Lenée N. Essig, LCSW, LLC 5810 Kingstowne Center Dr. Ste. 120-148, Alexandra VA 22315
(P) 703.749.4818 (E) lenee@leneenessiglcsw.com (W) www.leneenessiglcsw.com

Consent, Financial Fee Agreement, Authorization to Contact & Notice of Privacy Practices

Consent To Treatment

I, and or we, the undersigned, give my, and or our, consent and authorize Lenée N. Essig, LCSW, LCSW-C, LICSW, SEP, LLC to provide me, and or us, with psychotherapy services. I, and or we, understand that these services may include individual and family clinical interviews, assessments, consultations and treatments. Services may also include discussions with other individuals in my life by my therapist, but I, and or we, understand that she will contact no individual without my, and or our, prior written consent.

I, and or we, understand that I, and or we, have the right to refuse treatment or terminate counseling services should I, and or we, choose.

Confidentiality

Confidentiality is a high value and every effort is made to ensure that client information is kept confidential. However, the state of Virginia and the National Association of Social Workers specify certain conditions in which it may be necessary for information about a client's treatment be discussed with other professionals. The situations in which confidentiality is to be broken are:

1. If a therapist believes there is imminent danger that a client may harm him/herself or others.
2. If a therapist becomes aware of a client's involvement in abuse of children, elderly or disabled persons.
3. If a therapist is ordered by the court to release client records.
4. If a client signs an authorization for release form that allows a therapist to discuss a client case with another person; eg: doctor, psychiatrist, relative.

Financial Fee Policy & Agreement

The following is a clarification of the financial/fee policies and agreement. Please read this document and sign your name(s) indicating that you have read, and agree to the following information. Should you have any questions please feel free to discuss them with me.

- Your fee, applies to each ninety-minute, fifty to sixty-minute individual and/or couples session, and/or seventy-five minute group session. You are responsible for this fee and I ask that you make payment at the beginning of each appointment. If you are being billed monthly, payment is to be paid in full within two weeks of receiving the bill for services.

The right is reserved to postpone appointments until the balance is paid in full. Checks returned due to insufficient funds will incur a charge of $30.00.

- As the time scheduled for your appointment is reserved for you, I ask that you give 48 hours notice if it is necessary to cancel an appointment. If notice is given in less than 48-hours, you will be charged for that session ($165). Rescheduling of cancelled appointments may be made within the same week of the cancelled session, and only as my schedule allows. All missed visits without cancellation will be charged accordingly ($165).

  If we have regularly scheduled appointments, weekly, biweekly, or monthly, and you do not confirm two appointments in a row and/or there are not any sessions scheduled within 30 days (weekly, biweekly) and there is no response from you with my attempts to contact you future appointments will be cancelled and your file will be closed. You will still be responsible for all financial balances.

- If you terminate therapy with an outstanding balance of fees you will still be responsible for paying said fees, and if necessary, all costs of collection, including attorney's fees if collected by or through an Attorney-at-law. You are ultimately responsible for full payment of your account, including claims denied by your insurance company for any reason.

- Fees for other services, such as preparation of special reports (FMLA /Disability) The rate is $165 for the first hour. If preparation is longer than an hour, the charge is $45 per 15-minute additional increment(s). If the time is less than one hour the rate is $165.

- If a telephone conversation extends beyond 10 minutes, you will be billed in 10-minute increments for the duration of the call for up to an hour-long session or for as long as I am able to speak with you at that time. Depending on insurance and the nature of the call, I may be able to bill the call and you will be financially responsible for the copay, if it applies.

- The fee for court-appearances, preparation for court testimony including, but not limited to, consulting with attorneys, reviewing the file, report/letter writing and time spent traveling to court and waiting to testify is $300 an hour. Additional fees apply to parking and mileage.

  A retainer for court expenses will be due, and payable, a minimum of two full weeks prior to a scheduled court appearance. This retainer will cover the cost of (6) hours of total time initially allotted for my services [(3) hours for court prep and (3) hours court time]. This is a total of $1,800.00 for the retainer, regardless of how my time is spent on the day of court. There will be no refunds if I am called to court and nothing else is required of me that day. In the event of a settlement, or cancellation, of the trial/hearing with less than 72 hours' notice, a charge will be levied for those hours originally set aside for the trial/hearing. These services are not reimbursable by medical insurance

- From time to time the fees may change. I will notify you in advance if there is a change in the fee schedule.

