Lift Off Therapy Center, LLC
121 North Wayne Avenue, Suite #304, Wayne, PA 19087

POLICIES AND PROCEDURES

This document provides information about practical issues related to your participation in therapy with me. Please read the following information so you will be fully aware of important aspects of our professional relationship. Feel free to discuss any of the issues raised in these policies as well as any other questions that you might have concerning our working relationship.

Confidentiality Statement

A federal law, the Health Insurance Portability and Accountability Act (HIPAA), provides privacy protections and client/patient rights regarding the use and disclosure of your Protected Health Information (PHI). HIPAA requires that you are provided with a Notice of Privacy Practices (the Notice) for use and disclosure of PHI for treatment, payment, and health care operations. The law also requires that a signature is obtained acknowledging the receipt of the HIPAA notice.

Most issues discussed during the course of therapy are confidential in nature. In general, no confidential information will be shared with anyone without your written permission in the form of a signed authorization form meeting certain legal requirements imposed by HIPAA. There are a number of exceptions to this rule. Such exceptions include:

- Situations involving threats of harm or other indicators of potential harm to self or others
- Any reports of child abuse, child sexual abuse and/or child neglect
- Any reports of elder abuse
- Court cases where client records are court ordered
- Insurance companies seeking information about treatment subsequent to making payment
- Government agencies requesting information for health oversight activities
- Situations in which a psychologist must defend themselves against a complaint or lawsuit

In the case of such exceptions of confidentiality, I will discuss the situation with you and I will share with you any information which is released, whenever possible.

With regard to reports of child abuse, I am mandated to report suspected child abuse if anyone aged 14 or older tells me that he or she committed child abuse, even if the victim is no longer in danger. I am also mandated to report suspected child abuse if anyone tells me that he or she knows of **any** child who is currently being abused. I am required to make such reports even if I do not see the victim of suspected child abuse in my professional capacity.

If a client or family member is being seen by another professional, particularly a mental health professional, I may request that a release be signed so that efforts can be coordinated. It is also helpful in planning our work together that I obtain information from any previous therapeutic relationships or the results of psychological/psychiatric evaluations. These efforts are all intended to increase the efficiency of our time spent working together.

Occasionally I may need to consult with other professionals in their areas of expertise in order to provide the best treatment for you. In the event of such a consultation context, all cautions will be taken to preserve your confidentiality and information about you will be shared without using your name or other private identifying information. An explicit release of information will be secured for any consultation situation that requires identifying information or that may compromise your privacy.

It is very possible that current or former clients and/or their family members may come into contact with me out in the community. Out of respect for your privacy, I follow the "you first" rule during these times. As such, I will not initiate any contact, but will gladly return a greeting, smile, wave, etc. if given. Similarly, if you prefer to avoid such contact, I will respect that as well.

If you are seeking reimbursement for out-of-network care through your health insurance company, they may require information regarding your treatment in order to authorize or reimburse for services. In such insurance reimbursement situations, you will be requested to sign a release allowing me to share information with the insurance company. Please note that I have no control over, nor am I responsible for, information once it has been released to a third party. By signing this document, you acknowledge that you understand and agree to these limitations of confidentiality.

Child and Adolescent Policy

In the role of therapist, a provider is just that, and thus is not in a position to comment or give recommendations on matters like custody. This would be considered a conflict of interest, and the correct person to make such recommendations would be a custody evaluator, who could be recommended through the court system. It would be unethical and possibly illegal for a therapist to place himself/herself in that role, and it would not be beneficial for a child/adolescent.

If there is a split custody situation, I may only see a minor with consent in writing from both parents, and if there is a court order/decree in place, with a copy of that court order/decree. In joint custody situations, either parent may revoke consent at any time by informing me. Please note that in the Commonwealth of Pennsylvania, a minor aged 14 or older can legally consent to his or her own therapy, so parental consent is not required in this instance. If both parents are involved in treatment, it will be necessary to agree on a set of goals, to the extent possible.

If you are a minor, please be aware that your parents/guardians may be legally entitled to some information about your therapy. I will discuss with you and your parents/guardians what information is appropriate for them to receive and which issues are more appropriately kept confidential.

It is my policy to request that the parents respect the confidentiality between their child and me and that parents/guardians refrain from questioning their child about the specifics discussed during therapy sessions. However, I do encourage children to share important information and feelings with their parents/guardians. If a situation arises that I feel is important for parents/guardians to be informed, I will arrange a meeting for the child/adolescent and parents/guardians to discuss the pertinent issues. If such a meeting is not possible, I will discuss the issues alone with the parents/guardians after informing the child/adolescent of my intentions. In addition, one of the goals of family therapy is to encourage appropriate and open communication among family members. In this regard, our efforts in therapy will be directed toward this end. In such situations, I will be available to answer questions and to make suggestions to parents/guardians regarding their relationship with their children and regarding specific situations that may arise during treatment. I request that parents/guardians notify me of any changes in behavior/symptoms while their child is in treatment.

