Policies & Procedures

CLIENT THERAPIST AGREEMENT

The therapy relationship is a collaborative one. You and I will establish goals together and work to accomplish them. If you are a parent of a client, you will at times be invited to joint and/or individual sessions to collaborate on the best treatment options for your child. In order to facilitate our work, there are a number of policies and procedures that need to be followed. They are outlined below:

OFFICE HOURS

Our administrative office is open Sunday, Monday, and Thursday. Sessions are available Sunday through Thursday. Please call the office to arrange for scheduling sessions. At the end of each session, we will schedule and confirm the next session.

FINANCIAL AGREEMENT & CANCELLATION POLICY

My fee for private clients is $200 for a 50-minute session. If the session requires additional time, there will be a prorated charge based on the fee amount listed. Travel fees are case and location specific and can be discussed when travel is warranted. I accept credit cards, checks, or cash, and payment is expected on the day of treatment. Clients with an outstanding balance will not be seen until the balance has been settled.

Because your appointment time is held exclusively for you, I have made a 24-hour cancellation policy – for example, changes to appointments must be made before 5:00 PM on Sunday for a 5:00 PM appointment on Monday. If you do not cancel within 24 hours and miss the appointment, there will be a charge of $200 for a full session.

PHONE CALLS & TEXTS

If your situation requires attention outside of regular working hours, please call or text my cell phone at 646-396-0674, leave a detailed message, and I will respond as soon as I am able. If the phone call requires additional time beyond a 10-minute conversation, there will be a session fee charge for $40 per 10 minutes. If the situation is life-threatening, please contact 911.

CONDUCT OF THERAPY

I adhere to the Code of Ethics as a social worker and to the laws of New York and Maryland as they pertain to client-therapist relationships.

CONFIDENTIALITY

The content of all professional interactions in my practice will be held in confidence unless you waive this confidentiality in writing. However, confidential information can be subpoenaed by court order. Additionally, information concerning child or elder abuse, physical violence, or threats to others or self is REQUIRED BY LAW to be reported to the designated authorities. Therefore, this kind of information will not be kept confidential.

I have read and understand the above outlined policies and procedures of Embrace Therapy. By signing my name, I agree to adhere to these policies set forth by Embrace Therapy LCSW-C, LLC from the date of the signing and forward.

______________________________________ _______________________

(Signature) (Date)

CONFIDENTIALITY WAIVER

Under federal law, you have the right to confidentiality with regards to treatment and treatment sessions you receive from any social worker, counselor, therapist, or other specialist. This means that without prior consent from a client or his or her parents, a therapist or any other specialist may not have conversations about you with anyone.

However, to provide therapy services with a holistic approach, it is common practice to ask clients to allow the therapist to speak with other service providers they are seeing such as psychiatrists, psychotherapists, school counselors, and/or occupational or speech therapists.

For those clients over 18 years of age and for parents of clients under 18 years of age, you may be asked to sign a waiver so that your social worker can speak with your parents or other specialists with whom you are working. **You do not have to sign this waiver if you do not wish to do so and if you have any questions about what might be discussed if you do sign this waiver, you are welcome to speak with me before signing this document.**

This confidentiality waiver is in concordance with the ethical guidelines put forth by the American Psychological Association regarding client confidentiality.

I agree to allow Michali Friedman, LCSW-C to release information and discuss the case of (client's name) ________________________________ with (specialist's name) ________________

_______________________________ for one year, dated from (today's date) _________________.

Signature: ____ Date: ___________________________

Please sign and email to michali@embracetherapy.net.

CREDIT CARD AUTHORIZATION FORM

Please complete all fields. You may cancel this authorization at any time by contacting me.
This authorization will remain in effect until cancelled.

Credit Card Information				
Card Type:	☐ MasterCard ☐ Other	☐ VISA	☐ Discover	☐ AMEX
Cardholder Name (as shown on card):				
Card Number:				
Expiration Date (mm/yy):				
CVV Code:				
Cardholder ZIP Code (from credit card billing address):				

I, ________________________________, authorize ___________________________________ to charge my credit card above for agreed upon purchases in addition to a 3.5% credit card processing fee. I understand that my information will be saved to file for future transactions on my account.

____ ______________________________________

Customer Signature Date