Client Information and Office Policy Statement

Welcome! Thank you for choosing the Hudson Valley Center for Cognitive Therapy (HVCCT). We understand that the decision to seek therapy for your child is a very important one, and we are honored that you have decided to work with us. We would like to take this opportunity to acquaint you with information relevant to treatment, confidentiality, and office policies.

Cognitive Therapy: Cognitive Therapy is one of the most state-of-the-art and extensively researched methods of psychotherapy. A central idea in Cognitive Therapy is that perceptions of an event or experience powerfully affect emotional, behavioral, and physiological responses. By challenging one's thoughts and modifying habitual and engrained negative thinking patterns, one can learn to change his/her mood and behavior. This method has helped thousands reduce emotional distress and develop more effective coping skills that can be used in everyday life.

Financial Terms/ Insurance: Payment is due every session. There will be a $25 charge for any returned checks. In addition to therapy appointments, your therapist will prorate the session fee for time spent for other professional services rendered. Other services may include but are not limited to report writing, telephone conversations lasting longer than 10 minutes, attendance at meetings with other professionals you have authorized, and preparation of records or treatment summaries. If you become involved in legal proceedings that require your therapist's participation, you will be expected to pay for his/her professional time, even if he/she is called to testify by another party. The fees for professional time related to legal involvement (e.g., preparation and attendance at a legal proceeding) differ from that of the therapy session fee and will be discussed at that time.

If you fail to meet your financial responsibilities within 60 days and arrangements for payment have not been agreed upon, we reserve the right to turn your account over to a collection agency or appropriate court. If such action is necessary, you will be responsible for any expenses incurred. Please call Dr. Christine Ziegler at (845) 353-3399 x12 if you have any questions regarding these matters.

Insurance Reimbursement: Please note that services provided by therapists working at the HVCCT office are out of network for your insurance plan. Most insurance plans offer an out of network benefit for mental health. Please check with your insurance carrier regarding the details of your plan. It is your responsibility to find out about your coverage (e.g., deductibles, number of covered sessions, authorization needed to begin therapy, etc.). At your request, your therapist will prepare a form that you can submit to your insurance for reimbursement as outlined by your plan.

Cancelled/Missed Appointments: A scheduled appointment means that time is reserved only for your child. **If an appointment is missed or cancelled with less than 24 hours notice, you will be billed at your usual fee.**

Confidentiality: Issues discussed in therapy are generally confidential. However, there are limits to confidentiality. These situations include: 1) suspected abuse or neglect of a child, elderly person, or a disabled person, 2) when your therapist believes that your child is in danger of harming him/herself or another person, 3) if you or your child report that you intend to physically injure someone, the law requires your therapist to inform that person as well as legal authorities, 4) if your therapist is ordered by a court to release information, 5) when your insurance company is involved (e.g., filing a claim, insurance audits, case review, etc.), 6) in natural disasters whereby protected records may become exposed, or 7) when otherwise required by law. You may be asked to sign a Release of Information so your therapist may speak with family members or other professionals involved in your child's care.

Contacting Your Therapist: Your child's therapist may not be immediately available by telephone. When your therapist is unavailable, the telephone is answered by an answering machine which is monitored frequently. If it is a clinical emergency you are unable to reach your therapist, go to your nearest emergency room.

Electronic Communication/Email and Texting Policy: You are urged not to send text and email messages that contain clinical information since they are not HIPAA compliant, and your privacy could be compromised. Your therapist and the HVCCT do not guarantee your privacy for any electronic communication and do not guarantee that your email or text will be read or responded to in a timely manner. If you need to speak to your therapist before your next scheduled appointment, you should contact him or her by telephone. If you do choose to send an electronic communication, you agree to assume full responsibility for the risks, and will not hold your therapist or the HVCCT liable for any possible breach in confidentiality or failure to respond in a timely manner.

Record Keeping: A clinical chart is maintained describing your child's condition, his/her treatment, and progress, as well as notes describing each therapy session.

Client Satisfaction: We at the HVCCT are committed to working with you and your child to the best of our ability. We appreciate and welcome feedback about your therapy experience, particularly while your child is in treatment. If you have any concerns at any point with the course of treatment, please do not hesitate to speak candidly to your therapist. If your concerns persist, please call Dr. Christine Ziegler, Director of the HVCCT. It is very important to us that you and your child are comfortable working with your therapist and that you feel that your child's treatment is going in the direction you wish.

Consent for Treatment: You authorize that your child's therapist may carry out or order psychological examinations, treatment, and/or diagnostic procedures that now or during the course of your care are advisable. You understand that the purpose of these procedures will be explained to you upon request and subject to your agreement. You also understand that while the course of therapy is designed to be helpful, it may, at times, be difficult and uncomfortable.

I UNDERSTAND AND AGREE WITH THE ABOVE POLICY STATEMENTS AND HEREBY SIGN:

_____	_____
Printed Client Name	Printed Name of Client's Parent/Guardian
_____	_____
Signature of Client's Parent/Guardian Date	Therapist's Signature Date