



## NOTICE TO CLIENTS & CONSENT TO TREATMENT AGREEMENT

### TO OUR CLIENTS:

The NH Board of Mental Health Practice regulations, including the NH Mental Health Bill of Rights, require all licensed mental health professionals to provide clients with certain information. Also, in order to avoid confusion or misunderstandings, I am providing additional information about my practice. Please read this consent carefully and discuss any questions before signing.

#### 1. LICENSE AND CODE OF ETHICS

I am a Licensed Independent Clinical Social Worker (LICSW), licensed by the state of New Hampshire, and governed by the National Association of Social Worker's (NASW) Code of Ethics. My license is displayed in my office, and a copy of the NASW Code of Ethics is available at any time by request, or can be accessed online at [www.socialworkers.org/pubs/code/code.asp](http://www.socialworkers.org/pubs/code/code.asp). Information regarding my training, qualifications and experience are provided below. If you have any questions regarding my qualifications, please let me know so that I may address them.

#### 2. QUALIFICATIONS AND SCOPE OF PRACTICE

I, Joan Tavares, received my master's in social work from Salem State College's School of Social Work in 1995. My primary focus and training have been in working with children and families. Since obtaining my graduate degree I have worked as a child and family therapist in several mental health agencies; and worked for several years as a clinical supervisor. I am a goal oriented, solution-focused clinician with significant training and experience in cognitive behavioral paradigms.

The scope of my practice includes assessment/diagnosis, psychotherapeutic treatment, and consultation for mental health and behavioral disorders for children and families in the areas of depression, anxiety, ADHD, PTSD, and other related disorders. I also offer services related to trauma, grief and other non-normative life challenges. Every client is assessed for the appropriateness of my services in meeting their treatment goals. **In the instance that assessment reveals that my services are not appropriate for the needs of the client, the client will be referred to an agency/service that can better meet their clinical needs. Such needs include but are not limited to substance abuse as a primary diagnosis, domestic violence, sexual offending, and severe impairment of functioning.**

### 3. MENTAL HEALTH BILL OF RIGHTS

Pursuant to the New Hampshire Mental Health Bill of Rights, clients maintain certain rights. A copy of the NH Mental Health Bill of Rights is included with this form and posted in the waiting area. Please review the bill of rights carefully and let me know if you have any questions. **In addition, while we work to foster confidentiality, we believe in safety first, please be aware that it is your right as a parent/guardian to check-in on a session at any time.**

### 4. DIAGNOSIS AND RECOMMENDED TREATMENT

As part of the treatment process, I will discuss with you your/your child's diagnosis and my proposed treatment plan including my estimate of the length of therapy. Diagnoses are made on an individual basis based on your/your child's current symptoms/functioning in accordance with the criteria set forth by the most recent *Diagnostic Statistical Manual (DSM)*.

Psychotherapy can have benefits and risks. Since therapy often involves discussing unpleasant aspects of your life, you may experience uncomfortable feelings like sadness, guilt, anger, frustration, loneliness, and helplessness. On the other hand, psychotherapy has also been shown to have positive benefits. Therapy often leads to better relationships, solutions to specific problems, and significant reductions in feelings of distress, but there are no guarantees of what you will experience.

You should be aware that there are alternative types of services to those being offered by me. You may prefer to obtain counseling from someone other than me. You also have the choice not to obtain any counseling services. There are also risks and benefits associated with alternatives and with not pursuing any counseling. To the extent that you are interested in alternatives, you should discuss this with me.

### 5. CONFIDENTIALITY

Under New Hampshire law, communications between a client and a licensed psychotherapist are privileged (confidential) and may not be disclosed without the specific authorization of the client except under specific, limited circumstances. For example, the privilege does not apply in a civil commitment proceeding in which the issue is whether the individual is a danger to self or others or when a client is seeking treatment relating to a workers' compensation claim. Records may also be subject to audit by regulatory authorities. Also, many reporting laws create exceptions. See paragraph 6 below.

As part of maintaining a valid license, I am required to regularly discuss cases with colleagues. I also obtain formal supervision on certain cases when I believe it is necessary. In these situations, I do not disclose the identity of my client. My colleagues and any formal supervisor are, of course, legally bound to confidentiality as well. By signing this document, you are acknowledging that you understand that I may discuss your case in consultation and/or supervision and do not object to my doing so.

