

# Dena M. Plotkin

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213-864-6406

Welcome to my practice. This document contains important information about my professional services and business policies. Please read it carefully and write down any questions you might have so that we may discuss them. Once you sign this, it will constitute a binding agreement between us.

## **Services**

Psychotherapy is not easily described in general statements. It varies depending on the personality of both the therapist and the patient and the particular problems that the patient brings. There are a number of different approaches that we may utilize to address the issues you are bringing to therapy.

Psychotherapy has both benefits and risks. Risks sometimes include experiencing uncomfortable feelings. Psychotherapy often requires discussing unpleasant aspects of your life and giving up old patterns. Psychotherapy has been shown to have benefits for people who undertake it. Therapy often leads to a significant reduction in feelings of distress, better relationships, and resolutions of specific problems, as well as enhancement of feelings of happiness and well being.

Our first one or two sessions will involve an evaluation of your needs, in addition to beginning the therapy process. By the end of the evaluation, I will be able to offer you some initial impressions of what our work will include and an initial treatment plan, if you decide to continue. You should evaluate this information along with your assessment about whether you feel comfortable working with me.

Therapy involves a commitment of time, money, and energy, so you should consider your decision as an important one. If you have any questions about my procedures, we should discuss them whenever they arise. If your concerns persist, I will be happy to help you secure an appropriate consultation with another mental health professional.

## **Fees**

I work on a sliding scale fee. This means we agree on a price that works for both of us. Fees are subject to change and you will be informed at least 30 days prior to any changes. I accept checks, credit cards and pay pal. There will be a \$25 charge for all returned checks.

I also charge this amount on a prorated basis for other professional services you may require, such as report writing, telephone conversations, or treatment summaries.

## **Insurance Reimbursement**

Although I do not directly bill insurance companies, I am more than happy to provide you with any information you may need, in any format you may require, to assist you in the process of getting reimbursement for yourself. Some insurance companies may allow you to submit your invoices from therapy for reimbursement, but it will be your responsibility to obtain this information from your insurance company and submit the invoices. Insurance will not reimburse for missed or cancelled sessions, it will be your responsibility to pay for these sessions if you have not cancelled within 24 hours of the session.

## **Confidentiality**

In general, the confidentiality of all communications between a patient and a psychological assistant is protected by law and I can only release information about our work to others with your written permission. Your right to privacy is protected by the Protected Health Information Privacy Rule. However, there are a number of exceptions.

In most judicial proceedings, you have the right to prevent me from providing any information about your treatment. However, in some circumstances such as child custody proceedings and proceedings in which your emotional condition is an important element, a judge may require my testimony if he/she determines that resolution of the issues before him/her demands it.

There are some situations in which I am legally required to take action to protect others from harm, even though that requires revealing some information about a patient's treatment. For example, if I believe that a child, an elderly person, or a disabled person is being abused, I may be required to file a report with the appropriate state agency.

If I believe that a patient is threatening serious bodily harm to another, I may be required to take protective actions, which may include notifying the potential victim, notifying the police, or seeking appropriate hospitalization. If a patient threatens to harm him/herself, I may be required to seek hospitalization for the patient, or to contact family members or others who can help provide protection.

Should one of the situations described above occur, I would make every effort to fully discuss it with you before taking any action and to understand your intent.

I may occasionally find it helpful to consult with other professionals. In that case, I would not reveal any identifying information about my patient.

This summary of exceptions to confidentiality is intended to let you know about rare occasions when the law may require or allow release of information.

If you participate in marital or family therapy, I will not disclose confidential information about your treatment unless all person(s) who participated in the treatment with you provide their written authorization to release such information. **However, it is important that you know that I utilize a “no-secrets” policy when conducting family or**  
Informed Consent

**Marital/couples therapy/ confidentiality.** This means that if you participate in family, and/or marital/couples therapy, your therapist is permitted to use information obtained in an individual session that you may have had with him or her, when working with other members of your family. Please feel free to ask me about the “no secrets” policy and how it may apply to you.

### **Minors and Confidentiality**

Communications between therapists and patients who are minors (under the age of 18) are confidential. However, parents and other guardians who provide authorization for their child’s treatment are often involved in their treatment. Consequently, I, in the exercise of my professional judgment, may discuss the treatment progress of a minor client with the parent or caretaker. Clients who are minors and their parents are urged to discuss any questions or concerns that they have on this topic with their therapist.

### **Scheduling, Sessions and Cancellation Policy**

My normal practice is to conduct an evaluation, which will be part of the first one or two sessions. During this time, we can both decide whether we are a good fit to provide the services you need in order to meet your treatment objectives. If psychotherapy is initiated, I will usually schedule one fifty minute session per week at a mutually agreed upon time, although sometimes sessions will be more frequent, and with certain treatment modalities, longer in duration.

Once this appointment hour is scheduled, you will be expected to pay for it unless you provide 24 hours advance notice of cancellation or unless we both agree that you were unable to attend due to circumstances beyond your control. If it is possible, I will try to find another time to reschedule the appointment.

### **Contacting Me: Availability and Emergencies**

The number to contact me is 213-864-6406. I am often not immediately available by telephone, but monitor my messages frequently. You may leave me a message and I will make every effort to return your call on the same day, with the exception of weekends and holidays.

If I am unavailable for an extended period of time, I will provide you with the name of another professional whom you may contact if necessary.

If you cannot reach me, and you feel that you cannot wait for me to return your call, you should call your physician or the emergency room at the nearest hospital and ask for the mental health professional on call.

**In the event of a medical emergency or an emergency involving a threat to your safety or the safety of others, please call 911 to request emergency assistance.**

### **Contacting You**

I may need to communicate with you by telephone, mail, or other means. Please indicate your preference by checking one of the choices listed below. Please be sure to inform me if you do *not* wish to be contacted at a particular time or place, or by a particular means

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\_\_\_\_My therapist may call me at my home. My home phone number is:\_\_\_\_\_

\_\_\_\_My therapist may call me on my cell phone. My cell phone number is: \_\_\_\_\_

\_\_\_\_My therapist may text me on my cell phone.

\_\_\_\_My therapist may call me at work. My work phone number is: \_\_\_\_\_

\_\_\_\_My therapist may send mail to me at my home address.

\_\_\_\_My therapist may send mail to me at my work address.

\_\_\_\_My therapist may communicate with me by email. My email address is:\_\_\_\_\_

\_\_\_\_My therapist may send a fax to me. My fax number is:\_\_\_\_\_

### **Ending Therapy**

The length of your treatment and the timing of the eventual termination of your treatment depend on the specifics of your treatment plan and the progress you achieve. It is a good idea to plan for your termination, in collaboration with your therapist. Your therapist will discuss a plan for termination with you as you approach the completion of our treatment goals.

You may discontinue therapy at any time. If you or your therapist determines that you are not benefiting from treatment, either of you may elect to initiate a discussion of your treatment alternatives. Treatment alternatives may include, among other possibilities, referral, changing your treatment plan, or terminating your therapy.

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

If you have questions about any of these issues, I will be happy to discuss them with you.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Date

Informed Consent