JULIETTE-MARIE DE SOUSA, MA, MSW, LICSW

PSYCHOTHERAPIST
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INFORMED CONSENT AGREEMENT FOR PSYCHOTHERAPY SERVICES

Welcome, I look forward to working with you. This document contains important information about my professional services and business policies. Please read this document carefully and ask me about anything you do not fully understand. This agreement also contains summary information about the Health Insurance Portability and Accountability Act (HIPAA), a federal law that provides privacy protections and client rights with regard to the use and disclosure of your Protected Health Information (PHI) used for the purpose of treatment, payment, and health care operations. HIPAA requires that I provide you with this Notice of Privacy Practices (the Notice) for use and disclosure of PHI for treatment, payment, and health care operations. The Notice explains HIPAA and its application to your personal health information in greater detail. The law requires that I obtain your signature acknowledging that I have provided you with this information by the end of the first session. Although these documents are long and sometimes complex, it is very important that you read them carefully. Again, we can discuss any questions you have about the procedures.

When you sign this document, it will represent an agreement between us. You may revoke this agreement in writing at any time. That revocation will be binding on me unless I have taken action in reliance on it; if there are obligations imposed on me by your health insurer in order to process or substantiate claims made under your policy; or if you have not satisfied any financial obligations you have incurred.

BENEFITS AND EMOTIONAL RISKS OF PSYCHOTHERAPY

The majority of people who participate in therapy benefit from the process. The therapeutic process is generally quite helpful, but some risks do exist. Risks include sometimes experiencing uncomfortable feelings such as sadness, anger, guilt, or frustration. Also, psychotherapy often involves discussing unpleasant aspects of your life. However, most people find that therapy ultimately leads to a significant reduction in feelings of distress, better relationships, and resolutions of specific problems. Still, there are no guarantees about what will happen in any one individual's therapeutic process. How long you remain in therapy is a matter best discussed and decided upon by us together within the context of the accomplishment of your goals. While it is your right to end therapy when you decide that termination is in your best interest, ending therapy is an important part of the treatment process and is most productive when discussed in the context of your therapy. I will usually request a minimum of one wrap-up session after you have decided to terminate treatment to bring your therapy to an appropriate closure. I will remain willing to discuss your thoughts about terminating therapy with you during any session. As therapy progresses, I strongly encourage you to raise any questions you have about treatment goals, procedures, or your impression of the services you are receiving.

CONTACTING ME

I am not immediately available by telephone because I do not answer my telephone if I am working with a client. When I am unavailable, the telephone will be answered by confidential voicemail. I will return calls as soon as possible, usually within one business day. Outside of serious emergencies, I will often return evening and weekend calls on the next business day. You may also contact me via e-mail at juliette.marie.desousa@gmail.com, but since e-mail is not a confidential method of communication,

any information you send by e-mail cannot be guaranteed as confidential. Therefore, I ask that you limit email communications to routine business matters. If you need to contact me about any time-sensitive matter, such as a late arrival, any cancelation of sessions, or an urgent mental health matter, or if I have not promptly responded to an e-mail, please contact me by text at (202) 421-7643.

LICENSURE

I am a Licensed Independent Clinical Social Worker (LICSW; License Number: LC200003139) in the District of Columbia. I hold a bachelor's degree in International Relations from Georgetown University, a master's degree in Psychology from Catholic University, and a master's degree in Social Work from the University of Southern California.

EMERGENCIES

As I do not provide after-hours availability, in cases of a life-threatening emergency or psychiatric emergency (such as serious suicidal or homicidal feelings or an attempt), please call 911 or the suicide hotline at 988 or go to the nearest hospital emergency room. DC has a Crisis Line (202) 561-7000. Virginia and Maryland also maintain mental health crisis centers: (240) 777-4000 in Montgomery County and (703) 573-0523 in Fairfax County.

OTHER THERAPISTS AND DOCTORS

It is often very helpful to know all other clinicians and doctors who are caring for you. If another clinician has referred you or if you are working with another clinician for medication management, that clinician and I may need to have contact to coordinate treatment. I will ask you to sign a release of information form, allowing us to communicate. Similarly, if you have had significant therapeutic treatment in the past or currently have a significant medical condition that affects your cognitive functioning or emotional wellbeing, contact with those treating clinicians may also be requested.

CONFIDENTIALITY

The ethics codes of the National Association of Social Work, state and DC laws, and the federal HIPAA all protect the privacy of all communications between client and therapist. In most situations, I can only release information about your treatment to others if you sign a written authorization. This authorization will remain in effect for a length of time you determine. You may revoke the authorization at any time, unless I have taken action in reliance on it.

However, there are some disclosures that *do not* require your authorization, as follows:

● If you have an unpaid balance, and when given notification that you must make arrangements to pay the balance you do not contact me to make such arrangements, I may submit the information necessary to a collection agency to collect unpaid fees.