## 6. REPORTING REQUIREMENTS

Among the exceptions to confidentiality are New Hampshire reporting laws which require Licensed Clinical Social Workers to report to the appropriate authorities' certain types of conduct. For example, any person who suspects a child or incapacitated adult has been abused, neglected or exploited must report such suspicions to state authorities. Licensed Clinical Social Workers are required to warn the police or likely victims of a client's "serious threat of physical violence" to a person or property. There are also other reporting laws that require the disclosure of otherwise confidential information.

## 7. MINORS

### FOR PARENTS

Generally, the treatment of a minor child (under the age of 18) must be authorized by a parent or someone else with legal authority such as a guardian. Parental control over a minor's treatment includes the authority to access or release the child's otherwise confidential treatment records. Even parents without residential responsibility for a child retain decision-making authority over the child's treatment (joint legal custody) and treatment records unless a court has ordered otherwise.

In accordance with best practice standards set forth by the Board of Mental Practice State of New Hampshire and the NASW's Code of Ethics, Partners in Family Wellness, PLLC may request a copy of the divorce decree or other relevant legal documents. **Furthermore, we will make reasonable attempts to obtain consent from all guardians who retain legal decision-making responsibility before the start of treatment. If parents cannot reach agreement about treatment and access to records, it is the responsibility of the parents to resolve their differences through a court hearing prior to instituting treatment.**

If one parent is unavailable and we determine that it is appropriate to proceed with the consent of only one parent, the absent parent will retain equal right to the child's treatment records upon request while the child is a minor unless there is a court order to the contrary. If continuation of treatment becomes an issue, it is the responsibility of the parents to resolve the disagreement in court.

Upon turning 18, the child gains control over treatment, information and records.

### FOR MATURE MINORS

Because you are a minor (under the age of 18), I cannot treat you without parental consent. Parental control over your treatment includes your parents' right to access and release your medical and treatment records.

In very limited circumstances, a minor may prevent parental access to treatment records through a court hearing. In the event you object to either parent having access to your treatment records, I encourage you to raise this issue with your other parent or with a guardian ad-litem, if one has been appointed.

## **8. CONFLICTS OF INTEREST**

New Hampshire is a small state. From time to time, actual or potential conflicts of interest may arise. If I become aware of a conflict of interest in providing treatment to you, I may be required to refer you to another therapist. Regardless of the existence of a conflict of interest, you can be assured that any information will remain confidential.

## **9. COUPLES**

Treatment records of couple's sessions contain information about each person. Both clients should be aware that either person has a right to obtain treatment records unless both clients agree in advance that treatment records will only be released by joint consent.

## **10. COURT ORDERED TREATMENT**

If you are seeing me due to a court order requiring you to seek treatment, it is my policy that we not proceed with treatment until I have received a copy of the court order and have had an opportunity to review it. Because you have been ordered by the court to obtain treatment, there are limits on confidentiality in addition to the ones described in paragraph 5 entitled Confidentiality. For example, I may be obligated to file a report with the court that ordered you to seek treatment or with someone else.

## **11. GROUP THERAPY**

Unlike individual treatment, confidentiality of group therapy is not privileged, and therefore is not protected by law. Group members must sign and abide by a written confidentiality agreement prior to participating in the group which creates a contractual obligation to maintain the confidentiality of group therapy. However, I still am bound by reporting obligations (see Section 6) and may be required to disclose confidential information to comply with those obligations. Clients with concerns about confidentiality should discuss them prior to beginning treatment.

## **12. PROFESSIONAL BOUNDARIES**

Licensed psychotherapists are obligated to establish and maintain appropriate professional boundaries (relationships) with present or past clients (and, in some cases, client's family members). For example, therapists should not socialize or become friends with clients and should never become sexually involved with a client.

## **13. CONCERNS OR COMPLAINTS**

If you have any complaints about the treatment you have received or about billing, you should not hesitate to raise them with me or any of my colleagues. You may also contact the New Hampshire Board of Mental Health Practice, 49 Donovan Street, Concord, NH 03301, 603-271-6762.

#### **14. COST OF PROFESSIONAL SERVICES**

My billing rate varies based on the service provided and is subject to change at any time. If changes do occur, you will be notified in writing with your signature required. Please refer to Partners in Family Wellness' Fee Agreement, which you must sign prior to receiving services. Payment is due at the time your service is provided. **Failure to pay your balance promptly may result in the termination of services based on both clinical and ethical considerations, and in accordance with the guidelines set forth by the NASW's Code of Ethics.**

Partners in Family Wellness, PLLC understands that financial hardships do arise and will make every reasonable effort to work out payment plans based on individual needs. Failure to make reasonable payment within 30 days of services rendered will result in collection procedures up to and including placement with an outside collection agency. It is important to note, regarding minors with divorced parents, the financially responsible parent(s) agrees to pay regardless of any disagreements with the other parent.

