MAUREEN LYONS TASHJIAN, MSW, LCSW

Individual, Couples, and Family Therapy

Office Policies & Procedures

I have developed this guide to my office policies and procedures to answer questions about fees, appointments, insurance, messages and other issues. Please feel free to look it over and discuss it with me if you have any concerns.

Services Offered:

I will offer services specifically designed to meet your needs as an individual. The services may include individual, family or group psychotherapy. If it appears that you may need more intensive care I may make recommendations to supportive practitioners (ie: Psychiatrist, nutritionist, financial counselor, legal aid etc).

Appointment:

With rare exception, you are expected to meet with me at the time scheduled. Because this is a time set aside just for you, it is important that you keep this appointment. I do understand that on occasion you may need to cancel and in these circumstances I ask that you give me at least 24 hours notice to make that time available to someone else. The charge for a missed appointment is **$60.00**.

Cost for Service:

Due to the ever changing environment health care it is your responsibility to find out what you insurance does and does not cover.. The fee is $150.00 for an evaluation and $140.00 for a 45 minute follow up session. I do have contracted rates with most of the larger network insurance companies. I do file claims with the major insurance companies However, payment or copayments are required at the beginning of each session. If you need reports and forms filled out the fee is $30.00 unless it is a time consuming document in which case we will have to discuss the fee. You will be charged for any bank charges incurred for return checks. Balances for any late payments will be charged 1.5% per month.

Confidentiality:

The confidentiality of patient records is maintained by this office and is protected by Federal and /or State law. Generally, this office may not say to a person outside the Practice that a client attends treatment sessions or disclose information unless) the client consents in writing, 2) the disclosure is allowed by a court order or 3) the disclosure is made to medical personnel in a medical emergency or to a qualified personnel for research, audit or program evaluation. Violation of Federal and / or State law by a treatment facility or provider is a crime. Federal law does not protect any information about a crime committed by a client with the Practice, against any person who works for the Practice, or about any threat to commit such a crime. Federal law and regulations do not protect any information about suspected child (or vulnerable adult) abuse or neglect, or adult abuse from being reported under Federal and /or State law to appropriate State or Local authorities. Health care professionals are

required to report admitted prenatal exposure to controlled substances that are potentially harmful. It is the therapist's duty to warn any potential victim, when a significant threat of harm has been made. In the event of a client's death, the spouse or parents of a deceased client have a right to access their child's or spouse's records. Professional misconduct by a health care professional must be reported to other health care professionals, in which related clients records may be released to health care professionals to substantiate disciplinary concerns. Parents or legal guardians of non emancipated minors clients have the right to access the client's records.

This office is compliant with state and federal HIPPA regulations to insure your privacy. Please provide this office with a contact number that you are comfortable receiving messages
on:_____
_____

In the event of an emergency please provide this office with a person that we can contact:_____
_____

When appropriate, billing and financial information, may be given to a billing agent. My signature indicates I have read the confidentiality agreement and I have been given a copy at my request
GENERAL CONSENT TO RELEASE INFORMATION (to be revoked at anytime in writing Release of information: (example: primary care physician, psychiatrist etc) from:_____
_____

SIGNATURE_____DATE_____

WITNESS_____DATE_____