JANE PRELINGER LICSW

5028 WISCONSIN AVE. NW, STE. 400, WASHINGTON DC 20016

Statement of Understanding

Thank you for your interest in working with me in psychotherapy. This "Statement of Understanding" is provided so that you and I may agree to work together under the following conditions. Please read through it and ask any questions you may have. Signing this document represents an agreement between us. A copy will be provided for your records and one will remain on file.

Payment

Payment is expected at time of service. Payment may be made by check,cash or credit card. (Mastercard/Visa/American Express). Statements showing dates of visits, charges, and payments will be provided monthly. I ask that all clients, including those who prefer to pay by check and cash provide me with credit card information so that in the event that payment is not made at the time of service, I can apply the appropriate charge to your credit card. If for any reason, your account has an outstanding balance at the end of the month, that balance will be charged to your credit card.

Cancellation Policy

We will arrange a regular weekly appointment time. I do my best to be flexible if you wish to reschedule your appointment. If you need to cancel or change an appointment, please provide a minimum of 24 hours notice. For example, if your appointment is scheduled for 9:00 a.m. on Tuesday, you must cancel by 9:00 a.m. on Monday. If you do not give 24 hours notice you will be charged for the missed session. The time you schedule for your session is being reserved for you; if you do not attend or give me 24 hours notice, I am unable to use this time to see another client. However, if I am able to reschedule you within the same week, there will be no charge for the missed session.

Inclement Weather

If there is snow or other poor conditions, please call me to determine if we are going to meet. If driving conditions prevent you from coming to your appointment, we can try to make other arrangements.

Confidentiality

I will maintain our conversations in strict confidentiality. Use or disclosure of your protected health information (PHI) will be for 'treatment' and 'payment purposes' only. An example of 'treatment' would be if another health care provider were consulted. An example of 'payment purposes' is considered to be when authorizations for treatment (when required) and/or reimbursements are obtained from your health insurer.

No information regarding any aspect of your treatment will be released to anyone without your prior consent. The only exceptions are:

Child Abuse: If I have reason to believe that a child has been subject to abuse or neglect, I must report this belief to the appropriate authorities.

Adult and Elder Abuse: I may disclose PHI regarding you if I reasonably believe adult or elder abuse, neglect or exploitation is occurring.

Health Oversight Activities: If I receive a subpoena because my practice is being investigated, I must disclose PHI.

Judicial and Administrative Proceedings: If an evaluation is court ordered, the information must be released. You will be notified in advance if this is the case.

Serious Threats to Health and Safety: If you communicate to me a specific threat of harm to self or others, I am required to notify the police and the potential victim to ensure safety.

Communications

Communications regarding appointments may be done using cell phone or email and you should be aware that these systems may not be secure, and your use with me of these means constitutes an acknowledgement of this threat to confidentiality and waiver of that protection on my part.

I am not always available by phone, though I try to answer voicemail in a timely fashion. I will return messages to my voicemail during normal business hours. If I do not return your voicemail and you need assistance or you are faced with an emergency, it is your responsibility to seek assistance. If you feel unsafe and are experiencing an emergency, dial 911 or go to your nearest emergency room.

Absences

I may be out of the office from time to time and in such cases will strive to provide you advance notice and if desired, the name and contact information for a colleague providing coverage in my absence. Likewise, if you have vacation and or travel plans, I appreciate as much advance notice as possible.

Permission to Treat

I acknowledge that is my choice to participate in psychotherapy. I realize that therapy is a partnership and the outcome of therapy depends upon my personal investment in the therapy sessions. If I decide to terminate treatment, I will discuss termination before ending treatment.

I HAVE READ THE ABOVE TERMS AND CONDITIONS SET OUT IN THIS DOCUMENT. I UNDERSTAND THEM AND AGREE TO BE BOUND BY THEM.

PATIENT SIGNATURE: _____

PRINTED NAME: _____

DATE: _____

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www.stadterandprelinger.com