Unlimited You, LLC

Lucinda Testo, MS, LPC
350 Silas Deane Highway Suite #303
Wethersfield, CT 06109
860-759-8703

Client Information and Consent

By entering counseling with Unlimited You, LLC, you have already taken a step towards making a change in your life. Please take the time to read the following document and feel welcome to ask any questions regarding its content. The better you understand the counseling process and your role as an active participant, the more effective your treatment will be.

Qualifications Lucinda Testo, MS, LPC has been a therapist for over 12 years. Lucinda received her Master's Degree in Professional Counseling from Central Connecticut State University in 2004.

Confidentiality: State law and professional ethics require therapists to maintain confidentiality. This includes discussions, records and material produced by the client (example: artwork, journals). Release of your information requires your written permission except in the following cases: All mental health professionals are required by law to report abuse or neglect of minors and abuse, neglect and exploitation of elderly and disabled persons. All mental health professionals are required by law to notify appropriate medical or law enforcement agencies if a threat exists for immediate harm to the client or others. Legal issues involving the client that result in the demand for information as per a court order (example: child custody case). Information required by managed care companies or other parties responsible for payment. Clients under 18 do not have full confidentiality from their parents. Most records are kept in locked files and some is stored in electronic devices (cell phones, faxes, computer). All electronic communication compromises your confidentiality. Information released as outlined in the HIPAA/ HITECH Notice of Privacy Practice.

Professional Records: You should be aware that, pursuant to HIPAA/ HITECH, I keep Protected Health Information (PHI) about you in two sets of professional records. One set constitutes your Clinical Record. It includes information about your reasons for seeking therapy, a description of the ways in which your problem impacts on your life, your diagnosis, the goals that we set for treatment, your progress towards those goals, your medical and social history, your treatment history, any past treatment records that I receive from other providers, reports of any professional consultations, your billing records, and any reports that have been sent to anyone, including reports to your insurance carrier. Except in unusual circumstances that involve danger to yourself and/or others or where information has been supplied to me confidentially by others, you may examine and/or receive a copy of your Clinical Record if you request it in writing. Because these are professional records, they can be misinterpreted and/or upsetting to untrained readers. For this reason, I recommend that you initially review them in our presence, or have them forwarded to another mental health professional so you can discuss the contents. In most situations, we are allowed to charge a copying fee of $.75 per page (and for certain other expenses). The exceptions to this policy are contained in the attached Notice Form. If I refuse your request for access to your records, you have a right of review, which can be discussed upon request. In addition, I may also keep a set of Psychotherapy Notes. These Notes are for my own use and are designed to assist me in providing you with the best treatment. While the contents of Psychotherapy Notes vary from client to client, they can include the contents of our conversations, our analysis of those conversations, and how they impact your therapy. They also contain particularly sensitive information that you may reveal to me that is not required to be included in your Clinical Record. They may also include information from others provided to me confidentially. These Psychotherapy Notes are kept separate from your Clinical Record. Your Psychotherapy Notes are not available to you and cannot be sent to anyone else, including insurance companies without your written,

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signed Authorization. Insurance companies cannot require your authorization as a condition of coverage nor penalize you in any way for your refusal to provide it.

Minors and Parents: Clients under 18 years of age who are not emancipated and their parents should be aware that the law may allow parents to examine their child's treatment records unless it is decided that such access is likely to injure the child. Because privacy in psychotherapy is often crucial to successful progress, particularly with teenagers, it is sometimes policy to request an agreement from parents that they consent to give up their access to their child's records. If they agree, during treatment, I will provide them only with general information about the progress of the child's treatment, and his/her attendance at scheduled sessions. I may also provide parents with a summary of their child's treatment when it is complete if the parents request it. Any other communication will require the child's consent, unless I feel that the child is in danger or is a danger to someone else, in which case, I will notify the parents of my concern. Before giving parents any information, we will discuss the matter with the child, if possible, and do our best to handle any objections he/she may have.

Emergency: If you are unable to reach me and feel that you cannot wait for your call to be returned, please contact your family physician or the nearest emergency room and ask for the psychologist or psychiatrist on call. Clients who are in crisis or in an emergency situation are instructed to call 911.

Independent Practice: While the office space is shared with other mental health professionals, our practices are independent. They are not partners and do not have any legal associations with one another.

Fee Agreement: In order to provide you with the best possible service, it is important to address the issue of payment. The first session will be utilized to gather information about the client and will require additional time, especially if insurance will be used. The fee for the initial intake session is **$150.00**. You will be expected to pay at the time of service. The full service fee is **$125.00** per 50 minute session. Additional time may increase the session fee.