● I may periodically consult with other mental health professionals in order to provide you with optimum care. In these cases, I will not share your name or identifying information about you. These professionals must also abide by confidentiality and ethics laws. There are some situations in which I am legally obligated to take actions in order to attempt to protect you or other individuals from harm, and I may have to reveal some information about a client's treatment, specifically:

● If I know or have reason to suspect that a child has been or is in immediate danger of being a mentally or physically abused or neglected child, the law requires that I file a report with the appropriate governmental agency, usually the Child Protective Services Division of the Department of Human Services. Once such a report is filed, I may be required to provide additional information.

● If I have substantial cause to believe that a vulnerable adult is in need of protective services because of abuse, neglect or exploitation, even if by someone other than my client, the law requires that I file a report with the appropriate governmental agency, usually the Department of Human Services. Once such a report is filed, I may be required to provide additional information.

● In an emergency, if I believe that a client presents a substantial risk of imminent and serious injury to him/herself, I may be required to take protective actions, including notifying individuals who can protect the client and/or initiating emergency hospitalization.

● If I believe that a client presents a substantial risk of imminent and serious injury to another individual, I may be required to take protective actions. These actions may include notifying the potential victim, contacting the police, or seeking hospitalization for the client. If such a situation arises, I will make every effort to fully discuss it with you before taking any action and I will limit my disclosure to what is necessary, unless discussing it with you would jeopardize my or another person's safety.

In all other situations, I will ask you for an advance authorization before disclosing any information about you. While this written summary of exceptions to confidentiality should prove helpful in informing you about potential problems, it is important that we discuss any questions or concerns that you may have now or in the future. The laws governing confidentiality can be quite complex, and I am not an attorney. In situations where specific advice is required, formal legal advice may be needed.

If we see each other in public, I will follow your lead. It is your right and prerogative to acknowledge or not acknowledge we know each other. You should do whatever feels comfortable to you.

CONFIDENTIALITY & TECHNOLOGY

Some clients may choose to use technology in their counseling sessions. This includes but is not limited to online counseling via telephone, email, or text. It is important to be aware that these modes of communication can be relatively easily accessed by unauthorized people and hence can compromise the privacy and confidentiality of such communication. These modes of communication are not considered HIPPA compliant forms of communication. If you communicate confidential or private information via email, texts, fax or phone it assumes that you have made an informed decision and will be seen as your agreement to take the risk associated with such communication.

CONFIDENTIALITY & GROUP THERAPY

The nature of group counseling makes it difficult to maintain confidentiality. If you choose to participate in group therapy, be aware that your counselor cannot guarantee that other group members will maintain your confidentiality. However, your counselor will make every effort to maintain your confidentiality by reminding group members frequently of the importance of keeping what is said in the group confidential. Your counselor also has the right to remove any group member from the group should she discover that a group member has violated the confidentiality rule.

SOCIAL MEDIA POLICIES

I do not accept friend or contact requests from current or former clients on any social networking site (Facebook, Instagram, LinkedIn, etc.). I believe that adding clients as friends or contacts on these sites can compromise your confidentiality and our respective privacy. It may also blur the boundaries of our therapeutic relationship. If you have questions about this, please bring them up when we meet and we can talk more about it.

Interacting: Please do not use messaging on social networking sites such as X (Twitter), Facebook, or LinkedIn to contact me. These sites are not secure and I may not read these messages in a timely manner. Please do not use wall postings, @replies, or other means of engaging with me in public online if we have already established a therapeutic relationship. Engaging in this way could compromise your confidentiality.

Internet Searches: While my present or potential clients might conduct online searches about my practice and/or me, I do not search my clients with Google, Facebook, or other search engines unless there is a clinical need to do so, as in the case of a crisis or to assure your physical wellbeing. If clients ask me to conduct such searches or review their websites or profiles and I deem that it might be helpful, I will consider it on a case-by-case basis and only after discussing possible impacts to our professional relationship and your privacy.

MINORS

If you are under 18 years of age but over 14 and your parents have consented to treatment, you should be aware that District of Columbia law states that your parents can only review your records with your consent. If you agree, and sign a release of information form stating so, I will provide them with general information about the progress of treatment and attendance. The exception to this confidentiality is if I feel there is a high risk that you will seriously harm yourself or someone else. In this case, I will notify your parents of my concern. Before giving them any information, I will discuss the matter with you, if possible, and do my best to respond to any objections you may have regarding what I am prepared to discuss. Parents may also contact me about any matters of particular concern that have arisen, and I will usually address these in therapy. However, parents should be aware that therapy is not effective if the content of what is discussed with the teen is regularly shared with the parent. Therefore, while I may regularly update the parent about general progress of the treatment, and may request parent meetings from time to time, the content of what is disclosed will be discussed with teenagers ahead of the meeting, and the general themes of the meeting with the parent will be discussed afterwards, in order to provide a safe and confidential space for the teen. Parents can be assured that whenever a teen's safety or life may be in jeopardy, I will discuss these issues with the parent promptly and will alert the teen that I plan to do so. However, experimentation with risky behaviors is common in adolescents and may not always be disclosed, as addressing these behaviors may be part of the work of the treatment. By your signature below you agree to allow me to exercise my best professional judgment in disclosing information about treatment.