In the event of safety-related concerns, including threats of harm or other indicators of potential harm to self or others, I would be required to break confidentiality to ensure child safety. This includes any discussion of child abuse/neglect as well. In such cases I would speak with parents/guardians about any such information, and a report would need to be made, given mental health providers' status as mandated reporters.

Financial Agreement

I am not a contracted provider on any insurance panels, thus payment is your responsibility. If you have insurance, you should verify your out-of-network benefits before entering treatment. You have the option to submit claims to insurance for out-of-network reimbursement, but you are agreeing to pay my fees at the time of services.

The fee/responsibility per session is $175.00. A written report of your initial evaluation is optional and will be billed at $100.00. Additional fees will be charged for additional services rendered at your request (prorated and billed in 15-minute increments), including: preparation of special forms; letters written on your behalf; insurance reports; preparing summaries of treatment; meetings with others on your behalf with your authorization; or phone contacts over 15 minutes.

Lift Off Therapy Center, LLC accepts cash, checks, or credit cards. There is a $25 service charge for all returned checks, and should a check be returned, I reserve the right to request an alternate form of payment for future services. Fees may be subject to change, and should this occur, I will notify you in writing prior to this taking effect.

If your financial situation changes during the course of treatment and you find that you are unable to afford my fees, please discuss the situation with me as soon as you are made aware of it. In rare cases, arrangements can be made to defer payments or to decrease the frequency or length of sessions. Another alternative is referral to a community agency with coordination of services through communication of the work that has already been accomplished.

I will make every effort to resolve balances with clients prior to involving third parties such as collection agencies or attorneys. However, after 90 days of non-payment, the practice reserves the right to refer delinquent accounts to an outside agency or an attorney for collection. In this event you will be charged any fees incurred as a result, including attorney fees and court costs. Lift Off Therapy Center, LLC may deny subsequent services when account balances are unpaid.

Cancellations/No Show Policy

Scheduling an appointment means it will be held for you and, therefore, cannot be used by another person. Should you find it necessary to cancel or change an appointment, please do so as soon as possible so that there is adequate time to give the appointment to someone else on the waiting list. Cancellations will be accepted without fees up to 24 hours before the appointment (a minimum of 1 business day). When canceling an appointment, please leave a message on my confidential voice mail at (610) 601-2748. I will return the call to re-schedule the appointment as soon as I am available.

Cancellations made less than 24 hours before the scheduled appointment time will result in a $75.00 fee charged for the time reserved. Please note that insurance companies do not provide reimbursement for sessions that you have not attended, so you will be responsible for all fees incurred as a result of missed sessions. Exceptions to the late cancellation fee include emergencies or dangerous road conditions due to inclement weather.

Please note that if you arrive late, you will be charged for the full scheduled session and it will end at the pre-scheduled time. If the therapist is late, additional time will be allocated to your session to ensure that you receive the full scheduled session time. Please remember that coming regularly and on time is an indication of your commitment to therapy.

Professional Records

Pursuant to HIPAA, I keep Protected Health Information (PHI) about clients/patients in the Designated Medical Record. This includes information about reasons for seeking therapy, a description of the ways in which problems impact life, applicable diagnoses, the goals set for treatment, progress toward those goals, medical and social history, treatment history, any past treatment records that have been received from other providers, reports of any professional consultations, billing records, and any reports that have been sent to anyone, including reports to an insurance carrier. Except in unusual circumstances that involve danger to self or others or where information has been supplied to me by others confidentially, a client/patient may examine and/or receive a copy of the Designated Medical Record, if it is requested in writing. HIPAA provides clients/patients with several new or expanded rights with regard to their Designated Medical Record and disclosures of Protected Health Information. I am happy to discuss any of these rights with you. Clients/patients under 18 years of age who are not emancipated, as well as their parents/guardians should be aware that the law may allow both parents to examine their child's treatment records. By Pennsylvania law, Psychology Records must be maintained for seven years after the last client/patient contact (seven years beyond the age of 18 for a minor). After this period, the Designated Record Set and the Psychology Process Notes may be destroyed. Should the practice be closed, staff will indicate how records can be accessed.

Emergencies

In the case of serious, life-threatening emergency, you should call 911 or go to the nearest emergency room. As Lift Off Therapy Center, LLC is an outpatient practice and does not offer 24-hour care, practice staff are not considered "on call" outside of regular office hours. I am also unable to answer phone calls during sessions with other clients. I will, however, make every effort to return calls or to reply to messages in a timely manner (within 24 hours). It is the responsibility of the client to discuss after-hours care upon intake in order to ensure an appropriate referral if a higher level of care may be needed. In the event of a crisis or emergency, I request that you contact me after you have followed appropriate emergency procedures (e.g., calling 911, going to nearest emergency room, contacting county crisis intervention services, etc.).

