cannot be billed to your third-party payer. You will be personally responsible for this fee. Emergency circumstances leading to late cancellations or missed appointments will be taken into account.

FEE AGREEMENT

I agree to:

_____ remit at the beginning of each session a fee of $ _____ per 45-50 minute clinical hour.
_____ remit a copayment in the amount of $ _____ in keeping with the policies of my health benefits.
_____ the assignment of my health insurance benefit to Danielle Roginski, LCSW

By signing below I am indicating that I have read and understand the above Informed Consent for Psychotherapy, Financial Agreement, and Fee Agreement and agree to comply with them. I also give my consent to treatment.

Client's name (print) _____
Signature _____ Date _____

Client's name (print) _____
Signature _____ Date _____

Name of legally responsible parent or guardian (where required)
_____
Signature _____ Date _____

Psychotherapist's name _____
Signature _____ Date _____