

Susan Falcon, LCSW  
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Metairie, LA. 70002  
504-458-6256

Office Policies and Procedures  
Please Read the Following and Sign Where Indicated

I have been a Licensed Clinical Social Worker since 1987. I received a Bachelor of Social Work from Loyola University and a Masters of Social Work from Tulane University. In 2004, I completed the Divorce Mediation course at Loyola Law School. I am a Certified Gottman Therapist – please go to [TheGottmanInstitute.com](http://TheGottmanInstitute.com) to access my profile.

Confidentiality:

All information about you and your care – including the fact that you are coming here for treatment – will be held in the strictest confidence in compliance with HIPPA regulations. The only exceptions to this are:

- If you give me a signed release to release information
- If a court orders me to release the information
- If you disclose a plan to harm yourself, I am required to notify your family and legal authorities. If you disclose a plan to harm another person, I am required to warn the intended victim and legal authorities
- If you disclose abuse or neglect of children or vulnerable adults (the elderly, disabled), I must report this to the appropriate agency or legal authorities

In order to collect fees, information can be released to a third party payer (insurance)

If there is an emergency during the time we are working together or after termination, in which I become concerned about your personal safety, I may contact the person whose name you provided on your information form. \_\_\_\_\_

HIPAA –Notice of Privacy Practices

The Federal Health Insurance Portability and Accessibility Act requires mental health professionals to issue an official Notice of Privacy Practices. This describes how information about you is protected, the circumstances under which the information may be disclosed or used, and how you may gain access to the information. If you would like a full copy of the HIPAA notice, I will provide it.

Communication:

I do not email clients as email is not a secure form of communication. I am not on any Social Networking sites. Text messaging is not a secure means of communication and has the potential to compromise your privacy and become part of your legal medical record later. Texts between iPhones are encrypted, but other phones do not have this protection. Having said this, most clients do wish to be able to text regarding appointment times. If you would like to use texting for this, please sign below. If you wish to discuss anything more significant, please phone me. I check messages at the end of the work day. \_\_\_\_\_

Certification and Authorization to Release Information:

This is to certify that the information provided is correct to the best of my knowledge. I hereby authorize Susan Falcon, LCSW to release billing and diagnosis related information to my insurance company or other third party payer for purposes of billing, utilization review, or coverage determination purposes. \_\_\_\_\_

Guaranty of Account:

You are ultimately responsible for the charges related to your treatment. In absence of a valid payment agreement or assignment of benefits, full payment is due at the time of service. If your treatment is covered by a health insurance policy, you are responsible for providing me with the information I need to send your bill. You must pay the deductible at the beginning of the calendar year (if this applies) and any co-payment at each session. See attached insurance information form.

Fees:

- Therapy session for private pay clients: \$100.00
- Phone session: \$20.00 per 15 minutes
- Summation of Services: \$100.00 per hour
- Preparing/copying records, reports and letters: \$100.00 per hour.
- Court appearances, depositions, travel and preparation time: \$200.00 per hour
- Missed appointment without 24 hour notice: \$75.00

Cancellation Policy:

**I require a 24 hour notice of cancellation of an appointment. Messages may be left at my number nights and weekends. Without 24 hours' notice of cancellation, I must charge you \$75.00. Your insurance company does not pay for missed appointments. I do not call clients to remind them of their appointments, so please keep track of your appointments so that you do not incur this unnecessary cost. Please sign here that you understand and agree to this policy.**

X \_\_\_\_\_ X \_\_\_\_\_

Emergency Care After Hours:

If you are experiencing a psychiatric emergency, you should go to the Emergency Department of the nearest hospital where a physician can evaluate you. You may phone me, but I will direct you to go to the ER.

Termination:

It is usually beneficial for client and therapist to discuss the termination process and I encourage you to do so. I support all termination, for whatever reason. I also welcome the opportunity to discuss termination ahead of time. It is common for a client to take a break from counseling and to return at a later time. However, if I have had no contact with you for two months, I will close the case. We can always re-open your case if you contact me again.

Consent:

By signing this document, you acknowledge that you have received a satisfactory explanation and understand the information regarding therapy including problems, goals, and methods of treatment. You are consenting to treatment for yourself, your minor child, or your family. You have the right to cease therapy at any time.

You will be given a copy of this document.

Client Name (Please Print): \_\_\_\_\_

Client Name (Please Print): \_\_\_\_\_

Signature of Client: \_\_\_\_\_

Signature of Client: \_\_\_\_\_

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

Signature of Therapist: \_\_\_\_\_