Marie Margenau-Spatz, Ph.D.

INFORMED CONSENT AND AGREEMENT FOR PSYCHOTHERAPY USE AND DISCLOSURE OF HEALTH INFORMATION AND ASSIGNMENT OF MEDICAL BENEFITS

As we begin the psychotherapy process, I would like to inform you about the type of work we will be doing together, and any alternative treatments that are available to you. There are many different forms of psychotherapy. I utilize a practice I call "eclectic," meaning it draws from a variety of procedures that have been effective in helping people deal with their emotional and social lives.

While benefits can be expected from this treatment, it should be understood that no particular outcome can be guaranteed. We will work together to establish goals for therapy. In the course of our work, the goals may change, and I will assist you in further redefining them. The psychotherapeutic process can sometimes lead to the emergence of upsetting feelings and, on occasion, a patient may feel worse before feeling better. I will ask you to participate in a periodic review of your progress.

As your therapist, I place a high value on the confidentiality of the information you share with me. Federal Regulations (HIPAA) allow me to use or disclose Protected Health Information (PHI) from your record in order to provide treatment to you, to obtain payment for the services I provide and for other professional activities (known as “health care operations”). Nevertheless, I ask your consent in order to make this permission explicit. The Notice of Psychologists’ Policies and Practices To Protect the Privacy of Your Health Information, hereafter, “Notice of Privacy Practices”, which you have received, describes these disclosures in more detail. You have the right to review the Notice of Privacy Practices before signing this consent. I reserved the right to revise the Notice of Privacy Practices at any time. If I do so, the revised Notice of Privacy Practices will be posted in my office. You may ask for a printed copy of the Notice of Privacy Practices at any time.

Please note: There are a few possible exceptions to this confidentiality agreement:

1. As your therapist, I am required by law to report any suspected child abuse or neglect. This law is designed to protect children from harm.
2. In the event that I learn information that could result in severe injury or death to you or to someone else, I have a duty to notify some other person or official who, in my judgment, would reduce that risk of danger.
3. If you are currently involved in litigation or become so involved, the court may request a report, an evaluation or your entire mental health record. If you are required to sign an authorization for therapy records, please consult with your attorney.
4. If an insurance carrier or managed care company is paying for your treatment, you should be aware that your treatment records are available to them upon request. Though all insurance companies claim to keep such information confidential, it is possible that the insurance company might put your treatment information into a national medical databank. To further protect you, I will send them a Notice of Re-disclosure, which prohibits them from making any further disclosures as is regulated by Federal and State Law. You always have the right to pay for services yourself to avoid the problems described above.
5. I may occasionally find it helpful to consult with professional colleagues about a case. However, your name and other identifying information will never be revealed.

Offices
New York City: 65 West 55th Street, Ste. 4B, New York, NY 10019 Tel.: 212-757-5755 Fax: 212-956-5655
Westchester: 29 Hughes Terrace, Yonkers, NY 10701-1744 Tel.: 914-963-1636 Fax: 914-963-3336
Website: www.TheChangeWorksCoaching.com Email.: Marie@TheChangeWorksCoaching.com

6. I employ administrative staff with whom I will need to share some of your protected health information for clinical and administrative purposes such as: scheduling, billing and quality assurance. All staff members have trained *re*: protecting your privacy and have agreed not to release any information outside of the practice without my permission.
7. If I am away or unavailable, and another therapist is covering my practice, it may be necessary to share some information about our work together in order for the covering therapist to help you in an emergency situation.

In all the circumstances described above, I will try to discuss the situation with you before any confidential information is disclosed and will reveal only the **least amount of information necessary.**

The fee for psychotherapeutic services and the length of sessions will be agreed before or during the first session. In the event of longer sessions, they will be pro-rated at the same fee. Payment is due at the time of the session, unless other arrangements are made.

If you must cancel a session, it is required that you give me at least 48 hours advanced notice in order to avoid being billed for that time. If you give me less that 48 hours notice, you will be billed the entire fee for any appointment you cancel or do not keep for any reason.

Generally, there will be no charge for short phone conversations or letters. However, telephone contact or letters or reports of significant length with you or others about your treatment may be billed. Likewise, meetings outside the office related to your treatment will be billed including travel time and expenses.

You are making the choice to begin psychotherapy. You have the right to end your treatment at any time. If you decide to leave therapy, you are encouraged to speak with me before leaving so we can end our work together appropriately and I can assist you with making plans for future treatment if this is necessary or desired. Missing three consecutive appointments will constitute voluntary termination by you.

It is understood that I am engaged to provide you with psychotherapeutic treatment. Psychotherapeutic treatment does not include giving expert testimony in any litigation that you may be a party to in a lawsuit. Should I be subpoenaed by your attorney or be required by a court to participate in a deposition, to give expert testimony or any other services in connection with a lawsuit that you are a party to, you agree to pay me at a rate to be determined plus travel time and expenses.

You may ask me to restrict the use and disclosure of certain information in your record that otherwise would be disclosed for treatment, payment or health care operations; however, I do not have to agree to these restrictions. If I do agree to a restriction, that agreement is binding.

You may revoke this consent at any time by giving written notification delivered to me in person and evidenced by my signature of receipt or by United States Postal Service Certified Mail Return Receipt Requested. Such revocation will not affect any action taken in reliance on the consent prior to the revocation.

This consent is voluntary; you may refuse to sign it. However, I am to permitted to refuse to provide health care services if this consent is not granted, or if the consent is later revoked.

This consent agreement shall become effective immediately upon execution and shall remain in effect for the duration of any claim(s) or term of treatment including a reasonable time thereafter until its final

consummation. This consent agreement shall be binding upon you, your dependents and heirs, executors and administrators. A photocopy of this agreement shall be considered as effective and valid as the original.

By signing below, you consent to the use, release and disclosure of your Protected Health Information (PHI) as specified above in this document and to the terms of this Informed Consent by which you agree to authorize treatment, payment and health care operations.

Additionally, by signing below, you, as the Insured, expressly authorize assignment and payment of medical benefits paid by your health insurance company, as the Insurer, directly to Marie Margenau-Spatz, Ph.D., as the Provider of psychotherapy services rendered. Furthermore, you agree and accept that you shall be personally responsible for any and all unpaid balance(s) not paid by the Insurer; and you shall render payment to Dr. Marie Margenau-Spatz upon demand for any unpaid balances.

(Please print) _____

Insured / Patient Name

(Please sign)_____

Insured / Patient Signature

_____

Date