

Ifeyinwa (E-fee) Nzerem, LCSW
LCS #25252
Healthy Beginnings Psychotherapy
538 Hayes Street, San Francisco, CA 94102
415.225.4128 www.ifeynzerem.com

This document contains important information about my professional services and business policies. Please take time to read this carefully. Should you have any questions regarding these policies, please do not hesitate to raise any related questions. When you sign this document, it represents an agreement between us.

CONTACT INFORMATION

PSYCHOTHERAPY SERVICES & CONSULTATION:

Making a change in one's life is often one of the hardest steps to take in starting a new lifestyle. Healthy Beginnings Psychotherapy is design to meet individual's life challenges and is a collaborative process where you are allowed to express your thoughts in a non-judgmental environment. Psychotherapy varies considerably with respect to theoretical orientation, choice of intervention/technique, and duration of treatment. People enter psychotherapy for many reasons some related to a specific issue or difficulty, some to learn more about what motivates their choices and behaviors.

Client Initial _____

BEGINNING TREATMENT:

At the start of treatment, I conduct an initial assessment, which typically lasts 2-4 sessions. During these initial sessions, I gather information regarding your current and past difficulties, answer your questions and concerns, and inquire about family history, and past psychiatric and/or medical treatments. Upon completing this evaluation, I will discuss with you my clinical impressions and outline an initial treatment plan. During this time, it is important that we both consider if I am the best person to provide the services you need to meet your specific treatment goals. When psychotherapy begins, I typically schedule one 50-minute session per week. When clinically indicated or when cultivating a more intensive exploration, more frequent sessions may be necessary or suggested.

Client Initial _____

ORIENTATION:

I am trained in psychodynamic/psychoanalytic psychotherapy. Additionally, I am receiving postgraduate training with the American Professional Treating Eating Disorders (APTED) in widely practiced behavioral therapies (Dialectical Behavior and Cognitive Behavior therapies). Depending on what an individual is hoping to achieve in therapy, the duration for which they are able to commit to therapy, and the nature of their identified concerns, I will apply those interventions that are best suited for that individual's circumstances. If indicated, a referral to a more appropriate therapist will be provided (e.g., your presenting problem is outside the scope of my clinical expertise).

Client Initial _____

ENDING TREATMENT:

Just as every individual is complex and unique, so is every course of psychotherapy. The exact duration of treatment is difficult to predict. However, the progress and process of therapy is very important to discuss. Typically, therapy ends when initial "objectives" or goals have been met, and both patient and therapist feel that significant progress has been made. If at any time during the treatment relationship, you wish to consult with or transfer to another therapist, I encourage you to raise this in one of our sessions. I will do my best to help you find a qualified clinician with whom I will be able to consult with your written consent. If at any time you wish to end treatment, you have the right to do so. Because psychotherapy is a different kind of relationship, it is important to discuss your plans to end therapy prior to doing so. This will enable a review of the progress made and engage in a process of termination. Though endings in therapy can be difficult or sometimes reminiscent of past experiences of loss, they are important to discuss. On some occasions, it is the therapist who may choose to end a therapeutic relationship. Some reasons for this are: a patient is unable or unwilling to attend therapy regularly, a patient's use of behaviors make therapy ineffectual, a patient's need for services I am unable to provide (such as treatment for an area outside of my expertise and training), minimal progress despite appropriate treatment, and/or reasons related to my own circumstances or limitations.

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DUAL RELATIONSHIPS:

Therapy never involves sexual, business, or any other dual relationships that could impair my objectivity, clinical judgment, therapeutic effectiveness, or be exploitative in nature.

Client Initial _____

BENEFITS & RISKS OF PSYCHOTHERAPY:

Participation in therapy can result in a number of benefits to you, including improved relationships and resolution of specific concerns. Psychotherapy requires your active involvement, honesty, and openness. Oftentimes, this process is gradual and sometimes frustrating. I will often ask for your feedback on your treatment and its progress. During treatment, discussing unpleasant events, feelings, or thoughts may result in you experiencing strong feelings, or a change in mood. Attempting to resolve issues that brought you into therapy may result in changes that were not originally intended.

Client Initial _____

FEE RELATED POLICIES

FEES, PAYMENT & FINANCIAL ARRANGEMENTS:

We will agree to a fee at, or before, the first session. The usual and customary fee for a 50-minute psychotherapy session is \$150.00. During the initial consultation session(s), payment in full is due at the time of service. If we work together, you will be billed at the end of each month and payment in full is due at that time. In general, your fee will be assessed annually, though conditions may warrant more frequent assessment. Over time, the session fee may increase. Payment can be made by cash or personal check. If finances are a concern and may impede your ability to attend treatment as recommended and agreed upon, please bring this to my attention.

