Welcome

From the Office of: Harriet K. Breslow, L.C.S.W.-C.

This pre-session package contains the following documents:

l. Basic office information

2. Financial responsibility form

3. Informed consent to psychotherapy form [please familiarize yourself carefully with the enclosed important information on this form, so that it can be signed at the conclusion of the first session.]

4. Client questionnaire

5. Medical history and information

Although this seems to be a mountain of material, there are good reasons for having you read and fill out all these documents prior to the therapy session. These include making sure you understand the nature of the therapy relationship, and minimizing the amount of time taken out of the initial therapy session to obtain the necessary information required by insurance companies. In addition, having this information at the beginning of our session may allow me to understand the nature of your problem more quickly and throughly. Please feel free to ask any questions you may have concerning these or other matters. Of course, we will review the information during this session and later sessions when it is appropriate.

Basic Office Information

The confidentiality of your contact with me and this office will be respectfully and professionally maintained. You may contact me by phone 24 hours a day at 301-983-1321. However, I request that any calls after 10:00 P.M. and before 7:30 A.M. be reserved for emergencies. If I am unavailable, please leave a message on my answering machine, and I will return your call as soon as possible. When requesting that I return your call, please make sure that you leave the line open to incoming calls, and indicate what time I can reach you at a certain number. If your call is an emergency, please leave a message on my machine and in addition, call my cell phone at 301-996-1321, and leave me another message there. If I am out of town, I will either leave a number where I can be reached, or I will leave the number of a covering physician. At this time, many of my clients belong to several managed care companies, and it is therefore impossible for me to designate one covering physician for all networks. If, when I am out of town, my covering physician is not in your network, and, you wish to stay in network for medical backup, please call your managed care company for a direct referral to an in-network physician. If you are currently receiving medical back-up from an in-network physician, please contact him directly.

Therapy sessions are 45 minutes. The fee for an individual or family session is $110.00 per 45 minutes. However, with the advent of managed care, fees may vary. More detail about the fees is covered in my Financial Responsibility form. Usually my services are covered by health insurance. If you have concerns or problems paying my fees, please speak with me about them, and I will try to ease this process in whatever way is possible.

Parenting Coordination sessions are one to two hours, depending on the needs of the clients. Parenting Coordination fees are $250.00 per hour; they are not covered by medical insurance. All telephone calls, e-mails, and overtime sessions will be billed in 5-minute increments, based on the $250.00 rate.

RESPONSIBLE ATTENDANCE AT YOUR SCHEDULED SESSIONS IS A PART OF YOUR COMMITMENT TO THIS THERAPEUTIC RELATIONSHIP AND TO YOUR OWN GROWTH. ANY NECESSARY CANCELLATIONS MUST BE MADE AT LEAST 24 HOURS IN ADVANCE, OR YOU WILL BE RESPONSIBLE FOR THE ENTIRE PAYMENT OF THE SESSION.

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Parking is available in the local area. **PLEASE DO NOT PARK IN THE DRIVEWAY.** When you enter, PLEASE RING THE DOOR BELL to let me know that you have arrived, and then proceed through the short hallway to my waiting room directly ahead. To the left of the waiting room is a rest room; please feel free to use it.

Finally, in the course of our work together, if you have any questions, doubts or concerns, I urge you to speak openly of them. Our mutual interest in your personal well-being will be best served in this way.

I look forward to working with you.

Sincerely,

Harriet K. Breslow, L.C.S.W.-C.

FINANCIAL RESPONSIBILITY FORM

For the office of Harriet K. Breslow, L.C.S.W.-C.

This contract confirms my agreement for Harriet K. Breslow, L.C.S.W-C.,the therapist to provide therapy to _____ beginning _____ at a fee of 110.00 per hour session. (In case of a managed care referral the assigned co-pay will be determined by the company.) The co-pay assigned by (Co. Name) _____is _____ for a one hour session. Sessions extending beyond the hourly time limit will be billed at increments of 15 minutes of the agreed upon fee.

