Alanna M. Lipinski, Ph.D.
450 Central Avenue, Suite 201 Lancaster, NY 14086
716-221-0363
alanna@lipinskiPhD.com

POLICIES AND PROCEDURES AGREEMENT

Welcome to my practice! My practice is developed to help families and children recognize their strengths, become more confident in their ability to manage challenges, and reach their individual and family goals. Understanding my policies and procedures is important so that you and your family may have the most beneficial experience. Please read through this information carefully and sign if you are in agreement. When you sign this document, it will represent an agreement between us. I welcome any questions at our first visit or any time during the therapeutic process.

PSYCHOLOGICAL SERVICES

Psychotherapy is not easily described in general statements. It varies depending on the personalities of the provider and patient, and the particular problems you hope to address. Psychological services can involve difficult aspects you or your child's life. For example, you or your child may experience discomfort related to sadness, anxiety, or anger. However, in the long-term, therapy has also been shown to have many benefits, such as improved adjustment, decreased stress, improved relationships, and reduction in intrusive mental health symptoms. Therapy involves a great deal of commitment of time, money, and energy. **It is important to understand that the benefits of counseling result from commitment to the process, involving consistent attendance, engagement in the session, and practice of skills in between sessions.** While I cannot guarantee all goals will be met, I will apply all resources I have to help you and your child. Although therapy can be terminated at your discretion at any time, I ask that you discuss this with me so we may develop the best plan for you and your child. I believe therapy involves a goodness of fit between therapist and client. If our work together reveals challenges that are not within my area of expertise, I will provide an appropriate referral.

STATUS AS AN ACTIVE CLIENT

An active is client is someone who I am working with on a consistent basis. Unless we have conjointly agreed otherwise, you will no longer be considered an active client when there have been no appointments within 60 days. Therefore, if you seek to re-engage counseling following 60 days of no contact, you may be subject to a wait-list.

PROFESSIONAL FEES

The fee for our first meeting is $200. The fee for subsequent individual, family, or parent sessions is $175. The charge for other professional services you may need (i.e., consulting) is $175 per hour. Consulting services are not covered under health insurance.

Forensic psychology (i.e., involvement in a legal process) fees require a separate fee schedule. You will be expected to pay for all professional time including preparation time and transportation, even if I am called to testify by another party. These rates began at $250 per hour, but may vary depending on the level of involvement. Your records will only be released when I receive a subpoena with a court order.

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INSURANCE

Currently, I accept the following insurance: Independent Health, Blue Cross Blue Shield, and Univera. I only accept commercial plans. I will try to contact your insurer prior to our first session to understand your mental health coverage. I advise that you also call to ensure we have received consistent information. Ultimately, you are responsible for my fees if they are not covered by insurance. Please be aware that if health insurance is paying for services, your health insurance company requires that I provide them with information relevant to the services provided. I am always required to provide a clinical diagnosis and the dates of services provided. I am occasionally required to provide additional clinical information such as a description of the problem or treatment plans and summaries, or the entire record (in rare cases). I will make every effort to release only the minimum amount of information necessary. I encourage you to contact your insurer's customer service department should you have any specific questions regarding the information they require. You understand that, by using your insurance, you authorize me to release such information to your insurance company.

Co-pays or co-insurance may apply depending on your insurer. Co-pays/co-insurance fees are due at the beginning of the session. I accept cash, check, or credit card (including health savings accounts). There is a $30 fee for returned check to cover accounting/banking fees. When fees are not paid for services rendered, a collection agency may be used and given appropriate billing and financial information. If you are having difficulty paying for treatment, please speak with me so we can arrange a payment plan.

CONFIDENTIALITY

I am required by New York State law and professional ethical standards to keep what you say confidential. In most situations, I can only release information about your treatment to others with a written consent form. However, there are a few exceptions:

In legal proceedings, you have the right to prevent me from providing any information about you or your child's treatment. In some legal proceedings, a judge may order my testimony if he/she determines that the issues demand it, and I must comply with that court order.

There are some situations in which I am legally obligated to take action to protect others from harm, even if I have to reveal some information about a patient's treatment. For example, if I believe that a child, elderly person, or disabled person is being abused or has been abused, I must make a report to the appropriate state agency.

If I believe that a client is threatening serious bodily harm to another, 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 the client threatens to harm himself/herself, I may be obligated to seek hospitalization for him/her or to contact family members or others who can help provide protection. If a similar situation occurs in the course of our work together, I will attempt to fully discuss it with you before taking any action.

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PARENT/GUARDIAN AUTHORIZATION FOR MINOR'S MENTAL HEALTH TREATMENT

In order to authorize mental health treatment for your child, you must have either sole or joint legal custody of your child. If you are or become separated or divorced from the other parent of your child, please notify me immediately. It is necessary that you provide me with a copy of the most recent custody decree that establishes the custody rights of you and the other parent or otherwise demonstrates that you have the right to authorize treatment for your child.

