**Gae Savino, LCSW Mindful Heart Counseling Services, LCSW, CT**  St. Augustine Parish Hall 381N. Highland Ave. Ossining, NY10562 914-391-5966

**Notice of Practice Policies: Nature of Counseling Policy** Congratulations on your willingness to embark on the next steps in your personal and therapeutic growth. This notice outlines my policies regarding our work together.

Counseling provides an opportunity for growth and self-discovery in a safe, supportive, and therapeutic relationship. My counseling approach is eclectic as we explore approaches that are best suited to your needs.

We will work together - a mutual investment - to identify triggers that evoke feelings, lead to certain behaviors, and apply positive coping skills. Our work may improve your ability to manage feelings, communicate, relationships, and mental health concerns.

If you experience a mental health emergency, immediately obtain crisis services by dialing 911 and/or by going to the nearest hospital emergency room.

**Counseling Relationship** **Policy**  Our in-person sessions will be approximately 50-minutes. The counseling relationship is a professional relationship. Please do not invite me to social events, bring gifts, ask to barter or exchange services, request a personal reference, seek to befriend me on social media, e.g., Face book, or ask me to relate to you in any way other than the professional context of our therapeutic counseling relationship.

Counseling sessions are conducted in English. If translation services are necessary, the client arranges and pays for the translation services.

My session lengths and fees are: Individual: 50 minutes Fee: $125 per session \* Couple, family session: 60 minutes Fee: $150 per session \* Grief support groups: 1hour, 15 min Fee: TBD

Individual consideration is given to fees in advance of treatment.

I generally do not do phone or *Skype* sessions. In office sessions, we benefit from face-to-face interactions and our non-verbal cues that increase understanding and the therapeutic connections

I accept out-of-pocket payments via cash, checks, or money orders. I do not accept credit or debit cards, If a client’s check is returned due to insufficient funds, the client will need to pay all bank fees charged to my business account. If a client’s check is returned, two times in the course of treatment, the client must pay all subsequent payment in cash. Client must pay all payments within two sessions.

**Scheduling, Missed Session & Crisis Policy** In order for me to be most effective, I ask clients to schedule sessions in advance, and alert me with 24 hour notice if you need to cancel. If you cannot provide 24 hour notice, I will charge for the full cost of the missed session. If you and I collectively determine that your cancellation was due to an illness or emergency, there will be no charge.

**Setting Treatment Goals & Termination Policy** Our work together is important. It warrants our mutual commitment. We will work together towards the creation of therapeutic treatment goals and towards the outcome of your goals using a treatment plan including positive coping skills.

I request that if you wish to terminate, or close treatment that you and I schedule at least two sessions. These sessions will review and discuss our accomplishments, any unfinished work, any regrets, future goals, and any necessary referrals. I am open to discussing any financial needs in order to facilitate those final sessions.

**Confidentially Policy**  I maintain a strict policy of confidentially in accordance with NASW’s Code of Ethics and HIPAA regulations. In the event that I believe you are in danger, physically or emotionally, to yourself or another person, you specifically consent for me to warn the person in danger and to contact the following persons, in addition to medical and/or law enforcement personnel. Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Contact # (s): \_\_\_\_\_\_\_\_

The only time that confidentially is broken is when you report the possibility of self-harm, harm to others, or that you are being harmed, e.g., bullied. The appropriate authorities will then be notified for your safety and the safety of others.

**Client Rights** As a client, you may end our counseling relationships at any time, though I do ask that you participate in a termination session. You also have the right to refuse or discuss modification to any of my counseling techniques or suggestions that you believe might be harmful. I render counseling services consistent with accepted National Association of Social Worker (NASW) Code of Ethics.

**Records** **Policy** All communication becomes part of the client record, which is maintained in the form of paper files. Adult client records are destroyed seven years after the file is closed. Minor client records are destroyed seven years after the client’s 18th birthday.

**Effects of Counseling Policy** At any time, you may initiate a discussion of possible positive or negative effects of entering, continuing, or discontinuing counseling. Although there are expectations about benefits from counseling, I cannot guarantee any specific results. Counseling is a personal exploration and may lead to major changes in your life perspective and decisions. These changes may affect significant relationships, your employment, and/or your understanding of yourself. You may feel distress, usually only temporarily, by some of the things you learn about yourself or some of the changes you make. Although the exact nature of changes resulting from counseling cannot be predicted, I intend to work with you to achieve the best possible results for you.

**Conditions of Ongoing Counseling Policy** I reserve the right to postpone and or terminate counseling with youin any of the following circumstances: a) if you come to session under the influence of alcohol or drugs; b) if you do not comply with the medication recommendations of your psychiatrist or physician; c) if I believe you are not benefiting from counseling; d) if, in couple counseling, I learn that you are battering your partner/spouse; e)if I am impaired in providing competent counseling to you; or f) if I am seeing you in couple counseling and you and your spouse decide to divorce.

In group counseling, I reserve the right to deny group entry to anyone I consider detrimental to the therapeutic effectiveness of the group. Referrals will be provided. If you choose to decline the referrals, I will terminate our counseling relationship.

**Referral Policy** I acknowledge that not all conditions presented by clients are areas within my expertise. For this reason, you and/or I may believe that a referral with a particular expertise is warranted. In that case, I will provide alternatives including programs/services and or clinicians who may be available to assist you. We will discuss referrals. The client is then responsible for contacting and evaluating those referrals and/or alternatives.

**Consent to Treatment Policy** By your signature below, you are indicating 1) that you voluntarily agree to receive mental health assessment and mental health care/counseling, treatment or services, and that you authorize me to provide such assessment and care, treatment, or service as I consider necessary and advisable; 2) that you understand and agree that you will participate in the planning of your care, treatment, or services, and that you may at any time stop such care, treatment or services that you receive through me; 3) that you have read and understood this statement and have had ample opportunity to ask questions about, and seek clarification of, anything unclear to you; and 4) that I provided you with a copy of this statement.

By my signature, I verify the accuracy of this document and acknowledge my commitment to confirm its specifications.

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_

**Client Request For Confidential Communications**

I, Gae Savino, LCSW, Mindful Heart Counseling Services, LCSW, LLP assume that I may contact you by telephone at your home and at your work, and in writing at your home, unless you instruct me otherwise.

Under, HIPAA, you have the right to request that communications with you be confidential and by means of your selection. I will approve your request if in our opinion it is reasonable. Once I agree to your request, I am obligated to honor it, except if an emergency arises. I wish to be contacted as follows (check all that apply):

* At my home telephone number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_ You may leave a message with detailed information

\_\_\_ Leave message with a call-back number only

\_\_\_ Call only at specified times of the day: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

* At my work telephone number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_ You may leave a message with detailed information

\_\_\_ Leave message with a call-back number only

\_\_\_ Call only at specified times of the day: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

* At my cell telephone number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_ You may leave a message with detailed information

\_\_\_ Leave message with a call-back number only

\_\_\_ Call only at specified times of the day: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

* In writing at:

\_\_\_ My home address

\_\_\_ My work address

\_\_\_ My fax number (2) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_ My email address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If any means of contacting you will place you in danger, please specify: \_\_\_\_\_\_\_\_\_.

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