MISSED APPOINTMENTS WILL BE BILLED AT A FULL FEE AGREED UPON ABOVE. [In the case of managed care companies, this fee will not only include the co-pay, but will include the full fee provided to the therapist by the managed care company.] YOU WILL BE RESPONSIBLE FOR FULL PAYMENT FOR SESSIONS NOT CANCELED 24 HOURS IN ADVANCE. (Emergency situations or sudden extreme illness would be exceptions to this.) Please note: MISSED APPOINTMENTS ARE NOT COVERED BY INSURANCE.

Unless otherwise arranged, PAYMENT IS DUE AT THE END OF EACH SESSION. This includes all co-pays in accordance with managed care fees, as well as private insurance companies. If the client is a participant in a managed care organization, the client is responsible for contacting the managed care company to determine the correct co-pay. The therapist will file the claim with the managed care company, and the client is only responsible for the co-pay. The client is responsible to make sure that he has proper authorization for the initial visit and must have an authorization number when applicable. If the client has private insurance or no insurance, full payment is due at the end of each session, and the therapist will be happy to file claims for him with his insurance for direct reimbursement to him. If the client has private insurance, he is responsible for determining any insurance coverage, collecting any reimbursement, and procuring necessary forms to be completed by the therapist.- IT IS THE CLIENT'S RESPONSIBILITY TO SEE THAT THE FEE IS PAID WHETHER BY AN INSURANCE COMPANY OR BY ONESELF.

Telephone conferences with clients or collaterals (e.g. school officials, physicians, lawyers, relatives, etc.) extending beyond 10 minutes will be prorated at the above rate, to be paid by the next session. Long distance charges will be added to the therapy fee.

Out-of-office visits, for example, to schools and to homes, are calculated at the above agreed upon hourly fee for the time reserved, including travel time from and to the therapist's office. A mileage charge of $.40 per mile may be added to the charge. Such out-of-office visits as court appearances are charged at the above agreed upon fee on an hourly basis. However, due to the unreliability of court schedules, all court appearance will be billed in three hour segments, as it is impossible for the therapist to schedule any other appointments within that time frame in order to be available to the client. These court fees are to be paid in advance.

If it becomes necessary to take legal action to recover money due, the client is responsible for all collection and court costs and attorney's fees. In the case of nonpayment of bills, the client agrees to forfeit rights of confidentiality only to the extent necessary to collect such unpaid bills. Any bank charges for returned checks will be the responsibility of the client.

_____DATE_____
SIGNATURE OF CLIENT OR PERSON RESPONSIBLE FOR PAYMENT

_____DATE_____
THERAPIST'S SIGNATURE

Harriet K. Breslow, L.C.S.W.-C., B.C.D.

INFORMED CONSENT TO PSYCHOTHERAPY

I, _____, have fully discussed with Harriet K. Breslow, L.C.S.W.-C., B.C.D., the various aspects of the psychotherapy contract. This included a discussion of Mrs. Breslow's evaluation and diagnostic formulation, as well as the method of treatment. The nature of the treatment has been described, and goals have been agreed upon. Mrs. Breslow has further discussed with me scheduling, the nature of the fee and policies regarding missed appointments.

Some important issues regarding confidentiality need to be understood as we begin our work together. Please review the following material carefully so that we may discuss any questions or concerns of yours the next time we meet.

In most judicial proceedings, you have the right to prevent me from testifying. However, in child custody proceedings, adoption proceedings and proceedings in which your emotional condition is an important element, a judge may require my testimony if it is determined that resolution of the issues before the court requires it. If you are involved in litigation, or are anticipating litigation, and you choose to include your mental or emotional state as part of the litigation, I may have to reveal part of your treatment evaluation records.

If you are called as a witness in criminal proceedings, opposing counsel may have some limited access to your treatment records. Testimony may also be ordered in a legal proceeding relating to psychiatric hospitalization, and in certain legal cases where a client has died.

In addition, there are some circumstances where I am required to breach confidentiality without a client's permission. This occurs if I believe that a child is being abused, in which case I must file a report with the appropriate State agency. If I believe that a client is threatening to do serious harm to another, I am required to take protective action, which may include notifying parents, police, warning the intended victim, or seeking that client's hospitalization. If a client threatens to harm himself or herself, I may be required to notify parents and police, or to seek hospitalization of the client.