For clients utilizing their managed care companies, it is the client's responsibility to be aware of and be responsible for payment of all co-payments and deductibles. It is recommended that you determine your co-payment of in-network and out-of-network benefits before your first office visit by calling your benefits office or insurance company. Please be prepared to pay this amount in full at the closing of each session. It is requested that the client authorize payment of medical benefits directly to Unlimited You, LLC. Clinical Assessments, recommendations and/or general letters are charged at an additional fee.

Telephone calls will be charged at approximately the same rate as personal consultation. Emergency phone calls of less than ten minutes are not charged. However, if more than 10 minutes in a week is spent on the phone, including phone messages, you will be billed on a pro-rated basis for that time.

In the event disclosure of your records or testimony is required by law, you will be responsible for and shall pay the costs involved in producing the records and the therapist's time involved for preparing for and giving testimony at $150.00 per hour. Such payments are to be made at the time the services are rendered by the therapist. **Self-payment Option**: If you do not wish to involve your health insurance company, you have the option of self-payment for therapy services.

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Scheduling Appointments /Contact: Appointments can be made by calling 860-759-8703. If you leave a voicemail I will make every effort to return your call within 24 hours, with the exception of weekends and holidays. If you are difficult to reach, please inform me of some times when you will be available.

Missed or Cancelled Appointments: The client is asked to give at least 24 hours notice if unable to attend an appointment. Clients who do not give a proper notice will be charged **$50.00** for each missed appointment. Missed sessions CANNOT be billed to your insurance company and therefore the client will be responsible for payment of this charge.

Late Arrival: Clients who arrive late for appointments will have the time deducted from their scheduled session. Full payment will be required. Consistently showing up late to scheduled appointments may be reason for therapeutic concern and will be discussed during your counseling session.

Number and Length of Visits: The number of sessions needed depends on many factors and will be discussed with the therapist.

Termination of Services: Either the client or therapist may choose to terminate the counseling relationship at any time. If the counselor terminates the relationship, she will provide the client referrals for more appropriate services, should this be needed (example: payment issues, refraining from dangerous practices, problems emerge that is not within the scope of competence of the therapist). Not all people experience improvement in therapy and therapy may be emotionally painful, at times.

Consent to Treatment: I voluntarily agree to receive mental health assessment, care and treatment and authorize the undersigned therapist to provide such care, treatment or services as are considered necessary and advisable. I understand and agree that I will participate in the planning in my care, treatment or services that I receive through the undersigned therapist.

I have read this informed consent completely and have raised any questions I might have about it with my therapist. I have received full and satisfactory response and agree to the provisions freely and without reservations. I understand that my therapist is responsible for maintaining all professional standards set forth in the ethical principles of her professional association as well as the laws of the state of Connecticut governing the practice of psychotherapy and that she is liable for infractions of those standards. I understand that I will be fully responsible for any and all legal and/or collection costs arising as a result of my contact with my therapist, including appropriate compensation for her time involved in preparing for and doing court work.

Your signature below indicates that you have read the information in this Consent to Treat document and agree to abide by its terms during our professional relationship. It also confirms that you have received a copy of the Notice of Privacy Practices for Protected Health Information (HIPPA).

Client Signature_____Date_____

Parent/Guardian Signature (if applicable) _____Date _____

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ELECTRONIC COMMUNICATION

I have been advised and understand that the use of email, cell phone texting, and other forms of technology in psychotherapy has not been defined as a best-practice strategy. I have also been specifically advised of the following:

1. Email/texting communication can be utilized as a supplemental form of communication with therapist as deemed appropriate.

2. Email/texting communication is not to be used to provide/receive treatment services or take the place of therapy sessions.

3. Any information exchanged electronically or with the use of technology increases the risk of confidentiality breaches. No technology is 100% secure and the therapist cannot guarantee protection from unauthorized attempts to access, use, or disclose personal information exchanged electronically.

4. I agree to indemnify and hold harmless the therapist from and against all losses, expenses, damages and costs, relating to or arising from any information loss due to technical failure, my use of the email/ texting to communicate with the therapist. I have thoroughly considered all of the above information, and I have obtained whatever additional input and/or professional advice I deem necessary in making an informed decision regarding email/texting communication.

By signing, I consent to the use of email/cell phone texting as needed, within the guidelines above.

Client Signature _____ Date _____

Parent/Guardian Signature (if applicable) _____ Date _____