



silver|psychotherapy

5970 Frederick Crossing Lane. Suite 100
Frederick, MD 21704
(240)415-8893

Policies and Procedures 2022

Welcome to Silver Psychotherapy! We hope our time together will be one of healing. Please feel free to read, sign and ask your therapist if you have concerns about these policies.

APPOINTMENTS & CANCELLATIONS:

Each provider has a limited number of spaces per week, and every attempt is made to try and protect your timeslot. You can expect the following time commitment: 53 minutes for a psychotherapy session, 90 minutes for an intake, and 30 minutes for a medication check. Out of courtesy to your provider, and those that are waiting to begin treatment; please remember to cancel or reschedule your appointment 24 hours in advance. If the appointment is not canceled or rescheduled 24 hours in advance a late cancellation fee will be charged. This is necessary because a time commitment is made to you and is held exclusively for you. If you are running late, please contact your provider as soon as possible by calling their extension, sending a message through the client portal, or sending an email. If you are more than 15 minutes late for an appointment, your appointment time may be forfeited and you may be charged the no-show fee. These policies also apply to video sessions. Requests for longer sessions need to be discussed with the therapist in order for time to be scheduled in advance.

Late Cancellations/No-Show Fee Schedule:

Psychotherapy Late Cancel - \$75

Medication Check Late Cancellation -\$75

Medication Evaluation Late Cancel - \$125

Psychotherapy No-Show - \$155

Medication follow-up/Check No-Show - \$155

Medication Evaluation No-Show - \$230

* I consent to the Appointment and Cancellation Policy. CLIENT OR GUARDIAN INITIALS: _____

ADDITIONAL FEES AND SELF-PAY RATES:

There are certain fees that are not covered by your insurance. For example, you may need us to write a letter on your behalf for school, work, SSDI, etc. Those fees are not paid for by your insurance and the charges will be the client's responsibility. Should you require documentation, it will always be provided to you prior to

submission, and you will be charged according to the following fee schedule. The fee schedule below serves for all clients.

*Additional time (pre-arranged) - \$80.00 for 30 minute increments

*Paperwork, Report Writing, Form Completion - \$35.00 15 minute increments

*Phone consults - \$42.00 for 15 minute increments

*Court Preparation - \$155 per hour

*Court Appearance - \$1,500 Therapist per day ; \$2,000 Nurse Practitioner per day (must be prepaid)

* Copying fee - \$1 per page

SELF-PAY RATES:

*Medication Evaluation Intake (90 minutes) - \$230

*Medication Check (30 minutes) - \$155-185

*Psychotherapy Intake (90 minutes) - \$175

*Psychotherapy (53 minutes) - \$155

*Group Therapy - \$50

* I am aware and agree to the Additional Fee Structure: CLIENT OR GUARDIAN INITIALS:_____

METHOD OF PAYMENT:

Payment is run each day, using the credit card on file for the day of the appointment using a system called Stripe. A credit card must be on file at all times. This card will be charged after each appointment for your copay/deductible and may be utilized if there is a missed appointment or late cancel fee. If you prefer to pay with cash, please communicate that and a receipt will be issued.

If you are using your insurance, please refer to the specific terms of your agreement with your insurance company. Co-payments are due at each session. The sliding scale rate will be discussed with you by our Office Manager and a Good Faith Estimate will be supplied to you of the charges. Estimates will be revised every year or if the services change throughout the course of treatment.

Please advise us of any change in financial circumstances that might impact your ability to stay in treatment. We can work out a payment plan in those situations. Please be aware any unpaid bills may be sent to small claims court or our collection agency and you will be responsible for any associated fees for this process. A \$25.00 service charge will be charged for any returned checks.

* I agree to and am aware of the Method of Payment.

CLIENT OR GUARDIAN INITIALS: _____

INSURANCE:

Your health insurance may assist in paying for therapy sessions or medication management services. It is your responsibility to know your benefits and to notify our administration staff of any secondary coverage or EAP benefits. We recommend that you contact your insurance carrier as soon as possible in order to ascertain your psychotherapy or medication management benefits. Please keep in mind that your health insurance policy is your contract with an insurance carrier. Please notify our administration staff as soon as possible should your employment or insurance coverage change.

* I consent to the Insurance Policy.

CLIENT OR GUARDIAN INITIALS: _____

TELEPHONE ACCESSIBILITY:

We want you to reach out to us if you are having a hard time between sessions. If you need to contact your provider between sessions, please call our office at (240) 415-8893 and dial the provider's direct extension. You may also message the provider via the patient portal or email. If the therapist is not immediately available; they will make every attempt to return your call within 24 business hours. Please note that Face-to-face sessions are highly preferable to phone sessions. However, in the event that you are out of town, sick or need additional support, phone/telehealth sessions are available. If the time spent on the phone lasts longer than 15 minutes, we do reserve the right to charge \$42 per additional 15 minutes.