Please be aware that in cases where separation or divorce has occurred or is in process, the signatures and consent of BOTH parents are required for treatment when Joint Legal Custody is in place, regardless of which parent has physical custody of the child. Also please note that utilizing therapy to support custody petitions is generally not in the best interest of the parent or child, and I am not a qualified expert in custody evaluations.

COURT APPEARANCES

I do not provide information for attorneys, the courts, or for any forensic purposes. I do not participate in any court cases nor do I testify for any purpose.

PROFESSIONAL RECORDS

In conformance with HIPAA, I may keep Protected Health Information, or notes, about you in your file. I, also, may not keep notes based on my discretion and the nature of our work together.

FEES

Initial individual psychotherapy meetings are $250 and are 50 minutes in length. If either of us believes that for any reason you would be best served by another clinician or by another treatment modality, I will try to provide you with appropriate referrals. Should we both agree to continue, subsequent 50-minute sessions are $200. Initial couples counseling evaluation meetings are $250. Should all parties agree to continue, subsequent 55-minute sessions are $200. Group therapy meetings are $100. Each session is 75 minutes in length.

PAYMENT

My practice is a fee-for-service business and the client is responsible for payment at the time of the session unless other billing arrangements have been made. I am not credentialed with any health insurance plans. Therefore, my services are Out of Network (OON). If you would like to use your out-of-network benefits and/or FSA/HSA funds to assist with any payment or reimbursement of your therapy, please inquire directly with your insurance provider to determine your OON benefits and how to appropriately use them. I will provide you with a detailed receipt at the after each session (or monthly if you prefer) that you may choose to submit to your insurance company to seek reimbursement. You may pay by cash, check, credit card, or Zelle. I may store your credit card information in the secure platform. Rate increases may occur annually and will take effect on January 1.

INSURANCE

I do not participate in managed care plans nor do accept assignment of benefits, which means that I do not accept insurance for counseling or therapy sessions. However, you may wish to submit to your insurance company for reimbursement. Please be aware that if you choose to utilize your insurance benefits by requesting reimbursement, the insurance company may require me to provide them with a mental health diagnosis, information about your symptoms and to provide a "treatment plan" in order for you to receive reimbursement. In addition, they may request other information about your treatment, such as substance abuse history or suicidal/homicidal gestures or risk, progress and prognosis in order for treatment to be reimbursed. Although insurance companies have confidentiality procedures, once the information leaves my office I have no control over who it is shared with or how the data is stored. Please take these matters into consideration when choosing to seek reimbursement from your health insurance plan.

CANCELLATION POLICY

Please provide at least 48 hours notice if you need to cancel or reschedule your appointment. If you do not show up for your scheduled therapy appointment, or you have not provided notice at least 48 hours in advance, you will be charged the full cost of the session. Please be advised that insurance will not cover any of this charge. I hold your timeslot for you and advanced notice allows me the opportunity to fill the time.

If you have a spot on my permanent schedule, whether weekly or every other week, that time is yours and you will be charged if you do not attend the session. I will most likely not reach out if a session is missed, unless I am concerned about the safety of a client. It is the responsibility of the client to get in touch with me. If you miss three consecutive sessions, you will be taken off the permanent schedule.

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When you sign this document, it will represent an agreement between us. You may revoke this agreement in writing at any time. That revocation will be binding on me unless I have taken action in reliance on it; if there are obligations imposed on me by your health insurer in order to process or substantiate claims made under your policy; or if you have not satisfied any financial obligations you have incurred.

CONSENT TO TREATMENT

Signing below signifies that you have read this psychotherapy services agreement, agree to its terms, and have had it explained to you if you requested it. You freely and voluntarily choose to participate in treatment. This agreement will be valid until you discontinue therapy. You understand that you are free to discontinue therapy at any time. If you choose to withdraw your consent and to discontinue therapy, you hereby release me from all claims of liability for any ill effects that may result from the withdrawal of consent and discontinuation of participation in therapy.

Name of Client (please print): _____

Signature of Client: _____Date: _____

I acknowledge that I have been provided the **Notice of Privacy Practices** of Juliette-Marie deSousa, LICSW.

Name of Client (please print): _____

Signature of Client: _____Date: _____