

NOTICE TO CLIENTS AND CONSENT TO PSYCHOTHERAPY AGREEMENT

TO OUR CLIENTS:

The Board of Mental Health Practice regulations, including the Mental Health Bill of Rights, require all licensed mental health professionals to provide clients certain basic information. Also, to avoid confusion or misunderstandings, I am providing additional important information about my practice for your review and agreement. Please read it carefully and discuss any questions you have before signing below.

1. LICENSE AND CODE OF ETHICS

I am a licensed psychologist, governed by the Code of Ethics of the American Psychological Association. My license is displayed in my office. A copy of the Code of Ethics is available at all times in my office. I will provide information regarding my training, qualifications and experience at the initial meeting and upon request.

2. QUALIFICATIONS AND SCOPE OF PRACTICE

I received my Ph.D. in clinical psychology in 2004 from Loyola University Chicago. I received post-doctoral training in Neuropsychology at New York University Medical Center. My practice areas include neuropsychological assessment across the lifespan and psychotherapy with children, adolescents, and adults.

3. PSYCHOTHERAPY

As part of your (your child's) therapy, I will discuss with you your (your child's) diagnosis and my proposed treatment plan including my estimate of the length of therapy. Psychotherapy can have benefits and risks. Since therapy often involves discussing unpleasant aspects of your child's life, your child may experience uncomfortable feelings like sadness, guilt, anger, frustration, loneliness, and helplessness. On the other hand, psychotherapy has also been shown to have benefits for people who go through it. Therapy often leads to better relationships, solutions to specific problems, and significant reductions in feelings of distress. But there are no guarantees of what your child 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.

4. CONFIDENTIALITY

Under New Hampshire law, communications between a client and a licensed psychologist 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 5 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.

5. REPORTING REQUIREMENTS

Among the exceptions to confidentiality are New Hampshire reporting laws which require licensed psychologists 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 to state authorities. Licensed psychologists 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.

6. 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. Parental control over a minor's therapy includes the authority to access or release the child's otherwise confidential therapy records. Even parents without residential responsibility for a child retain decision-making authority over the child's therapy and therapy records unless a court has ordered otherwise.

When parents with decision-making authority cannot agree on access to or release of their child's confidential therapy information, a court will decide following a hearing.

I believe it is best to identify and resolve potential parental agreements before therapy begins. Therefore, it is my policy to treat minors only with the consent of both parents, to the extent both are available. If both are available but cannot reach agreement about therapy and access to records, it is the responsibility of the parents to resolve their differences through a court hearing prior to instituting therapy.

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 have a right to the child's 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 therapy includes their right to access and release your medical records.

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

7. CONFLICTS OF INTEREST

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

8. 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.

9. PROFESSIONAL BOUNDARIES

Licensed psychologists 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, psychologists should not socialize or become friends with clients and should never become sexually involved with a client.

10. COST OF PROFESSIONAL SERVICES

My billing rate is \$225 per session. Payment must be received by the end of each session. Payment can be made by cash or check payable to “Portsmouth Neuropsychology Center, LLC.” We do not accept credit cards. Portsmouth Neuropsychology Center, LLC works as an out-of-network provider and therefore does not participate directly with insurance plans.

11. CANCELLATION POLICY

It is your responsibility to cancel an appointment at least 24 hours before the time of the appointment. If you do not cancel or do not show up, you will be charged \$225 for that appointment.

12. 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.

13. CHARGES FOR ADDITIONAL SERVICES

In the event I am requested or required by subpoena to provide ancillary forensic professional services relating to my role as your psychologist, such as preparing a treatment summary, phone calls/meetings, deposition or trial preparation and attendance, you agree to compensate me according to the following rates:

\$400/hour

Record review, preparation time, telephone calls, and in-person conferences for any legal contexts, including but not limited to depositions and hearing. Charges are calculated in 15 minute increments and payment is required within 30 days of receiving the invoice.

\$4,000/day

Deposition and courtroom testimony. Please note that this fee also applies if I am subpoenaed or receive a court order to provide testimony. Payment for deposition and/or courtroom testimony must be made 72 hours in advance of the offering of such testimony and is entirely non-refundable.

PNC also bills separately for out-of-pocket forensic expenses, such as travel expenses, mileage, overnight delivery, copies, etc.

14. LIMITS OF AVAILABILITY AND PROVISIONS FOR EMERGENCY COVERAGE

In the event of an emergency, you can reach me at (603) 433-0800. If I am unavailable, you can leave a message on my voice mail and I will return your phone call as soon as possible. Phone calls are not checked after 5pm during the weekday. Please note that calls received after 12pm on Friday may not be returned until the following Monday.

15. PROFESSIONAL RECORDS

I maintain a file for each client or set of clients. This includes intake, diagnosis, treatment plan, billing, consent to treatment, treatment notes, discharge summary and any other written or electronic information I received from or about the client. Treatment notes include the date and time of each session and a brief summary of key facts and issues discussed as well as treatment recommendations. The client (or parent) is entitled to a copy of the records for a fee which covers copying and administrative costs. If you wish to see a copy of your records, I recommend that you review them with me so that we can discuss the contents.

16. ELECTRONIC COMMUNICATIONS

I do not respond to electronic communications (e.g., e-mail, texts) from you regarding your therapy. My office manager utilizes e-mail for scheduling and billing.

ACKNOWLEDGEMENT AND ACCEPTANCE

Client Name: _____ Date of Birth: _____

I do hereby seek and consent to take part in psychotherapy with Dr. Laura Rubin.

I understand that no promises have been made to me as to the results of this psychotherapy.

I am aware that I may stop therapy at any time but will still be responsible for payment for services rendered.

I know that I must call to cancel an appointment at least 24 hours before the time of the appointment. If I do not cancel or do not show up, I will be charged \$225 for that missed appointment.

I am aware that I am responsible for any information provided to the insurance company and that Portsmouth Neuropsychology Center does not participate in insurance plans.

My signature below shows that I understand and agree with all of these statements.

Signature of Client (or Person Acting for Client)

Date

Printed Name of Client (or Person Acting for Client)

Relationship

I, the clinician, have discussed the issues above with the client (or other representative). My observations of this client's behavior and responses give me no reason to believe that this client is not fully competent to give informed and willing consent.

Signature of Clinician

Date