Melissa Lowe, Ph.D., LMHC
797 Washington Street, Suite 4, Newton, MA, 02460
Notice Acknowledgement
Last Updated: 04/01/2013

Melissa Lowe, Ph.D., LMHC

TREATMENT AND FEE AGREEMENT

1. The confidentiality of communication between a client and psychotherapist is protected by law. We release information to others about our work together only with your written permission.

The following are some exceptions:
Courts - Generally, you have the right to prevent your therapist from testifying in a court of law. However a therapist might be ordered to testify in certain legal proceedings such as those relating to: child custody, adoption, psychiatric hospitalizations and court ordered evaluations and when you, the client, introduce your mental or emotional condition as an element of a claim or defense, and the judge or presiding officer finds that it is more important to the interests of justice that the communication be disclosed than that the relationship between the client and the social worker be protected.

Social Workers must turn over their records if a lawfully issued Bishop order accompanies a subpoena.
Harmful intents or act - If I believe that a child, elderly or disabled person is being abused, we are required to file a report with the appropriate state agency and breach confidentiality without the client's permission. We do try to discuss this with a client when possible. Also, if in our professional judgment we believe that a client is threatening serious harm to another, we are required to take protective actions, which may include notifying the potential victim, notifying the police, or seeking the client's hospitalization. If a client threatens to harm him or herself, we may seek hospitalization or contact family members or others who can help provide protection.

Consultation with other professionals - We sometimes find it helpful to consult about clinical work with other professionals who are also legally bound to maintain confidentiality.

Use of insurance - If you use insurance, we are required to provide the insurer with clinical diagnosis, and sometimes treatment plans and clinical summaries. Massachusetts's law prohibits insurers from releasing any data about outpatient mental health care without specific permission. You cannot be required to consent to such a release as a condition of coverage. If your insurer does not agree to cover those services that your therapist and you deem to be necessary and appropriate, you and your therapist will negotiate a mutually agreeable fee.

Primary Care Physician: As a matter of routine most insurance companies request that we maintain contact with your primary care physicians to insure coordinated care. If you do not wish us to contact your physician please let us know.

Overdue payments for services - If a client's account is overdue and suitable arrangements for payment has not been agreed to, we have the option of using other means to secure payment. In most cases, the information that would be released would be the client's name, the nature of the services provided, and the amount due.

Under eighteen years of age - If you are under eighteen years of age, please be aware that while the specific content of our communication will remain confidential, your parents do have the right to receive general information on how your treatment is proceeding.

2. If Melissa Lowe, Ph.D., LMHC, determines an inability to be of professional assistance to the client, they must either avoid initiating the counseling relationship or immediately terminate that relationship. In

either event, the counselor must suggest appropriate alternatives. In the event the client declines the suggested referral, Dr. Melissa Lowe is not obligated to continue the relationship.

3. Melissa Lowe, Ph.D., LMHC will avoid any type of dual relationship with clients including intimate relationships.

4. Each client is ultimately responsible for the fees for service. The fee is $____80.00__ per session. Please be prepared to pay after each session in cash, check or through insurance. Clients using their insurance are also responsible for co-payments. In the event that your insurance dose not cover our services, your insurance is no-longer valid, you have utilized your benefit, or your insurance company retroactively demands payment from us, the client is responsible for payment.

I authorize Melissa Lowe, Ph.D., LMHC to release to all payers, whether an insurance company, Medicaid, or a state agency, the information necessary for billing for services provided to me and/or my family. Further, I authorize any and all payers to pay directly to Dr. Melissa Lowe for services.

If you are responsible for filing claims please obtain an insurance form from your agent or employer. Fill in the required personal information. Where applicable, have your employer fill in the indicated sections. Bring back this form, and our Insurance Verification form, into the office on your next visit.

5. All sessions are by appointment only. The client is responsible for appearing at each scheduled session on time. If the client cannot appear, they are responsible to contact the office to reschedule at least 48 hours before the appointment. If the client does not appear or cancels in less than 48 hours, they will be held responsible for the full fee. The client understands that a cancelled session is not covered by insurance.

6. Therapy will be terminated at a mutually agreeable time according to the client's needs. The client may terminate service at any time.

7. Sometime after your last session we may send you a client survey form to fill out and return. The survey is designed to improve the quality of our services. Further, I understand and agree to all of the aforementioned terms, restrictions and conditions.

8. _____ I have received the Melissa Lowe, Ph.D., LMHC HIPAA privacy notice. I have received a copy of the client Information pamphlet that describes my rights as a client, the limits of confidentiality, how to make a complaint, Melissa Lowe, Ph.D., LMHC payment policy, and missed appointment policy. I have heard and understand the procedure for making a formal complaint and have been given the name and phone number of my contact person.

_____
Client Name
_____/_____/_____
Date

Parent or Legal Guardian*
*Parental consent is not necessary if client is 18 years of age or older

_____
_____/_____/_____
Melissa Lowe, Ph.D., LMHC Date

Melissa Lowe, Ph.D., LMHC
797 Washington Street. Suite: 4, Newton, MA 02460 ph: 303-819-5757 fax: 617-209-7889

FACE SHEET

TODAY's DATE:_____

NAME: _____

ADDRESS: _____

SOCIAL SECURITY NUMBER:_____

D.O.B.: _____

PHONE NUMBER: _____

WORK PHONE: _____ Email: _____

EMPLOYER: _____

REFERRAL SOURCE: _____

INSURANCE: _____

ID NUMBER: _____

INSURANCE AUTHORIZATION NUMBER:_____

NUMBER OF VISITS:_____

Insurance phone number_____

Name of insured, address, phone, DOB_____

_____

OTHER INVOLVED AGENCIES/PROVIDERS (if not applicable, N/A):

_____
_____
_____
_____
_____
_____

OTHER INFORMATION:

RELEASE AND REQUEST FOR MEDICAL INFORMATION

Date: ___/___/___

Dear Dr. _____(Client's PCP)
Regarding: _____(Client's Name) DOB: ___/___/___

I had the pleasure of seeing your patient at our clinic today for mental health assessment. The results of the visits are:

Diagnosis: _____

Proposed treatment:
_____

We would appreciate your attention in forwarding results of his/her latest physical exam and or most recent office note for our records. If you have any additional information or concerns regarding this patient, please feel free to contact me.

Sincerely,

_____
Clinician's Name

The signature below acknowledges my consent to the release/exchange of information between Melissa Lowe, Ph.D., LMHC and my Primary care Physician. I understand that I may revoke this consent in writing at any time, except where information has already been released. Unless otherwise revoked, this authorization will expire open termination of this episode of behavioral health treatment or termination with your current primary care physician, whichever occurs first. The primary care physician is hereby notified that any information disclosed to him or her pursuant to this release and Request for medical information is protected by state and federal laws and may not be disclosed without expressed written authorization.

_____	_____	___/___/___
Physician's name	Patient/Guardian/Parent signature	Date
_____	_____	___/___/___
Address:	Witness Signature	Date

I refuse to allow release/exchange of information between Melissa Lowe, Ph.D., LMHC and my Primary Care Physician.

_____	_____
Patient Signature	Witness Signature

Copied and sent to PCP on ___/___/___

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