CONSENT FOR TREATMENT AND EVALUATION

I do hereby seek and consent to take part in treatment and/or a psychological evaluation with Dr. Sylvia Kalicinski-Don, Ph.D, licensed marriage and family therapist MT 2876. I understand that attending scheduled therapy sessions, developing a treatment plan with this clinician, and regularly reviewing our work toward meeting the treatment goals, are in my best interest. I understand that I agree to consent to therapy services and will play an active role in this process. I understand that no promises have been made to me as to results of treatment, evaluation of or any procedures provided by this clinician, as treatment benefits, while likely, cannot be guaranteed. I have the right to inquire fully about the credentials, education, and experience of Dr. Sylvia Kalicinski-Don and to have my questions answered to my satisfaction.

I am aware that I might discontinue services with Dr. Sylvia Kalicinski-Don at any time. My only obligation will be to pay all outstanding fee for the services I have already received. I understand that under certain circumstances I may lose other services or may face other consequences, if I stop treatment. I understand that if payment for the services I receive here is not made, the clinician may stop my treatment.

Please find below a detailed explanation from Dr. Sylvia Kalicinski-Don, Ph.D., about her Office Policies and Procedures. Please review them carefully.

INITIAL CONSULTATION

Our first one to three sessions will be utilized toward conducting a thorough psychological assessment, screening, evaluation, and establishment of therapeutic treatment goals. This assessment focuses on determining the best treatment plan possible and is specific to each individual client. It is extremely important for this initial assessment to be as comprehensive as possible. Therefore, please bring completed patient forms (under 'Client Forms' section of website) to this appointment and make sure to provide information about previous providers and any past or current psychiatric treatment. Please remember that a comprehensive assessment is necessary as it allows me to provide the best possible care. Additionally, we will mutually determine if I am the best fit for your individualized care. If we decide to not work together, I am happy to provide alternate referrals to other providers in the mental health field. Please note, however, that although I attempt to identify top quality professionals with very high standards of care, I cannot be responsible for the services/treatment that they provide.

PSYCHOTHERAPY

Often called 'talk therapy', this form of treatment can be helpful to individuals, couples, and families. Benefits can include significant stress reduction, improved relationships, resolution of specific problems, and improved insight. However, therapy is not guaranteed to work for everybody and can be a large financial commitment as well as requiring a significant amount of time and energy. Moreover, psychotherapy may also require exploring unpleasant aspects of your life and can, at times, lead to feelings of distress (i.e., guilt, anxiety, frustration, etc.). These unpleasant aspects are generally temporary but are extremely important to discuss when

present. Always remember that anything can be discussed in therapy. Thus, it is important to let me know if you feel that your goals aren't being met. These issues can be addressed in session.

IF YOU ARE PROVIDED PSYCHOTHERAPY BY ANOTHER PROFESSIONAL AT THE SAME TIME
Many non-licensed and licensed mental health professionals provide psychotherapy. I assume no responsibility for psychotherapy provided elsewhere.

SESSION DURATION and PROFESSIONAL FEES
Initial Assessment and screening (90 minutes) is $270.00

Individual psychotherapy (50-minute session) is $150.00

Couples Counseling (50-minute session) is $175.00

Family Therapy (75- minute session) is $200.00

Additionally, other professional services that require longer than 10 minutes of time are billed at $50 per 15-minute increment. This includes report writing, telephone conversations, and preparation of treatment summaries.

Fees may be subject to change over time and will be reviewed on a yearly basis.

BILLING AND PAYMENTS
You are expected to pay for each session at the beginning of each appointment.
I accept checks, cash, and credit cards (MasterCard, Visa, American Express, or Discover) for all professional services.
A $25 fee is charged for all returned checks.

INSURANCE REIMBURSEMENT
I am not a part of any insurance panels. As such, I am considered "out of network" for most PPO plans. If you have a health benefits policy that provides mental health coverage, you may be entitled to insurance reimbursement for any provided professional services. You can discuss this with your insurance company by contacting them directly. Regardless of insurance reimbursement, full payment for all services at my office is required at the time of each appointment. I can provide you with a service invoice/receipt (sometimes referred to as a super bill) that you can submit to your insurance company. I do not bill your insurance company directly. Please also note that if reimbursement is pursued by you, most insurance agreements require you to authorize me to provide clinical information directly to them. This can include

a clinical diagnosis, historical information, treatment plans or summaries, and sometimes a copy of your chart records. In such cases, this information will become a part of the insurance company files and can be used by them to consider future insurability.

CANCELLATIONS AND NO-SHOW POLICY

Once your appointment is scheduled, you will be expected to pay the full professional fee unless you provide at least 48 hours (2 business days) advance notice of cancellation. Both telephone and email are acceptable ways to alert me of a cancellation.
Please remember that business hours are considered weekdays from 8 a.m. to 6 p.m. Monday through Friday and exclude all standard holidays.

