**Psychotherapy Information Disclosure Statement**

**And Conditions of Treatment/Consent**

NANCY H. SHERIDAN, MSW, LICSW

35 Center St. (Rt. 28)

PO Box 915

Wolfeboro Falls, NH

(Ph) 603-730-2999

(Fax) 603-569-8925

**The New Hampshire Board of Mental Health Practice** requires that all Licensed Independent Clinical Social Workers provide the following basic information to the clients they treat:

My background: I am a NH Licensed Clinical Social Worker (#436). I earned my Master’s degree in social work (MSW) at Smith College School for Social Work in Northampton, MA. I earned a Bachelor of Science in Elementary and Special Education from Fitchburg State College, Fitchburg, MA. My MSW training prepared me to work with individuals, families and groups in therapy as well as advocacy. I follow the National Association of Social Workers Code of Ethics. My approach to working in therapy with people is integrated based on my 25 years experience. I combine strength-based, relational counseling focused on the client’s identified goals and skills. My professional training includes solution-focused family and individual therapy, group therapy, social skills for children and teens living with Asperger’s Syndrome and high functioning Autism, working with children, teens and families dealing with special education issues.

Continuing education is a requirement for LICSWs. It is in my nature, being a life-long learner, to go beyond the annual requirements for conferences and trainings. Specific fields of interest and study include Autism Spectrum Disorders, strength-based work, adolescents and women. I am happy to provide more detail of my trainings.

**Confidentiality:** Client confidentiality and safety within the therapeutic relationship is important. When clinically indicated it may become necessary for me to communicate with a third party. In this event the client or guardian may sign a release of authorization/information form that allows communication of specific information to occur. Confidentiality does not apply in civil commitment proceedings in which the issue is whether a client is a danger to self or others.

If you are using health insurance reimbursement I am required to submit information including a diagnosis and treatment plan to the named insurance company. In order to provide optimal treatment I engage in regular individual and group clinical collaboration/consultation with other qualified mental health professionals who ascribe to the laws of confidentiality. Please let me know if you have any specific requests regarding confidentiality and whether or not I may leave phone messages on your answering machine at work, home, your cell phone or with family members.

If you are a minor under 18 years of age, your legal guardians have access to your clinical records with the exception of substance abuse counseling and family planning issues.

Under New Hampshire law, communications between a Licensed Independent Clinical Social Worker and a client are confidential with some exceptions noted as follows:

1. 330-A: 35 Civil Liability; Duty to Warn. –
“Any person licensed under this chapter has a duty to warn of, or to take reasonable precautions to provide protection from, a client's violent behavior when the client has communicated to such licensee a serious threat of physical violence against a clearly identified or reasonably identifiable victim or victims, or a serious threat of substantial damage to real property”.
2. I am legally responsible to report the neglect, abandonment, physical, sexual and emotional abuse of a child under the age of 18 as well as elderly persons or persons identified as vulnerable adults. If I have good reason to believe that you are abusing or neglecting a child or vulnerable adult, or if you give me information about someone else who is doing this, I must inform Child Protective Services within 48 hours and Adult Protective Services immediately.
3. If I believe that you are in imminent danger of harming yourself or others, I may legally break confidentiality and call the police. I am obligated to do this regarding any client under the age of 18 or any vulnerable adult, and would explore all other options with you before I took this step. If at that point you were unwilling to take steps to guarantee your safety, I would call the police.
4. If you tell me of the behavior of another named health or mental health care provider that informs me that this person has either a. engaged in sexual contact with a patient, including yourself or b. is impaired from practice in some manner by cognitive, emotional, behavioral, or health problems, then the law requires me to report this to their licensing board in the state of New Hampshire. I would inform you before taking this step. *If you are my client and a health care provider, however, your confidentiality remains protected under the law from this kind of reporting.*

**Records:** Your medical record includes assessment, diagnosis, treatment planning and recommendations, dates of service and progress notes, personal demographics, any financial statements provided and insurance information. Your medical record will be kept a minimum of seven years as required by NH law. You are entitled to view your records and receive copies. If you wish to review your records I recommend you make an appointment. If you request copies a nominal fee will be charged and copies will be provided within ten business days or within a reasonable amount of time.

# **Conflicts of Interest:** New Hampshire is a small state. From time to time, actual or potential conflicts of interest may arise. In the event that I become aware of a conflict of interest in providing treatment to you, I may be required to refer you to another therapist. Regardless of the existence of a conflict of interest, you can be assured that any information will remain confidential. Since we live in an especially small community, I will not acknowledge you in public unless you address me first.

**Your responsibilities as a client:**

The fee for a 45-minute appointment is $65.00 for individual and/or family therapy, expected at the start of our appointment. The fee for group therapy is $30. It is your responsibility to pay that fee by cash or check. If you choose to use your health insurance I will provide you with a bill that you may submit for reimbursement. It is your responsibility to call your insurance company to see if they will cover my services in their out of network category.

Cancelations: Everyone’s time is valuable. If you miss a session without canceling, or cancel with less than 24 hours notice, you are responsible for the fee of that session before or at your next appointment with me.

The fee for written reports, telephone contacts other than brief cancellation/rescheduling will be charged based on the self-pay fee of $65 per hour, pro-rated. Insurances will not cover these fees. Requests for court appearances, documents and assessments are strongly discouraged. If you accrue a debt and do not pay your debt, I reserve the right to give your name and the amount due to a collection agency.

**COMPLAINTS**: I welcome your expressed concerns, questions, satisfaction and dissatisfaction with your treatment. I hope to create an environment that is empowering and safe for my clients. I hope to satisfy your concerns directly. If an understanding cannot be reached between us you may register a complaint with the New Hampshire Board of Mental Health in Concord, NH. I have a copy of your rights as a Mental Health patient that I will supply at your request.

Financial Agreement & Insurance Information

In signing this form I recognize that I am responsible for all fees as outlined above. I further acknowledge that any debt not paid within 2 weeks will be reported to an outside agency for collection. I further acknowledge that insurance company’s policies change and that I am responsible for my bill regardless of insurance reimbursement policies.

The fee for hourly service is $65.00 unless otherwise noted.

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Client signature date

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Parent/guardian signature date

**CLIENT CONSENT TO PSYCHOTHERAPY**

I have read this statement, had sufficient time to be sure that I considered it carefully, asked any questions that I needed to, and understand it. I understand the limits to confidentiality required by law. I consent to the use of a diagnosis in billing, and to release of that information and other information necessary to complete the billing process. I agree to pay the fee of $65.00 per session. I understand my rights and responsibilities as a client, and my therapist’s responsibilities to me. I agree to undertake therapy with Nancy H. Sheridan, MSW, LICSW. I know I can end therapy at any time I wish and that I can refuse any requests or suggestions made by Nancy Sheridan. I am over the age of 18.

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Parent/guardian signature date