

## **Informed Consent**

Welcome to New Reflection's Clinical Services. I would like you to have a clear understanding of the services that I provide and my expectations of you, my client. Please read the following information so that you can knowledgeably sign the Informed Consent. If you have any questions or need clarification, please ask for assistance.

### **Services Offered**

New Reflection's Clinical Services provides outpatient counseling. I work with all age groups, providing individual, group, couple, family and interventions. Psychiatrist services can be arranged through a referral. Sessions are 50 minutes in length. Telephone consultations are also available.

I strive to return all messages as quickly as possible Monday through Saturday. Routine messages left on the weekend may be returned on Monday. I do not guarantee 24 hour crisis coverage and if I am not available when you feel you are in crisis, please call the DuPage Crisis line at 630-627-1700, proceed to your local hospital emergency room, or call 911.

### **Initial Assessment and Counseling Process**

Initial assessments take place at the first appointment. These appointments are used to gather data, complete intake information, and to determine the best course of care. If on going counseling is recommended, I will diligently work to provide the best therapeutic methods and tools available. For counseling to be successful, your commitment to the process is absolutely essential. This includes regular attendance and active participation, assignments between sessions to enhance or speed your growth, and completion of the therapeutic process through planned termination of counseling services.

You may begin to find some relief of symptoms initially, and it may be tempting to terminate. However, this initial relief is often temporary if counseling is stopped abruptly. As all therapists want to see clients have the greatest growth possible during the time they are with them, I will work with you to plan a successful wrap-up. This is an important part of the counseling process, and I highly encourage you to honor your own effort by not neglecting this phase.

### **Fees**

Individual, family, couples and interventions are \$100. per session. Group therapy is \$50. per session. Home interventions are \$120. per session. If you are paying out of pocket, there is a 20% discount. I am also able to do a sliding scale, given the situation. Telephone consultation less than 10 minutes is complimentary if not overused. Phone consultation 11-30 minutes is billed at \$25. Insurance companies will not cover these fees.

If a check is returned for insufficient funds, the client is responsible for any bank fees assessed, and an alternate method of payment is required.

**Insurance**

I will bill most insurance companies' as a courtesy to you. If I am not able to work with your insurance company, I will request payment in full and provide you the necessary information to submit your claim. **The first session must be paid in full until benefits, deductibles, and co-pays are verified by your insurance company.** If benefits have already been verified, you will find this information on the attached **Benefits Inquiry sheet.**

**Cancelled or Missed Appointments**

Due to the nature of counseling services, I do not overbook my schedule: therefore I request a **24-hour notification of cancellation** so that others may utilize that time. I also realize financial accountability enhances your commitment to your counseling work. As a result, charge your insurance company and a \$60.00 fee for those paying out of pocket, If I do not receive this notice. Insurance companies will not cover missed appointments. Full payment for the missed session is due within one week. Please note that 2 or more instances of missed appointments without notifying me may result in termination of services.

**Confidentiality**

Legal and ethical standards require me to maintain confidentiality. Information cannot be divulged without your written consent. There are two major exceptions: if you are or become a danger to yourself or others. In addition, I am mandated by the State of Illinois to report any real or alleged abuse to children, elderly, or incapacitated people.

**Agreement**

I have read and understand the above statement on services, policies, and procedures. My signature below indicates that I give my full consent to receive services at:

*New Reflection's Clinical Services*  
*francoise mastroianni ms.,lcpc.,cadc.,ceda.,ccsas.*

Client (age 17 and over)----- Date-----

Client (age 12-16)----- Date-----

Client (under age 12)----- Date-----

Client guardian (for minors)----- Date-----