Your agreed upon fee for a 50-minute psychotherapy session is \$_____. **Client Initial** _____

LATE PAYMENTS:

There will be a returned check fee of **\$25.00** should there be any problems clearing your check. If, for any reason, you do not pay your bill at the time of service or within 30 days from the date of your monthly invoice, a **\$35.00** late fee will be assessed for each 30 days that you do not pay. I understand that it can sometimes be difficult to stay on top of bills and payments. Thus, if you should have any concerns or questions about your fee or monthly invoice, please contact me, so that we can discuss it.

If you do not pay your bill for more than 60 days and suitable arrangements for payment have not been agreed to, I have the option of using legal means to secure payment, including the use of collections agencies or small claims court. If such legal action is necessary, the costs of such proceedings will be included in the claim. In most cases the only information released about a client in such a process would be your name, the nature of the services provided and the amount due.

INSURANCE:

I am a fee for service clinician. However, I do accept supplement payment from the following insurance companies: ATENA, Blue Shield EAP, Value Options EAP, Sutter Health EAP, and Claremont EAP. However, if your health insurance carrier enables you to choose an "out-of-network" provider (typically found on PPO plans), you may be able to seek reimbursement for your treatment with me. Psychotherapy is also typically covered by Medical Savings Accounts. Upon request, I am able to provide a statement for you to submit to your insurance company. This statement is your receipt for tax or insurance purposes. Be aware that submitting a mental health invoice for reimbursement carries a certain amount of risk. If you intend to use your insurance, I recommend that you contact your plan to ask about psychotherapy benefits and rates of reimbursement for out-of-network providers. It is your responsibility to verify the specifics of your coverage. Please remember: my services are provided and charged to you, not your insurance company, so you are responsible for payment.

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COMMITMENT TO CARE:

Based on my commitment to providing care to a diverse group of patients, I have limited availability for lower-fee slots. If I cannot accommodate your financial situation, I will try my best to assist you in finding appropriate resources.

Client Initial _____

CONFIDENTIALITY POLICIES

CONFIDENTIALITY:

Your privacy in working with/being under the clinical care of a Licensed Clinical Social Worker (LCSW) is protected by law, and your disclosures are generally held to be confidential. In the case of these sessions, you hold the legal right of privileged communication, which means that in a court of law, a Licensed Clinical Social Worker (LCSW) may not reveal any information you have revealed in session, unless compelled by a court order or a valid subpoena. In general, a mental health professional may not reveal any personally identifiable information about you to anyone, unless you first provide authorization by signing a consent form (exceptions discussed below). For example, in the event that it would be beneficial to discuss your treatment with a third party (e.g., referring psychiatrist, physician, etc.), when you would be personally identified, I would first discuss this with you and obtain your written consent. I may occasionally find it helpful to consult about a case with other professionals. In these consultations, I make every effort to protect your identity. The consultant is also legally bound to maintain confidentiality.

COMPUTERS, E-MAIL, VOICEMAIL & FAX COMMUNICATION:

It is very important to be aware that computers, and e-mail and cell phone communications can be relatively easily accessed by unauthorized people, which can compromise the privacy and confidentiality of such communication. E-mails, in particular, are vulnerable to such unauthorized access due to the fact that servers have unlimited and direct access to all e-mails that go through them. Additionally, Ifeyinwa Nzerem LCSW's e-mail and data on her computer is not encrypted. It is always possible for faxes to be sent erroneously to the wrong fax numbers and that computers, including laptops, may be stolen. Ifeyinwa Nzerem, LCSW's computer is equipped with a firewall, virus protection and passwords, and she also backs up all confidential information, including notes, from her computer onto external devices (stored in a locked, off-site location) on a regular basis. Please notify Ifeyinwa Nzerem, LCSW if you decide to avoid or limit, the use of e-mails, cell phones or faxes (if applicable), or storage of confidential information on her computer. If you communicate confidential or private information via e-mail, Ifeyinwa Nzerem, LCSW will assume that you have made an informed decision, and will view it as your agreement to take the risk that such communication may be intercepted, and she will honor your desire to communicate on such matters via e-mail. Due to computer or network problems, e-mails may not be deliverable, and Ifeyinwa Nzerem, LCSW may not check her e-mails daily. Please do not use e-mail for emergencies.

