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Stephen M. Szopa, LCSW
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Welcome. I look forward to us working together. These are my office policies, privacy statement and some answers to frequently asked questions:

1. If we are meeting as a couple or a family, sessions are 1 hour and 15 minutes in length. In most cases, we can meet at the same time on the same day each week, if that is helpful to you.

2. My fee is $250.00 per session. Please pay the full session fee at the time of service. There will be a charge of $50.00 per 15 minutes spent on the telephone discussing clinical matters. There is no charge for discussion of administrative matters such as scheduling and billing concerns. If there is a charge for report-writing or letter-writing, I will inform you in advance. Payment may be made by check, credit card, or cash.

3. Please note that you are responsible for any unpaid balances on your account. If you are two or more payments behind and have not discussed possible solutions with me, I may recommend that we discontinue our meetings until the balance is paid in full. In the unlikely event that we cannot resolve balances owed to me, I may use a collection agency to collect the unpaid balances.

4. Your treatment is confidential. I will not disclose your attendance or any clinical information unless:

a. You release me (usually in writing) to speak or write to someone about your treatment
b. You become a danger to yourself or others - examples: suicide intent with a plan of action; abuse of children, elderly or incapacitated adults; plan or intent to do harm to someone
c. You work in a healthcare field and your actions or omissions endanger clients under your care.

If you initiate a civil lawsuit against someone and your treatment notes are needed, the opposing council may have the right to see your notes. There are also times in which criminal proceedings may require my releasing details about your treatment.

I participate in a Peer Consultation group in which I might discuss your situation with other mental health professionals without using your name or any other identifying data. If you do not want me to discuss your situation, even anonymously, please let me know and check here. ⌂

If you have any questions or complaints about the confidentiality of your treatment, please let me know so that I can assist you. Please note that I transmit medical information electronically, usually at your request. Transmissions by fax, cell phone and email can be intercepted by people who are not the intended recipient. I also access faxes and voice mail online. Please let me know if you do not want me to use these methods to communicate with you.

5. Please let me know of any planned cancellations or the need to reschedule one week in advance when possible. If a situation arises in which you do not give more than 24 hours notice of nonattendance, you will be billed a cancellation fee of $250.00. If you are ill or in an emergency situation, please call me as soon as possible so we can discuss options.

6. Please let me know if you have any questions about the progress of therapy or questions about when it is time to end therapy. The best decisions are the ones we make together.

7. I can usually be reached in an emergency between 9:00 AM and 9:00 PM seven days a week. If you have an emergency during these hours that involves suicide, homicide or any other life-threatening situation, you should page me by calling (703) 550-4178. Please leave a leave a message as to the nature of your emergency, include your telephone number, and then press "94" before hanging up.

If you do not receive a return call within 10 minutes, please call CrisisLink, a free service that provides support and recommendations, at 703-527- 4077. If you are away from the DC Metropolitan Area, you can telephone 1-800-273-TALK (8255). Between 9:00 PM to 9:00 AM, please call CrisisLink directly. Messages about any other matters should be left on my confidential voice mail: (703) 550-4178. Please do <u>not</u> use email for any urgent or emergency communication.

Consent (please initial**):**

___ I authorize Stephen M. Szopa, LCSW to provide me (or the person for whom I am responsible) with verbal Psychotherapy, Counseling and/or Personal Coaching Services.

___ I have read and understand these office policies and HIPAA privacy procedures and intend to abide by them.

_____

Signature Date

_____

Signature Date