When a family is in conflict, particularly conflict due to parental separation or divorce, it is very difficult for everyone, particularly for children. Although my responsibility to your child may require my helping to address conflicts between the child's parents, my role will be strictly limited to providing treatment to your child. You agree that in any child custody/visitation proceedings, neither of you will seek to subpoena my records or ask me to testify in court, whether in person or by affidavit, or to provide letters or documentation expressing my opinion about parental fitness or custody/visitation arrangements.

PRIVACY

As your child's therapist, I am responsible for your child's protected health information (PHI) – information in your child's health record that could identify your child. I abide by federal regulations (HIPAA) and mental hygiene law to ensure your child's privacy. Therefore, I will primarily communicate with you face-to-face, via telephone, or via US mail. Email communication is reserved for basic exchanges (i.e., scheduling). I ask that you do not email me regarding clinical questions about your child. If this occurs, I will encourage you to set up an appointment. Ordinary precautions such as pin codes, voicemail boxes, email deletion, paper shredding, fax, mail, and secured computers are not infallible. You are always at risk of breeches in confidentiality when electronic, phone, or mail communication is used to communicate personal information. By agreeing with these policies and procedures, you understand the risks inherent in communicating personal information by phone, email, or by mail.

Occasionally, I encounter a client in public places in the community. To uphold confidentiality, I will not approach or acknowledge you in these situations unless you do so first. Should this situation occur in the community, it is important to explain this to your child, as they may mistakenly believe I was ignoring them or not happy to see them.

APPOINTMENTS AND CANCELLATIONS

Your first visit will be approximately 60 minutes, depending on the nature of the presenting problem. The first session is typically a parent only session, to gather more information about your child and your concerns. Following the initial session, appointments are approximately 50 minutes in length. Depending upon the nature of the presenting concern, I may meet with your child individually, parents individually, and/or parents and

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children together. Appointments are generally scheduled on a weekly or bi-weekly basis, depending on your child's needs and treatment goals.

If you need to cancel an appointment, please provide at least 24 hours' notice by calling me at 716-221-0363. If you do not attend the scheduled session or provide 24 hours' notice of cancellation, a $75 fee will be assessed. Future visits will not occur until the fee is collected. Insurance does not cover the cost of the missed visit.

CONTACTING ME

I am often not immediately available by telephone. Though I am usually in my office between 9am and 5pm, I will not answer the phone when I am with a patient. When I am unavailable, my telephone is answered by voicemail. I will make every effort to return your call promptly.

EMERGENCIES

There may be rare instances when you need my assistance in an urgent manner, such as matters of safety. You may contact me at 716-221-0363. Under such circumstances, I will respond as soon as I am able. Please indicate in your voicemail message "This is urgent." **However, if you feel your life is in danger or that the life of another is in danger, do not wait for my return phone call. I advise you to seek immediate assistance by calling 911 or Crisis Services at 716-834-3131.**

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I have read and understood the Policies and Procedures above. My signature below indicates my agreement with these terms and consent for treatment from Alanna Lipinski, Ph.D. I understand that I have the right to terminate therapy at any time.

_____
Child Name

_____
Printed Name

_____ _____
Patient Signature Date

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REQUEST FOR ELCTRONIC COMMUNICATION

In order to reduce no-show appointments, automated text messages or email messages are available. Please indicate below if you would like a reminder email or text message 1-2 days before your scheduled appointment. The only information disclosed will be the therapist's name (Dr. Alanna Lipinski), and the date and time of appointment. In addition, you can also authorize Dr. Alanna Lipinski to communicate basic exchanges (i.e., scheduling/rescheduling, confirm an appointment, send psychoeducation reading material, etc.) via text and/or email

☐ Automated Text (SMS) Message Appointment Reminder: _____

☐ Automated Email Appointment Reminder: _____

☐ Texts for Basic Exchanges: _____

☐ Emails for Basic Exchanges: _____

Be aware that by signing this form you are releasing me from any liability associated with leaving basic information that may identify you/your child as my client. ***I understand that if there is a mental health crisis, the only appropriate way to communicate with Dr. Alanna Lipinski is by telephone. Dr. Alanna Lipinski will not provide clinical information via text/email.***

_____
Child Name

_____
Printed Name

_____ _____
Signature Date

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AUTHORIZATION TO RELEASE INFORMATION
(Pediatrician, School, Psychiatry, Other)
(Print additional copies if you would like me to release/obtain information from multiple sources.)

To: _____
(Name of agency or individual)

Address: _____

_____

Phone: _____

Fax: _____

Re: _____
(Child name/DOB)

The agency or individual specified above is authorized to *release and obtain the following information* to/from **Dr. Alanna Lipinski** for the purpose of evaluation/treatment:

_____ Any relevant health information

_____ Specific information (please specify): _____

This authorization allows **Dr. Alanna Lipinski** to send/receive the above information to/from the above-named agency or individual. The specific purpose(s) of this disclosure is/are:

_____ To coordinate with other health/mental health providers

_____ Other _____

I authorize Dr. Alanna Lipinski to release health information in order to coordinate treatment for my child's benefit. This remains in effect one year after the date Dr. Alanna Lipinski ceases to provide services. I understand this can be revoked, in writing, at any time.

_____
Printed Name

_____ _____
Signature Date