- You are responsible for any applicable co-pays and/or out of network expenses, which results from failure of notifying me of any changes in insurance coverage (e.g. change in policy). In such:

    1. If claims are denied, or payment is reduced because of non-notification of change in insurance coverage, my fee-for-service rate applies to those claims.
    2. I am not financially responsible for previous billed sessions prior to notification or due to non-notification of change in insurance coverage.
    3. Insurance does not cover late canceled or missed appointments.

- I am not a Medicare or TriCare provider. If your carrier is either Medicare (Part B) or TriCare you agree not to submit a claim (or to request that I submit a claim) to the Medicare or TriCare program with respect to services rendered. If applicable, please refer to signed agreement for additional information.

    _____ I am a Medicare B or TriCare recipient _____ I am not a Medicare B or TriCare recipient

In addition, I and or we, authorize the release of any medical or other information to the named insurance company(s) and/or their designated agent(s) necessary to approve and/or pay any claims, if applicable. I hereby assign and authorize payment of all medical benefits payable pursuant to any claims to Lenée N. Essig, LCSW, LICSW, LCSW-C, SEP, LLC, for services rendered.

I, and or we, I authorize the release of any medical or other information necessary to process claims for reimbursement. I, and or we, also request payment of government benefits either to myself or to the party who accepts assignment below**.**

I, and or we, understand that Lenée N. Essig, LCSW, LICSW, LCSW-C, SEP, LLC, uses a third-party billing software for filing with insurance companies, and give(s) permission for this.

Payment is expected at the time services are rendered, unless otherwise noted above, or prior arrangements have been made.

Notice of Electronic Signature

By electronically signing, you acknowledge and agree that your electronic signature is legally binding, and you intend to be bound by the terms and conditions set forth in this document. You understand that your electronic signature carries the same legal affect as a handwritten signature and signifies your acceptance of the contents herein.

You further acknowledge that you have read, understood, and agree to comply with any applicable laws and regulations governing electronic signatures, including but not limited to the Electronic Signatures on Global and National Commerce Act (ESIGN) and the Uniform Electronic Transactions Act (UETA). If you do not agree to be bound by this electronic signature agreement, please refrain from signing or accepting this document electronically.

Lenée N. Essig, LCSW, LLC 5810 Kingstowne Center Dr. Ste. 120-148, Alexandra VA 22315
(P) 703.749.4818 (E) lenee@leneenessiglcsw.com (W) www.leneenessiglcsw.com

Agreement

I, and or we, _____, [Name of Client], agree to pay $_____ (fee for service rate) per session or $ _____ (co-pay) for services rendered by Lenée N. Essig, LCSW, LICSW, LCSW-C, SEP, LLC.

Notice of Privacy Practices & Good Faith Estimate

I have been provided with access & copy of the *Privacy Practices* in accordance of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), as well as a copy of the *Practice Policies*. In addition, if applicable, I have been provided with a Good Faith Estimate.

Authorization to Contact by Telephone/Verbally in Event of Breach of PHI

I, _____ [Name of Client], authorize Lenée N. Essig, LCSW, LICSW, LCSW-C, SEP, LLC, to provide notice to me by telephone or verbally in the event of a breach of my protected health information (PHI) by Lenée N. Essig, LCSW, LLC. Such conversation shall be documented by Lenée N. Essig, LCSW, LICSW, LCSW-C, SEP, LLC.

Note: Pursuant to the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Final Rule modifying the HIPAA Privacy, Security, Enforcement and Breach Notification Rules, the verbal or telephonic notice provided to me pursuant to this authorization shall not be simply for the administrative convenience of Lenée N. Essig, LCSW, LICSW, LCSW-C, SEP, LLC.

_____ _____

Client/Guardian Signature Therapist Signature

_____ _____

Client/Guardian Signature Date

_____

Date

I, and or we, have read, understand and agree to the above consent, policies and financial agreement.