IF YOU ARE EXPERIENCING A MENTAL HEALTH EMERGENCY, PLEASE CALL 911 OR PROCEED TO THE NEAREST EMERGENCY ROOM.

* I consent to the Telephone Accessibility Policy.

CLIENT OR GUARDIAN INITIALS: _____

ELECTRONIC/AUDIO COMMUNICATION:

Although we utilize HIPAA compliant platforms, we cannot ensure the confidentiality of any form of communication through electronic media, including text messages. If you prefer to communicate via email or text messaging for issues regarding scheduling or cancellations, we will do so. While we try to return messages in a timely manner, we cannot guarantee immediate response and request that you do not use these methods of communication to discuss therapeutic content and/or request assistance for emergencies.

Services by electronic means, including, but not limited to telephone communication, the Internet, facsimile machines, and e-mail are considered telemedicine by the State of Maryland. Under the Maryland Telemedicine Act of 1996, telemedicine is broadly defined as the use of information technology to deliver medical services and information from one location to another. If you and your therapist choose to use information technology for some or all of your treatment, you need to understand that:

(1) You retain the option to withhold or withdraw consent at any time without affecting the right to future care or treatment or risking the loss or withdrawal of any program benefits to which you would otherwise be entitled.

(2) All existing confidentiality protections are equally applicable.

(3) Your access to all medical information transmitted during a telemedicine consultation is guaranteed, and copies of this information are available for a reasonable fee.

(4) Dissemination of any of your identifiable images or information from the telemedicine interaction to researchers or other entities shall not occur without your consent.

(5) There are potential risks, consequences, and benefits of telemedicine. Potential benefits include, but are not limited to improved communication capabilities, providing convenient access to up-to-date information, consultations, support, improved quality, change in the conditions of practice, improved access to therapy, better continuity of care, and reduction of lost work time and travel costs.

*Effective therapy is often facilitated by what the therapist gathers within a session or a series of sessions, a multitude of observations, information, and experiences about the client. Therapists may make clinical assessments, diagnoses, and interventions based not only on direct verbal or auditory communications, written reports, and third-person consultations, but also from direct visual and olfactory observations, information, and experiences. When using information technology in therapy services, potential risks include, but are not limited to the therapist's inability to make visual and olfactory observations of clinically or therapeutically potentially relevant issues such as your physical condition including deformities, apparent height, and weight, body type, attractiveness relative to social and cultural norms or standards, gait and motor coordination, posture, work speed, any noteworthy mannerism or gestures, physical or medical conditions including bruises or injuries, basic grooming, and hygiene including appropriateness of dress, eye contact (including any changes in the previously listed issues), sex, chronological and apparent age, ethnicity, facial and body language, and congruence of language and facial or bodily expression. Potential consequences thus include the therapist not being aware of what he or she would consider important information, that you may not recognize as significant to present verbally to the therapist.

AUDIO RECORDING:

Silver Psychotherapy strictly prohibits audio or video recording of any therapy or testing session without all parties expressed written consent. By signing this document, you also agree to pay a fee of \$2,000 for each session in which you record all or part of the session without our clinicians expressed written consent.

* I consent to the Electronic Communication Policy. CLIENT OR GUARDIAN INITIALS: _____

RELEASE OF INFORMATION/LEGAL TESTIMONY:

Should any staff be compelled by the court or yourself to provide records and/or testimony, there will be fees assessed for preparation, travel, and time spent in chambers. Court-related services include: talking with attorneys, preparing documents, traveling to court, depositions, being on-call to the court, and court appearances. The court appearance fee is \$1,500 for a therapist and \$2,000 for our nurse practitioner per day as a retainer paid prior to appearance; and \$155 per hour of court preparation time/letter writing. These fees also apply to any legal matters in which you need us to provide documentation on your behalf such as divorce, child custody, workman's comp. A Release of Information will need to be signed prior to submission or discussion with outside parties. After proper service of a subpoena is executed by your attorney, we will block that day for your court proceeding. Should the schedule of the courts change, we require 72 hours notice of cancellation to avoid paying any fee for the blocked day- otherwise, you will be responsible for paying for the clinician's time at our standard clinical rate.