The clear intent of these requirements is that a social worker has both a legal and ethical responsibility to take action to protect endangered individuals from harm when his or her professional judgment indicates that such danger exists. Fortunately, these situations rarely arise in my practice. If such a situation should arise, it is my policy to fully discuss these matters with a client before taking any action, unless there is a good reason not to do so.

There are several other matters concerning confidentiality:

1. I may occasionally find it helpful or necessary to consult about a case with another professional. In these consultations, I do not reveal the identity of the client. The consultant is, of course, also legally bound to maintain confidentiality. If I think it would be helpful to refer you to another professional for consultation, then, of course, with your authorization, I will discuss your case with her or him.

2. I am required to maintain complete treatment records. Clients are entitled to receive a summary of these records, unless I believe the information would be emotionally damaging and, in such cases, the summary can be given to the client's appropriate designee. The client will be charged an appropriate fee for preparation of treatment records.

3. If you use third party reimbursement, I am required to provide the insurer with a clinical diagnosis and usually a treatment plan and summary. In managed care cases, this is done usually after 6 to 10 sessions, in order to justify additional sessions if needed. If you require it, I will provide you with a copy of any report I submit, unless again, I believe it would be detrimental to your well being, in which case, the report would be given to the client's designee.

4. If you are under 18 years of age, please be aware that while the specific content of our communications is confidential, your parents have a right to receive general information on the progress of your treatment, as well as notification of any serious threat to your welfare.

5. Finally, while there is no legal precedent, many experts believe that information shared either in group psychotherapy or in marital therapy may not be protected in court proceedings.

While this summary of exceptions to confidentiality should prove helpful in informing you about potential problems, you should be aware that the laws governing these issues are often complex, and I am not an attorney. I encourage our active discussion of these issues. However, if you need more specific advice, formal legal consultation may be desirable.

I have read the above, fully understand the diagnosis, the nature and limitations of treatment, the limits of confidentiality in this relationship, and circumstances in which confidential communications may need to be breached.

Date_____ Signature_____

Date_____ Witness_____

CLIENT QUESTIONNAIRE

Please complete the following questionnaire - Please PRINT ALL ANSWERS - The information you provide will be used conscientiously in your care and is STRICTLY CONFIDENTIAL.

Email : _____

Today's date_____ Client's name_____Age_____
Client's birth date_____ Client's social security number(SS#)_____
Client's home address_____ Home phone:(___)_____
_____Zip__ Work phone:(___)_____
Marital Status Single __ Married____Widowed____ Divorced____ Wife: Cell :(___)_____husband:cell:____

Place of employment_____ Occupation:_____
(If applicable) Year in school_____
(If applicable)Parents of Minor/Spouse Information
Mother's name_____Father's name_____Spouse's name_____
Address_____ Address_____Address_____
_____ _____ _____
(o)(___)_____(h)(___)_____ (o)(___)_____(h)(___)_____(o)(___)_____(h)(___)_____
Occupation_____Occupation_____Occupation_____

Insured Person's name:_____Insured's SS# _____
Insured's birth date:_____Insured's place of employment_____
Insured's marital status: Minor_____ Single_____ Married_____ Separated_____ Divorced_____
Person responsible for payment:_____Insurance Co._____
Plan Name_____Policy #_____Phone number:(___)_____
If you are using a managed care company, please enter the following information.
Authorization# _____Client's Co-pay $_____Number of visits authorized_____
ADDRESS TO SEND CLAIMS:_____

QUESTIONS FOR CLIENT: Who Lives in your household?