CONTACTING ME

I always attempt to be accessible for all urgent issues. I am typically not immediately available by telephone. Please leave a voice message and I will return your call as soon as possible. Calls are generally returned within 1 business day. Please always leave a phone number where you can be best reached. If your call is an emergency, please contact 911 immediately instead of calling the office. Emergency psychiatric services are provided by all hospitals through their emergency rooms and do not require appointments. Emergency room physicians can contact me at any time so please provide them with my contact information.

If I am unavailable for extended periods of time (i.e., vacation, conferences, etc.), I can provide you with the name of a trusted colleague for coverage, if needed and contact information will be provided on the office voicemail. Please also note that email should never be used for urgent or emergency issues. This is not a confidential means of communication and we cannot ensure that email messages will be received or responded to in a timely fashion.

ELECTRONIC MAIL (EMAIL)

Always be aware that email is not a confidential means of communication. We cannot guarantee that email messages will be received or responded to in a timely fashion. As such, email is not an appropriate way to communicate confidential or urgent information. The content of any e-mail should be limited to non-urgent matters such as scheduling of appointments, directions or similar issues.

PROFESSIONAL RECORDS

Both law and professional standards protect mental health records. Although you are entitled to review and/or receive a copy, these records can be misinterpreted given their professional nature. In rare cases when it is deemed potentially damaging to provide you with the full records directly, they are available to an appropriate mental health professional of your choice. Alternatively, we can review them together and/or treatment summaries can be provided. Please note that professional fees will be charged for any preparation time required to comply with such requests.

LEGAL TESTIMONY

Legal matters requiring the testimony of a mental health professional can arise. This, however, can be damaging to the relationship between a patient and his/her clinician. As such, I generally recommend that you hire an independent forensic mental health professional for such services.

I am aware that the procedures utilized for selecting and implementing therapeutic interventions; and maintaining my privacy will be carried out in accord with the rules and guidelines of the American Association for Marriage and Family Therapy and other professional organizations. All interventions and assessment measures that are chosen will be suitable for the purposes described above (in psychological terms, their reliability and validity for these purposes and population have been established in relevant scientific and psychological research). All service-related documents, psychological assessments, treatment plans, and results will be kept in a secure place.

Historically, mental health services have been associated with absolute confidentiality between the family and clinician. Currently, Federal and Florida laws and regulations and professional ethics require clinicians to maintain complete confidentiality of information and communications revealed in the course of treatment. In these cases, the clinician cannot release any information about my family without my expressed and informed permission. There are some exceptional circumstances where clinicians are required or permitted to communicate information about mental health services to persons outside the family. I am aware that an agent of my insurance company, billing service or other third-party payer may be given information about the type(s), cost(s), date(s), and providers of any services or treatments I receive. Other exceptions include the following situations:

- The client presents a clear and present danger to himself or herself and refuses to accept appropriate treatment.
- The client communicates to the clinician an imminent threat of physical violence against a clearly identified or reasonably identifiable victim, or the clinician has a reasonable basis to believe there is a clear and present danger of physical violence against such a victim.
- The client introduces his or her mental condition as a defense in a legal proceeding.
- In child custody or adoption cases, the judge determines that the clinician has information bearing significantly on the client's ability to provide suitable care or custody and this information bears significantly on the welfare of the child.
- The client initiates legal action against the clinician, and client information is necessary or relevant to the clinician's defense.
- The clinician has grounds to believe a child under the age of 18, an elderly person (over age 60), or a handicapped adult, has been or is at risk of being abused or neglected.
- A Judge orders a clinician to release client information.

With a properly signed Release of Information, I understand that Treatment Summary letters may be provided in lieu of releasing the complete psychological records to a requesting party.

I have discussed responsibility for payment for treatment and I assume financial responsibility for myself and/or my family members for all psychological services rendered; including psychotherapy, psychological assessments, and other psychological services including mindfulness-based interventions.

If an emergency arises after working hours and in the event that I cannot contact Dr. Sylvia Kalicinski-Don, I will call 911 or go to the nearest emergency room if I believe I am a danger to myself or others or my child may be a danger to him/herself or others.

My signature below shows that I have read, understand and agree with all of the statements within this Consent for Treatment. A photocopy of this agreement will be considered valid as an original.

X_____

Signature of Client Date :_____

Signature of Parent or Guardian Date:_____

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My signature below shows that I have received the Notice of Privacy Practices regarding the use and disclosure of my Protected Health Information from Dr. Sylvia Kalicinski-Don, and that I consent to the use and disclosure of my Protected Health Information for the purposes of Treatment, Payment, and Health Care Operation on this date:_____

X_____

Signature of Client/Parent or Guardian Date:_____

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