Telephone Accessibility

Questions and concerns may arise after you leave my office. I ask that you make a note of these issues and discuss them with me during your next visit. If you decide that waiting until the next meeting to address these issues may cause danger or detriment to someone, please contact me. If you believe you need to see me before the next scheduled appointment, please be sure to let me know and every effort will be made to schedule an appointment. If you need to contact me between sessions, please leave a message on my confidential voice mail at (610) 601-2748. I am often not immediately available; however, I will attempt to return your call within 24 hours. Again, in the event of an acute emergency situation, please call 911 or go to any local emergency room. Also, please let me know any specific requests as to when, how, or where (e.g., personal voicemail) it is okay to leave messages for you in order to confirm, change, or cancel appointments.

Electronic Communication

Telephone is my preferred form of contact because I cannot ensure the confidentiality of any form of communication through electronic media, including emails or text messages. Please note that any emails

sent between us will be retained in the logs of our respective internet service providers. While it is unlikely that someone will be looking at these logs, they are, in theory, available to be read by the system administrator(s) of the internet service provider which subsequently compromises confidentiality. Please also note that mental health providers are cautioned to maintain printed copies of all written communication to and from clients, such that any emails/texts/social media posts made may be documented and archived in a client's chart which subsequently become part of their legal record.

Please **do not** use electronic methods of communication to request assistance for acute emergencies as I cannot guarantee an immediate response. In the event of an acute emergency you should call 911 or go to the nearest emergency room. I also request that you do not use electronic methods of communication to discuss therapeutic content as confidentiality cannot be assured. As such, I typically will not respond to such emails and will wait to address mental or behavioral health related issues via phone or at your next appointment.

If you elect to communicate via email for administrative purposes (e.g., scheduling, cancellations, etc.), I will gladly do so although I cannot guarantee that I will be able to do so in as timely a manner as via telephone. By signing this document, you acknowledge that you understand that email is not a confidential mode of communication and you give me permission to reply to emails that you initiate.

Internet/Social Media Policy

Though Lift Off Therapy Center, LLC maintains a professional presence on the internet, this is for informational purposes only and is not considered treatment or professional advice. Due to the importance of your confidentiality and the importance of minimizing dual relationships, I do not accept friend or contact requests from current/former clients on any social networking site (e.g., Facebook, LinkedIn, etc.). I believe that adding clients as friends or contacts on these sites can compromise both your confidentiality and our respective privacy. It may also blur the boundaries of our therapeutic relationship. Please do not leave messages or wall postings to contact me as these sites are not secure and no response will result.

Terminating Therapy

Clients often seek to end therapy when they recognize that they have optimized the benefits of therapy and/or have fully met their goals for treatment. In other instances, clients may elect to terminate therapy prematurely because the issues discussed in therapy can be distressful or it is difficult to persevere with the work of maintaining long-term changes. Whatever the reasons for ending treatment, it is important that your feelings and intentions are discussed within therapy sessions and that termination is processed and planful.

I will also raise the topic whenever I believe that it is in your best interest to change the frequency of sessions or to discontinue treatment either due to maximization of treatment benefits or due to lack of observable benefits/progress. If I determine that psychotherapy is not being effectively used or if you are in default on payment, I may terminate treatment following appropriate discussion with you and a termination process. I will not terminate the therapeutic relationship without first discussing and exploring the reasons and purpose of terminating.

If therapy is terminated for any reason or you request another therapist, I will provide you with a list of qualified psychotherapists to treat you. You may also choose someone on your own or from another referral source.

Please note that for legal and ethical reasons I must consider the professional relationship discontinued should you fail to schedule an appointment for three consecutive weeks unless other arrangements have been made in advance.

Professional Coverage

There may be periods of time (e.g. vacations) when I am either out of town or otherwise unavailable to return telephone calls. In these instances, other qualified professionals may be designated to provide coverage for me who would be responsible for returning phone calls in my absence. Should I become unavailable due to long-term illness or death, my colleagues will access your phone number in order to notify you of my unavailability. At your request, these professionals would be able to provide a referral for further care. By signing this document, you give permission for me to reveal your name and phone number, as well as your reason for seeking therapy, to the qualified professional(s) who are providing coverage in my absence or who may be contacting you should I become unavailable due to illness/death.

Treatment Contract

Now that you have read these policies, I ask that you sign below that you have read and understood the information contained in this document. Your signature indicates that you agree to enter into a professional relationship with me under the conditions as set forth in this document. It further indicates that you understand that you may terminate treatment at any time and that I may terminate treatment under some circumstances in which you do not comply with these policies or I feel that you are not benefiting from treatment.

My signature below indicates that I have read and understand all of the preceding information and agree to abide by it. I understand that I may ask my provider questions at any time about any of this, should the need arise.

_____ _____

(Signature) (Date)

On behalf of _____, my minor child or person entrusted to me for guardianship, I agree to the above policies and give permission for Brian McManus, Ph.D. to provide treatment for my child.

_____ _____

(Signatures of both parents/legal guardians) (Date)

_____ _____

(Signatures of both parents/legal guardians) (Date)