* I consent to the Release of Information/Legal Testimony Policy. CLIENT OR GUARDIAN INITIALS:_____

SOCIAL MEDIA AND TELECOMMUNICATION:

Due to the importance of your confidentiality and the importance of minimizing dual relationships, we do not accept "friend" or contact requests from current or former clients on any social networking site (Facebook, LinkedIn, etc). We believe that adding clients as friends or contacts on these sites can compromise your confidentiality and our respective privacy. It may also blur the boundaries of our therapeutic relationship. If you have questions about this, please bring them up when we meet and we can talk more about it.

Right to Respond to Reviews:

In the event that you exercise your right to create an online review, file a complaint with any regulatory body, or engage in commentary in the media about our practice, clinicians, or your treatment, you also waive your right to confidentiality. By signing this agreement, you give Silver Psychotherapy LLC permission to respond publicly and privately to any such complaints in the course of protecting its reputation, defending its ethics, or clarifying facts related to your treatment.

* I consent to the Social Media and Telecommunication Policy CLIENT OR GUARDIAN INITIALS:_____

CONFIDENTIALITY:

Silver Psychotherapy maintains your personal health information and confidential material according to the guidelines established by the Health Insurance Portability and Accountability Act (HIPAA). These guidelines, along with the ethical standards set by our professional code of ethics determine the handling of this information. The notice stating the specific privacy policy and practices, instructions for requesting an accounting of any disclosures of this information, and restrictions on disclosures can be provided to you in printed form on the portal. For those staff that are provisionally licensed, information will be shared during clinical supervision with their clinical supervisor. Additionally, information may be shared throughout the course of treatment in clinical consultation with other clinicians of Silver Psychotherapy. Our professional code

of ethics requires us to keep everything discussed in the strictest of confidence. When appropriate, and with your written permission (Release of Information Form) only, we exchange information with physicians, hospitals, family, or other professionals.

The only exceptions to this are mandated by law. The Maryland law dictates that situations involving abuse of a child or elder (present or past) must be reported. The other situation that requires notification is if yours or someone else's life is in danger because of serious suicidal/homicidal intent and with a plan/means of harm.

* I consent to the Confidentiality Policy CLIENT OR GUARDIAN INITIALS: _____

MANAGED CARE AND CONFIDENTIALITY:

Many managed care companies require access to your records or periodic treatment reports. We are willing to share those reports with you. As a consumer of mental health services, it is important to understand the benefits and limitations of your policy. If you wish to forego your insurance coverage and pay "Out of Pocket" or "Self Pay" then employers and insurance providers will not have access to your records unless you sign a Release of Information to allow access.

* I consent to the Managed Care & Confidentiality Policy. CLIENT OR GUARDIAN INITIALS: _____

MINORS:

In the state of Maryland, the age of Consent for mental health treatment is 12yo. This means that children 12yo and older can consent to treatment with or without their parent's permission/knowledge. If you are a minor, your parents may be legally entitled to some information about your therapy but would have to formally request the information and it would be discussed with you prior to the release. If you are between the ages of 12 and 18, the law may provide your parents the right to examine your treatment records if after being informed of your parents' request to examine your records, you do not object or your therapist does not find that there are compelling reasons for denying them access to the records. Notwithstanding the above, your parents are always entitled to the following information: current physical and mental condition, diagnosis, treatment needs, services provided, and services needed. Before giving them any information, your therapist will discuss the matter with you, if possible, and do their best to handle any objections you may have with what is prepared to discuss.

In cases of Divorce and Child custody, please be aware that both parents must consent to treatment if there is shared joint custody. The Divorce Decree/ Child Custody Agreement will be required to be on file and adhered to by our staff.

* PLEASE HAVE THE MINOR PROVIDE CONSENT TO THE MINOR POLICY MINORS INITIALS: _____

TERMINATION:

Ending relationships can be difficult. Therefore, it is important to have a termination process in order to achieve some closure. The appropriate length of the termination depends on the length and intensity of the treatment. We may terminate treatment after a discussion with you, and if determined that the psychotherapy is not being

effectively used or if you are in default on payment. We will not terminate the therapeutic relationship without first discussing and exploring the reasons and purpose of terminating. If therapy is terminated for any reason or you request another therapist, we will provide you with a list of qualified psychotherapists to treat you. You may also choose someone on your own or from another referral source.

Should you fail to schedule an appointment for four consecutive weeks, unless other arrangements have been made in advance, for legal and ethical reasons, we must consider the professional relationship discontinued.

* I consent to the Termination Policy. CLIENT OR GUARDIAN INITIALS: _____

* BY SIGNING BELOW I AM AGREEING THAT I HAVE READ, UNDERSTOOD AND AGREE TO THE ITEMS CONTAINED IN THIS DOCUMENT.

* TODAY'S DATE _____

** indicates a required field*

Updated 2/4/2022