BTR Psychotherapy

BTR PSYCHOTHERAPY
Gideon King House
35 King Street, Suite 7
Burlington, VT. 05401

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, Alexander Roodman, have received a copy of this office's
(patient name)
Notice of Privacy Practices.

Alexander Roodman
Print Name

Alexander Roodman
Signature

7-14-22
Date

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

___Individual refused to sign

___An emergency situation prevented us from obtaining acknowledgement

___Other (please specify)

_____

_____

_____

BTR Psychotherapy

Gideon King House
35 King Street, Suite 7
Burlington, VT 05401

Lyn Taylor Hale, MS, LCMHC
lthale@btrpsychotherpay.com
802-999-1283

INFORMED CONSENT STATEMENT
(BTR Psychotherapy is an Affiliation of Independent Practitioners)

NAME: Alexander Roodman **DATE:** 7-14-22

My signature below indicates that I have read and reviewed the contents of this statement with Ms. Lyn Taylor Hale and consent to its provisions.

1. All services are strictly confidential, however, exceptions to this do exist. I have been informed of certain exceptions under which Ms. Taylor Hale may breach that confidence, such as known or suspected abuse or neglect of a child, an elderly person or a disabled person, imminent and potentially lethal suicide threats, imminent intentions of homicide or bodily harm to others. Also, records under court order must be released to the court even without consent to the client. Also, information needed to process insurance claims limit confidentiality.

2. I understand that my participation in therapy with Ms. Taylor Hale, or the participation of my child or ward, is completely voluntary, and that I may terminate treatment at any time.

3. I understand that although many people benefit from psychotherapy, a positive outcome in psychotherapy cannot be guaranteed.

4. I understand that a clinical record will be kept in my name (or in my child's or ward's name), into which will be placed any pertinent materials submitted by me or others (i.e. schools, attorneys, other professionals, etc.). I understand that Ms. Taylor Hale will include in this record an initial evaluation, summaries of each of our meetings, which include ongoing assessment, notes detailing telephone contacts, and copies of any insurance correspondence. I also understand that my record may, under certain circumstances, be subpoenaed or court-ordered must be released. I understand furthermore that my insurance company may have the legal right to request access to my record. Ms. Taylor Hale has explained to me that she will make a reasonable attempt to inform me of any legal efforts to access my record. I acknowledge as well that, in collaboration with Ms. Taylor Hale, I may review my record (or that of my child or ward) upon request within a reasonable time frame and that such a review will occur within a scheduled appointment session. While every effort will be made to protect my privacy, should I choose to communicate with Ms. Taylor Hale via email or text messaging, confidentiality cannot be guaranteed.

5. I understand that I may at any time question or decline any therapeutic course or activity proposed by Ms. Taylor Hale. I also understand that I may ask at any time for clarification or elaboration about any treatment.

6. I understand that the signature of all persons who have reached the age of consent who have ever been present at any of my own or my child's therapy sessions will be required in the event that I should wish the record to be released. I further understand that if all who have ever attended do not agree to release the record, that the record will not be released.

7. Unless otherwise indicated, sessions are **50-minutes** in length.

8. I have been given a copy of this statement for my own records.

My signature below is my consent to treatment for myself and/or my child or ward.

Signature Alexander Roodman Date 14 July 2022

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PAYMENT AND INSURANCE INFORMATION

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Payment:
My rate is $150 per full session for individual, couples or family therapy. Payment may be made by check, cash or credit/debit card at the time of each session or monthly in advance. My group therapy rate is generally half of my hourly rate but is also determined by duration of the group and the number of people in the group. Each individual, couples or family session lasts 50 minutes.

Insurance:
Since I choose not to be paneled with insurance companies, payment is solely your responsibility and is not based on whether the insurance company reimburses for your sessions.

If you are interested in submitting claims to your insurance company, I recommend that you call your mental health insurance company to determine your benefits. Sometimes this is a different company than your medical insurance. Check the back of your insurance card and call the number that applies to mental health. You will need to tell them that you are interested in seeing an out-of-network Master's level clinician for outpatient mental health services. They can tell you what your coverage is and how to submit claims.

Let me know if you will be submitting your statement to the insurance company so I can be sure to include the necessary information. Insurance companies require a diagnosis and treatment code in order to process claims. They may also require treatment reviews and/or request additional clinical information.

Any administrative work I need to perform on your behalf is billed on prorated basis of my current hourly rate. This includes reports, letters, and telephone calls to contact other practitioners and insurance companies on your behalf.

Appointment Cancellations and Appointments Missed without Prior Notice:
Because counseling is most effective with regular attendance, because other clients are waiting for needed service, and because my source of income depends on seeing a regular schedule of clients, consistent attendance at sessions is important. In the event that you are sick or unable to be present at your session, it is helpful to provide a 24 hour notice of cancellation. Appointments not cancelled with 24 hours notice MAY be billed at my full rate of $150/session. No call/No show appointments **will** be billed $150/session. Please note that insurance will not reimburse for missed appointments. You may utilize voice mail or text (802-999-1283) 24 hours a day to leave a message of the necessity to cancel. Repeatedly not attending scheduled sessions will result in termination of therapy.

David Roodman	Dan Roodman	7/14/22
Print Name	**Signature**	**Date**

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AUTHORIZATION FOR PAYMENT PROCESSING

NAME: David Roodman DATE: 7-14-22

My signature below indicates that I have read and reviewed the contents of this statement and consent to its provisions.

- I authorize Lyn Taylor Hale, MS, LCMHC to charge the credit/debit account indicated below at the rate of $150.00 per therapeutic session hour.
  - For Alexander Roodman (client name)

Processed transactions may appear signed as "agreement"

*no shows and cancellations with less than 48 hours' notice may be billed at a rate of $150.00

Name on Card	David Roodman
Card Number	5424 1815 2281 5492
Expiration Date	July 2025
CSC	883
Zip Code	20002

Individual receipts of transaction and a monthly bill statement will be provided and sent via email indicated

Email Address	droodman@gmail.com

Signature David Roodman Date 7/14/22

BR Psychotherapy

Mai Pherr ~~David Roodman~~ | | 7/14/22

Print Parent/Guardian Name | Signature | Date

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Alexander Redman	Alexander Redman	20 July 2022
Print Name	**Signature**	**Date**

Print Parent/Guardian Name	**Signature**	**Date**

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