**Joan Rockwell, LCSW**

**2915 Hunter Mill Road, Suite 14, Oakton, Virginia 22124**

This document contains important information about my professional services and business practices. Please read it carefully and feel free to ask questions.

* **Client Data Form:**

Please complete the **Client** **Information Form** as this information is necessary for communicating, and filing insurance company claims.

* **Notice of Privacy Practices:**

Please read the **HIPAA** agreement carefully, sign it, and return the signature portion to me. In order for me to accept insurance, I **must** have a copy of this form on file.

* **Insurance Coverage:**

Understanding your insurance coverage is essential to ensure a seamless billing process and to avoid unexpected costs. Please complete and return the *Insurance* *Form*. You are responsible for understanding your insurance plan(s), including knowing what services are covered and whether pre-authorization is required. If pre-authorization is necessary, please ensure it is obtained before your first session. Failure to do so may result in a rejected claim, and you may be responsible for the full session payment.

I am a provider for most insurance companies. However, if you plan to use your insurance, please contact your insurance carrier to confirm that I am in-network.

To help you better understand your financial responsibilities, my website includes two helpful forms:

* Questions to Ask Your Insurance (In-Network)
* Questions to Ask Your Insurance (Out-of-Network)
* **Financial Agreement:**

My session fee is $180.00, payable at the time of service. If your insurance is out-of-network, I can submit a claim on your behalf upon request. If your deductible has not been met, you will be responsible for the full session fee.

* **Session Length:**

**Sessions are 55-60 minutes.** Critical issues that come up at the end of the session will have to wait until our next session. We can agree to schedule a second session during the week upon request.

* **Missed Sessions Policy:**

Out of consideration for my time, as well as the needs of others, if you need to cancel a session, **please do so with as much advance notice as possible**. Insurance **does not** cover missed sessions. You will be charged a **$75.00 late cancelation fee** if notification is given in less than 24-hours in advance.

* **Communication:**

The most expedient way to contact me is by phone or text. Please use text and e-mail for scheduling issues or if you would like me to call you. Text and e-mail are not confidential and potentially violate HIPAA.You can leave a confidential voicemail at (703) 919-9594. I will make every effort to return your call as quickly as possible. If you cannot safely wait for my return call, please call 911 or go to your nearest emergency room. Please note that phone calls do not take the place of sessions so should be as brief as possible. If more than a few minutes are need, we can schedule a session.

**If you contact me and I do not respond within 24- hours, I did not receive your message whether it was via phone, text or e-mail, so please reach out again.**

* **Forensic and Litigate Services:**

I do not participate in lawsuits of any type on a plaintiff’s behalf unless compelled to do so by subpoena or court order. Due to the complexity of legal involvement, if you become involved in legal proceedings that require my participation, deposition, telephone time, transportation costs, court appearances, report writing, consultation, and supervision, even if I am called to testify by another party you will be charged $250.00 per hour for preparation and attendance at any legal proceeding.

* **Confidentiality:**

You have the right to confidentiality regarding any records, communications, or other information pertaining to your treatment or evaluation. Information may only be shared if you sign a release of information that specifies who is to receive the information and the nature of the information to be shared.

* I reserve the right to consult with professional colleagues regarding treatment and evaluation. Such discussions do not include the use of names or identifying information. Exceptions to confidentiality do exist in order to protect yourself and others. A list of such exceptions is provided on my *HIPAA Form*. However, below is a brief summary of exceptions.

***Exceptions to Confidentiality:***

* **Danger to Self or Others:**

The law requires mental health professionals to report information that indicates that an individual is in imminent danger of hurting himself or another person. If I believe that you are a threat to yourself or someone else, I am obligated by law to take protective action. This action may include seeking hospitalization, contacting family members or others who can assist in providing protection. This action may include notifying a potential victim, contacting the police, or seeking hospitalization. I will make every effort to fully discuss this with you before taking any action.

* **Abuse of Children and/or Adults:**

The law requires all mental health providers report information believed or reasonably suspected to constitute abuse or neglect of children. The law also requires the report of suspected abuse of persons 65 or older or of another adult who may be in need of protective services due to disability.

* **Court Orders:**

Certain records (which differ by jurisdiction) can be subpoenaed by legal process. This possibility also applies to reports and testimony. In addition, you may give up your confidentiality if you choose to make your mental status an issue as part of a court proceeding.

* **Social Service Referrals:**

If you are referred for evaluation or treatment by a Social Service Agency as part of an evaluation or intervention, there may be a requirement to share information regarding attendance, findings, recommendations and/or progress in treatment. The details of the information to be shared in such instances will be discussed with you prior to my discussion with representatives of such agencies.

* **Conflict of Interest:**

There are some circumstances in which a conflict of interest may interfere with my ability to provide psychotherapy for you. If such a circumstance arises, I may consult with another clinician to determine the best course of action. If it becomes necessary for us to end our work together, I will assist you in finding a new therapist. If you choose to sign a release of information, I will consult with your new therapist to minimize any disruptions to your treatment.

* **Discontinuing Services:**

Your participation in treatment is entirely voluntary. You may choose to discontinue services at any time. Ending treatment is an important part of the therapeutic process. Please inform me if you plan to discontinue treatment so that it may be worked into the therapeutic process. If at any point in treatment your clinical needs exceed my expertise, training, or experience, we may determine that different provider would be more appropriate. In such an event, I will make every effort to connect you with another therapist who can meet your needs.

* **Delinquent Accounts:**

Collection agencies or attorneys may be given identifying information only in order to pursue delinquent accounts. If your bill is sent to collections, you will be responsible for any fees incurred.

**Joan Rockwell, LCSW**

**2915 Hunter Mill Road, Suite 14, Oakton, Virginia 22124**

**703-919-9594**

**joanrockwell.lcsw@gmail.com**

**Consent for Treatment**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, (name of client or guardian as applicable), agree and consent to the policies, procedures, fees, and payment arrangements as described above.

Your signature below indicates that you have read the information in this document and agree to abide by its terms during our professional relationship.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Print Client Name

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Client Signature Date Signed

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Guardian or Legal Representative if Needed Date Signed