INFORMED CONSENT

Thank you for choosing Jodi Taub, LCSW. Today's appointment will take approximately 45 to 60 minutes, depending on the time spent verifying the initial documents prior to the session. Subsequent sessions are scheduled for 45 minutes. I realize that starting therapy is a major decision and you may have some questions. This document is intended to inform you of my policies, State and Federal Laws, and your subsequent rights. If you have other questions or concerns, please feel free to ask during the time of your session.

I, Jodi Taub, LCSW, have earned a Bachelor of Arts Degree in Psychology from Indiana University. I obtained a Master's Degree in Clinical Social Work and a Post Master's Degree in School Social Work from Loyola University of Chicago. I am licensed by the State of New York as a Licensed Clinical Social Worker. I have over 17 years of clinical experience in treating children, adolescents, adults and families. I utilize various treatment modalities with a focus on cognitive-behavioral therapy for most conditions, although other treatment approaches are used depending on the person or condition. Treatment practices, philosophy and plan limitations and risks will be discussed with you today.

CONFIDENTIALITY AND EMERGENCY SITUATIONS: *Your verbal communication and clinical records are strictly confidential except for: a) information shared with your psychiatrist or psychiatric nurse practitioner, b) information (diagnosis and dates of service) shared with your insurance company to process your claims, c) information you and/or you child or children report about physical or sexual abuse; then, by New York State Law, I am obligated to report this to the Department of Children and Family Services, d) where you sign a release of information to have specific information shared and e) if you provide information that informs me that you are in danger of harming yourself or others f) information necessary for case supervision or consultation and h) or when required by law. If an emergency situation for which the client or their guardian feels immediate attention is necessary, the client or guardian understands that they are to contact the emergency services in the community (911) for those services. Jodi Taub, LCSW. will coordinate with those emergency services and provide standard therapy and support to the client or the client's family.*

Signature(s)_____Date:_____

FINANCIAL/INSURANCE ISSUES: *I ask that at each session you pay 100% of the fee. I am an Out of Network Provider, which means that I do not bill or accept insurance payments. The patient is solely responsible to manage insurance benefits. I will provide the appropriate receipts for reimbursement. However, it is the patient's responsibility to coordinate and request payments*

from the insurance carriers. I have the right to deny services in the event that a session is not paid. In the event you have not met your deductible, the full fee is due at each session until the deductible is satisfied. If your insurance company denies payment, you are still responsible for your payment in full. I ask that you pay for services when rendered. After 60 days any unpaid balance will be charged 1.5% interest a month (18% APR). In the event that an account is overdue and turned over to my collection agency, the client or responsible party will be held responsible for any collection fee charged to our office to collect the debt owed. I ask that every client authorize payment of medical benefits directly to Jodi Taub, LCSW.

I have received a copy of my fee schedule _____

*Lastly, if you need to cancel or reschedule an appointment, please give **48** business hours advance notice, otherwise you will be billed at the hourly rate. However, I do ask that you attempt to keep cancellations to a minimum. If cancellations occur more than 3 times within the calendar year, this therapist has the right to terminate services.*

Signature(s)_____***Date***_____

COORDINATION OF TREAMENT: *It is important that all health care providers work together. As such, we would like your permission to communicate with your primary care physician and/or psychiatrist. Your consent is valid for one year.* Please understand that you have the right to revoke this authorization, in writing, at any time by sending notice. However, a revocation is not valid to the extent that we have acted in reliance on such authorization. *If you prefer to decline consent no inform will be shared.*

____**You may inform my physician(s)** ____**I decline to inform my physician**

PHYSICIAN NAME:_____
CLINIC:_____
ADDRESS:_____
PHONE:_____

Signature(s)_____***Date***_____

CONSENT FOR TREATMENT OF CHILDREN OR ADOLESCENTS:

I/We consent that _____ *maybe treated as a client by Jodi Taub, LCSW. At times it maybe necessary to schedule appointments during school hours. We ask for your cooperation to provide the most timely treatment for you and your children.*

Signature(s)_____***Date***_____

Email/Texting/Social Networking: *In today's highly online dependent society, it important to discuss my policy in terms of online communication. These policies reflect current licensure expectations, and current expert field translation of HIPPA laws.*

It is an ethical policy that I will decline a personal connection on Facebook in my personal domain. If you choose to request a membership to any social networking forum, please note that I will have to decline, with the exception of LinkedIn, which is a professional site.

As is written, understood, and interpreted my current state and national professional regulations under my licensure and under HIPPA standards, the use of email and texting can only be used for scheduling purposes only. I will not be able to provide a written response to either texting or email relating to any emotional issues, current life events, and or concerns. Although, I do check my email and phone texts on a regular basis, please note that there may be a response delay, which is inherent to any/or, all Internet or texting communication.

Please note that, at certain times, some patients' names have been searched under various search engines. The purpose of this venture may be to seek additional biographical information, an attempt to contact a patient, and safety concerns regarding a patient's background.

Please consent that if you do use text, email, or Skype that you recognize that these may not be secure forms of communication. Please note that Skype may not be reimbursed by your insurance company.

Please sign and confirm that you agree and understood the above stated policies.

Signature(s)_____***Date***_____