Name	Relationship to you	Age
l._____	_ _____	_____
2._____	_____	_____
3._____	_____	__ _____
4._____	_____	__ _____

Children living outside your home:

Name	Age:
l._____	_____
2._____	_____

If this is blended family or the parents of a minor are separated, please indicate which child lives in which household._____
_____
If this is blended family, are there any children born of this second marriage.?_____

Name & phone # of Primary Care Physician_____ Tel.(___)_____
Name of referring party if other than a managed care company_____Tel.(___)_____
Name of school & school counselor, if client is a minor_____Tel.(___)_____
Name and phone # of previous therapist (if applicable)_____Tel.(___)_____
Please list the names and phone numbers of two relatives or close friends who may be contacted in case of emergency.
Name_____Relationship_____Tel:(___)_____
Name_____ Relationship_____Tel:(___)_____

* * * * *

I, _____, authorize Harriet K. Breslow, L.C.S.W.-C. to make any professional contact that she deems helpful to my treatment with professionals connected with this psychotherapy. This can include psychotherapists, primary care physicians, teachers, counselors, nurses, lawyers and insurance companies , managed care companies, or other professionals in whom I have entrusted my health care. [No contact will be made without your prior knowledge and consent.]

Signature of client, or parent if client is a minor_____Date:_____

Signature of parent if client is a minor_____Date:_____

Past Psychiatric History: Please list all previous therapists, dates of treatment, and any hospitalizations.

_____
_____
_____
_____

Please list all medications prescribed for these psychiatric conditions and any negative side effects which may have resulted from taking them._____

_____
_____
_____

Chemical Dependency: Have you ever been treated for substance abuse: Yes( )No( ) If so, please
explain_____
_____

Have you ever used any of the following substances? Alcohol( ) Cocaine( ) Heroin ( )
Methodone( ) Tranquilizers( ) Barbiturates( ) Seconal ( ) Hallucinogens (LSD PCP)( )
Pain Pills ( ) Stimulants (amphetamines, speed) ( ) Narcotics (Codeine, percodan, demerol) ( )
Other ( ) Please explain_____
How Long? 1-5 years ( ) 5-10 Years ( ) 10-15 years ( ) + 15 years ( )
Date of Last Use:_____ Frequency of Use_____
Any periods of Sobriety _____Amount & method of use_____
_____
Any relapse triggers, if known:_____-
Legal & social, work consequences_____
_____
Do you have periods of blackouts, seizures, withdrawal symptoms, medical complications
Yes ( ) No ( ) If so please explain_____

Do you have family or community support? Yes ( ) No ( )
Do you have financial stressors? Yes ( ) NO ( )
Do you have current legal problems Yes ( ) No ( )

Employment/Education History: Please give highest level of education achieved_____
Has Employment ever been a problem in the past: ( )Yes ( ) No If yes, please explain briefly

_____
_____

How would you rate your satisfaction and success in your employment? ( )High, ( )Good ( ) Fair ( )Poor

Please indicate how your emotional status or problems have affected the following::

	No Effect	Little Effect	Some Effect	Much Effect	Significant Effect	Not Applicable N/A
Marriage /Relationship	1	2	3	4	5	N/A
Family	1	2	3	4	5	N/A
Job/School Performance	1	2	3	4	5	N/A
Financial Situation	1	2	3	4	5	N/A
Outside Interests	1	2	3	4	5	N/A
Physical Health	1	2	3	4	5	N/A
Anxiety/Nerves	1	2	3	4	5	N/A
Mood	1	2	3	4	5	N/A
Eating Habits	1	2.	3	4	5	N/A

(if yes- weight gain _____lbs. Weight loss_____lbs.

Sleeping Habits:

Do you have trouble falling asleep Yes ( ) No ( )

Do you have trouble waking up in the middle of the night Yes ( ) No ( )

Do you awake too early in the morning Yes ( ) No ( )

Sexual Functioning	1	2	3	4	5	N/A
Ability to concentrate	1	2	3	4	5	N/A
Ability to control your temper	1	2	3	4	5	N/A
Experience feelings of hopelessness	1	2	3	4	5	N/A

Do you think about committing suicide Yes ( ) NO ( )

Have you ever made or carried out a plan to commit suicide Yes ( ) No ( )

Homicidal Ideation Yes ( ) No ( )

HAVE YOU EVER BEEN ABUSED? Yes_____ NO_____

Please list all previous Significant Illnesses:_____

_____

_____

All medicines that you are currently taking and for what purpose_____

_____

_____

_____

Do you have any current physical symptoms:_____

_____

_____

_____

Does your family have a history of significant medical problems or psychiatric illness:_____

_____

_____

_____

Do you have any allergies_____

_____