***RICHARD PANTALEONI, LCSW***
***Individual and Family Psychotherapy***
***51 E 42 Suite 820, New York, NY 10017***
***203-240-4180 rick.pantaleoni@gmail.com***

## OFFICE POLICIES, MEANS OF COMMUNICATION, AND INFORMED CONSENT

Welcome to my practice. I look forward to working with you. Please read this document carefully, since it contains important information about my professional services and business policies. If you have any questions, please feel free to discuss them with me.

Licensure: I am a Licensed Clinical Social Worker (LCSW) within the state of New York engaged in private practice providing mental health care services.

Scheduling & Referrals: Appointments are for 50 minutes. I see clients on a weekly basis, typically at a fixed recurring day/time. When this is not possible, I make reasonable efforts to work with your schedule. If you need to contact me between sessions, please call 203-240-4180 and I will return your call as soon as possible. I check my messages a few times a day unless I am out of town.

On some occasions, I may determine you need a higher or more specialized level of care than I can provide. In these cases, I will make every effort to work with you to find the most appropriate and potentially helpful referral to meet your needs.

Payment and Billing Procedures: You have agreed to a fee of $_____ per session. You are expected to pay for services at the end of each session. I currently accept only cash or checks (made payable to **Richard Pantaleoni, LCSW**). I do not accept credit cards at this time. I do not accept insurance, but can supply you with a paid receipt for services rendered either after each session, or at the end of each month. You may submit this receipt to your insurance company for partial reimbursement if your plan provides for out-of-network benefits.

Cancellation Policy: I appreciate your courtesy in providing me with as much notice as possible if cancelling or rescheduling an appointment. If you cancel with less than 24 hour notice, I will bill you for the session as if it had been kept. Difficulties achieving regular attendance reduce therapy's effectiveness. In such circumstance, I reserve the right to terminate my services.

Confidentiality: Information shared between you, as the client and me, as your treating psychotherapist is confidential and protected by law. Information cannot be disclosed without permission in writing from you or your parent/legal guardian if you are a minor. In some instances, the law may require me to disclose information without your consent. These provisions are described in the Notice of Privacy Practices which I provide you.

Litigation Limitation: Due to the nature of the therapeutic process and the fact that it often involves making a full disclosure with regard to many matters that may be

confidential in nature, it is agreed that should there be legal proceedings (such as divorce and custody disputes, immigration issues, injuries, lawsuits, etc) neither you (the client) nor your attorney nor anyone else acting on your behalf will call me to testify in court or at any other proceeding, nor will a disclosure of the psychotherapy notes be requested.

Emergency Procedures. If an emergency situation arises and you need to talk to someone right away, you can call 911 or go to the nearest Emergency Room. Assistance is also available by calling the 24 hour hotline at 1-800-LIFENET.

Means of Communication. It is important to be aware that email and cell phone communication can be accessed by unauthorized people, thereby compromising the privacy and confidentiality of such communication. Please indicate your consent to communicating with me by the following means:

| | | |
|---|---|---|
| **Email** | Yes _____ | No ____ |
| **Text message** | Yes _____ | No ____ |
| **Therapist use of cell phone** | Yes _____ | No ____ |
| **Ok to leave voice messages** | Yes _____ | No ____ |

Consent to Treatment: I, voluntarily, agree for myself and/or my child (if applicable) to receive mental health assessment, care, treatment, or services and authorize the undersigned therapist to provide such care, treatment, or services as are considered necessary and advisable. If applicable, I understand and agree that I will participate in the planning of my child's care and that I may stop such care that I receive through the undersigned therapist at any time. By signing this Informed Consent form, I acknowledge that I have both read and understood all the terms and information contained herein. Ample opportunity has been given to me to ask questions and seek clarification of anything unclear to me.

By signing below, you acknowledge that you have read and understood the above policies, and agree to follow them.

Date: _____

Signature of Client: _____

Name of Client (please type or print) _____

Name of Minor ( if applicable)
(For Minors) Signature of Parent/Legal Guardian_____

Name of Parent/Legal Guardian _____

Witness By _____