EXCEPTIONS TO CONFIDENTIALITY:

There are circumstances when a Licensed Clinical Social Worker (LCSW) may break confidentiality, or is required to break confidentiality. Should such a circumstance arise, I will make every reasonable effort to discuss with you my ethical or legal obligations to disclose confidential information before doing so. Exceptions to confidentiality include, but are not limited to, the following circumstances. Disclosure is required by law as follows:

1. If I have reasonable suspicion that a minor/child (age 18 and below), elderly person (age 65 and above), or a dependent person (age 18-64) is being abused or neglected, I must report this to the appropriate agency.
2. If I believe a client is threatening serious bodily harm to another individual, I am required to take protective actions, which may include notifying the potential victim, notifying the police, and/or seeking appropriate hospitalization for your child.
3. If I believe a client is threatening serious bodily harm to him/herself, I may be required to seek hospitalization for the client, or to contact family members or others who can provide protection.

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Disclosure may be required as follows:

1. If you have not paid your bill for treatment within 30 days, your name, payment record and last known address may be sent to a collection agency or small claims court.
2. In couples or family therapy, confidentiality and privilege do not apply between the couple or family. At the start of our work together, we will discuss my "secrets policy" or how information will be shared with the couple or family.
3. Health Insurance and Confidentiality of Records:

Should you choose to submit statements for consideration for reimbursement from your insurance carrier, your carrier may require disclosure of confidential information in order to process claims. Only the minimum necessary information will be communicated to your insurance carrier, including diagnosis, the date and length of our appointments, and what services were provided. Often the billing statement and your company's claim form are sufficient. Sometimes treatment summaries or progress toward goals are also required. Unless explicitly authorized by you, Psychotherapy Notes will not be disclosed to your insurance carrier. While insurance companies claim to keep this information confidential, I have no control over the information once it leaves my office. Please be aware that submitting a mental health invoice for reimbursement carries some risk to confidentiality, privacy, or future eligibility to obtain health or life insurance.

Client Initial _____

RECORD KEEPING POLICIES

RECORD KEEPING:

I am required by both the law and the standards of my profession to maintain appropriate treatment records. These may include diagnosis, therapy goals, progress in treatment, documentation of mandated disclosures (e.g., report of child abuse), and other information (such as important communication). You have a right to review and/or receive a copy of your records unless in my professional opinion, I find that doing so would be likely to cause you substantial harm, endanger your life or physical safety, or pose a significant risk of harm to another individual. Alternately, I can prepare an appropriate summary of these records. Given their inclusion of professional language, these records may be difficult to interpret or understand. If you wish to review your records, I recommend you review them in my presence so we can discuss their content.

Please notify Ifeyinwa Nzerem, LCSW if you decide to avoid or limit, in any way, the use of emails, faxes (if applicable), or storage of confidential information on her computer.

Client Initial _____

TELEPHONE AVAILABILITY & EMERGENCY POLICIES

TELEPHONE AVAILABILITY, CONSULTATION & EMERGENCIES:

Telephone calls are typically returned within 24 hours. I do not answer my phone when I am in session or at a training/meeting, so I am not always immediately available. However, I check my voicemail frequently, and return calls as promptly as possible. I generally do not return calls on the weekends or after 8:00 pm on business days, unless the call is urgent, in which case I will return it as soon as reasonably possible. If I am unavailable for an extended period of time, I will provide the name and number of another clinician whom you may contact if necessary.

If you need to contact me between sessions, please leave a message for me at 415-225-4128. Phone consultations of 5 minutes or less will not be charged. Longer phone consultations with you will be billed at your regular session rate, prorated for the length of time, and can be paid at your next appointment unless otherwise discussed.

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Please note **I do not provide emergency services**. In an emergency situation, please call 911, contact your primary care doctor, or go to the nearest hospital emergency room:

San Francisco General Hospital ER, 1001 Potrero Ave., SF, CA 415-206-8111
San Francisco Suicide Prevention 415-781-050

Client Initial _____

CANCELLATION POLICIES

CANCELLATION:

Appointment scheduling involves the reservation of a time specifically for you. During the initial consultation session(s), I ask patients to provide at least 24-hr notice (or 1 business day), by phone, to cancel or reschedule a session, otherwise, the full fee will be charged and due at the time of your next session, unless otherwise discussed. Sessions begin on time. Should you arrive late; the session will still end at the regularly scheduled time.

Should we work together, I will be happy to explain my cancellation and rescheduling policy for ongoing patients, during your initial consultation.

Client Initial _____

GENERAL

If you have a concern or complaint about your treatment, please talk with me directly about it. If we cannot resolve your concern, you can contact the Board of Behavioral Science, which oversees licensing, and they will review the services I have provided.

Board of Behavioral Sciences
1625 N Market Blvd., Suite S-200
Sacramento, CA 95834

I have understood and agree to comply with the above office policies and conditions:

Patient Name (print)

Patient Name (sign) Date

Patient Name (print)

Patient Name (sign) Date