#### **15. LIMITS OF SERVICES**

Unless specifically agreed to otherwise, my role is to provide psychotherapy services, not to assess fitness for custody, serve as an advocate on other issues or act as an expert witness.

#### **16. CHARGES FOR ADDITIONAL SERVICES**

In the event you request or require me by subpoena to provide ancillary professional services relating to my role as your [or your child's] therapist, such as preparing a treatment summary, report writing, deposition or trial preparation and attendance, travel time, etc., you agree to compensate me, in advance, at the rate of \$125.00 per hour.

#### **17. CONTACTING YOUR THERAPIST/ EMERGENCY COVERAGE**

**In the event of an emergency (for example, if you are in crisis, if you or one of your family members is thinking of harming yourself or someone else, or if you feel you are losing control) call 911 or your local police/emergency services number.** If you want to reach your therapist, call **603-898-3388** to leave a message or refer to your therapist's contact information that was provided at intake. If your phone number is blocked, please unblock it in order to receive a return call. You will be informed of any holiday/after-hours/vacation coverage.

#### **18. PROFESSIONAL RECORDS**

I maintain a file for each client or set of clients. The client, or parent/guardian, is entitled to a copy of the records for a fee of \$2.00 per page, which covers copying and administrative costs. If you wish to see a copy of your records, please provide me with a written request, and I will provide the requested record within 30 days of receipt. I recommend that you review the records released with me so that we can discuss the contents.

## 19. MANAGED CARE/INSURANCE

**Clients are strongly encouraged to communicate directly with their managed care company regarding their benefits, and the limitations of those benefits, before starting treatment.**

Most managed care companies limit the number of sessions which will be fully or partially reimbursed. Any concerns about the confidentiality of managed care records should also be directed to the managed care company. You should also be aware of potential risks associated with any written diagnosis being submitted to your managed care company. If you do not want this information shared with your managed care company, we can discuss private payments.

Many health care plans offer *out-of-network benefits*, in which you still may be eligible for reimbursement of services. Families with *out-of-network benefits* pay for services upfront but get directly reimbursed by the insurance company following services. We encourage you to call your insurance carrier to inquire if *out-of-network benefits* are available to you.

In the event that you request that we bill your insurer, you give authorization to Partners in Family Wellness, PLLC to release and exchange confidential information about your treatment and family history to your insurance company or third party payer in order for services to be provided and reimbursed. **You understand that if your insurance company or third-party payer does not pay for a service, you are ultimately responsible for the payment of your account. You are responsible for full payment of all claims denied by your insurer, unless the denial is due to an action, or failure to act, by Partners in Family Wellness.**

In accordance with the NASW Code of Ethics, services may be terminated for failure to pay an outstanding balance if Partners in Family Wellness deems it clinically appropriate to do so.

## 20. ELECTRONIC COMMUNICATIONS

Some insurance companies require that I send billing and other information electronically (e.g., by facsimile or e-mail). Partners in Family Wellness will take reasonable steps to protect confidentiality of such facsimile and email transmissions and will abide by all applicable legal requirements governing same. However, PFW cannot guarantee the confidentiality of such communications. If you do not consent to electronic communications, please inform me immediately, before beginning treatment, so that I can determine whether and how to proceed. I do not accept or respond to electronic mail communications about treatment issues. **As of 7/14/17, please see my Psychotherapy Social Media Policy in written form. As of 7/23/2020, please see my Telehealth Electronic Informed Consent.**

## 21. SCHEDULING AND CANCELLATIONS

For your convenience, we offer day and evening appointments. We understand the value of time, so we work very hard to avoid scheduling delays. We appreciate the same consideration in return. **Once your appointment time is scheduled and reserved, you will be expected to pay for that appointment unless you provide 24 hours advance notice.** No-shows and last-minute cancellations will be charged a 'missed appointment fee' of \$25.00.



**Client Name:**  
**DOB:**

**ACKNOWLEDGEMENT AND ACCEPTANCE  
OF  
NOTICE TO CLIENTS AND CONSENT  
TO TREATMENT AGREEMENT**

My signature below indicates that I have read and understand this document and agree to abide by its terms:

\_\_\_\_\_  
Client [or Parent/Guardian] Signature/

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness Signature/ Date

\_\_\_\_\_