Francine D. Pritt, MS, LPC, NCC
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412-265-4574

Thank you for choosing Francine D. Pritt, MS, LPC, NCC. I realize that starting counseling is a major decision and you may have many questions. This document is to inform you of my policies, state, and federal laws, and your rights.

DISCLOSURE STATEMENT

Therapy is a relationship that works in parts because of clearly defined rights and responsibilities held by each person. This frame helps to create the safety to take risks and the support to become empowered to change. As a client in psychotherapy, you have certain rights that are important for you to know about because this is your therapy, and goal of well-being. There are also certain limitations to those rights that you should be aware of. As a therapist, I have corresponding responsibilities to you.

The following pages are My *Responsibilities to You as Your Therapist:*

I. Confidentiality

With the exception of certain specific exceptions described below, you have the absolute right to the confidentiality of your therapy. I cannot and will not tell anyone else what you told me, or even that you are in therapy with me without your prior written permission. Under the provisions of the Health Care Information Act of 1992, I may legally speak to another health care provider or a member of your family about you without your prior consent, but I will not do so unless the situation is an emergency. I will always act so as to protect your privacy even if you do release me in writing to share information about you. You may direct me to share information with whomever you chose, and you can change your mind and revoke the permission at any time. You may request anyone you wish to attend a therapy session with you.

You are also protected under the provisions of the Federal Health Insurance Portability and Accountability Act (HIPPA). This law insures the confidentiality of all electronic transmission of information about you. Whenever I transmit information about you electronically (for example, sending bills or facing information), it will be done with special safeguards to insure confidentiality. If you elect to communicate with me by e-mail at some point in our work together, please be aware that e-mail is not completely confidential. This is the same for all text messages, which has become a preferred method for some clients to communicate. All e-mails are retained in the logs of your or my internet service provider. Any e-mail I receive from you, and any responses that I send to you, will be printed out and kept in your treatment record.

The following are legal exceptions to your right to confidentiality. I would inform you of any time when I think I will have to put these into effect.

1. If I have good reason to believe that you will harm another person, I must attempt to inform that person and warn them of your intentions. I must also contact the police and ask them to protect your intended victim.

2. 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, I may legally break confidentiality and call the police or the county crisis team. I am not obligated to do this, 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 crisis team.

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 Pennsylvania. 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. *The next is not a legal exception to your confidentiality. However, it is a policy you should be aware of if you are in couple's therapy with me.* If you and your partner decide to have individual sessions as part of the couple's therapy (unilateral therapy), what you say in those individual sessions if it is relevant to therapy, will be discussed in our joint sessions.
Do not tell me anything you wish kept secret from your partner. I will remind you of this policy before beginning such individual sessions. Therapy will only work if it's rooted in truth.

Signature of understanding________________________________ Date______________________

Record-Keeping:

Psychotherapy Notes: The information you give me is YOUR information and you control access to it. What I write during sessions is MY information and I control access to it. If you want your information released, I will write a summary of our work together and send that, but, in general, I do not release copies of my clinical notes. I maintain my own clinical notes they may be kept electronically or in hard copy. These notes may contain your personal thoughts, feelings, plans and information, art work, or other pertinent material that you share with me during sessions. They may also contain notes to myself including observations, concerns, treatment options, ideas, observations and other clinical issues. I refer to these notes to maintain clinical and treatment continuity across sessions. The information recorded in these notes is not needed by your insurance company or other health care providers to support or define the service you receive from me. These notes are not necessarily open to you although I will be happy to discuss those notes with you if you have concerns. Ask questions about this at any time, in any session - I will be happy to discuss these concerns with you. Under the provisions of the Health Care Information Act of 1992, you have the right to copy of your file at any time. You have the right to request that I make a copy of your file available to any other health care provider at your written request. I maintain your records in a secure location that cannot be accessed by anyone else. There is a $100.00 fee for a copy of your file**.**

Signature of understanding________________________________ Date______________________

Diagnosis: If a third party such as an insurance company is paying for part of your bill, I am normally required to give a diagnosis to that third party in order to be paid. Diagnoses are technical terms that describe the nature of your problems and something about whether they are short-term or long-term problems. If I do use a diagnosis, I will discuss it with you. All of the diagnoses come from a book titled the Diagnostic and Statistical Manual of Mental Disorder, DSM-V, I have a copy in my office and will be glad to let you view it and learn more about what it says about your diagnosis.

Other Rights You have: The right to ask questions about anything that happens in therapy. I'm always willing to discuss how and why I've decided to do what I'm doing, and to look at alternatives that might work better. You can feel free to ask me to try something that you think will be helpful. You can ask me about my training for working with your concerns, and can request that I refer you to someone else if you decide I'm not the right therapist for you.

Managed Mental Health Care: If your therapy is being paid for in full or in part by managed care firm, there are usually further limitations to your rights as a client imposed by the contract of the managed care firm. These may include their decisions to limit the number of sessions available to you, to decide the time period within which you must complete your therapy with me, or to require you to use medication if their reviewing professional deems it appropriate. They may also decide that you must see another therapist in their network rather than me, if I am not on their list. Such firms also usually require some sort of detailed reports of your progress in therapy, and on occasion, copies of your case file, on a regular basis. I do not have control over any aspect of their rules. However, I will do all that I can to maximize the benefits you receive by filing necessary forms and gaining required authorizations for treatment, and assist you in advocating with MC as needed.

Signature of understanding________________________________ **Date**______________________

My Training and Approach to Therapy: I received my Masters of Science in Counseling Psychology from Chatham University, 2005 and Bachelor of Arts in Communication from Buffalo State University, 1990. I was awarded my license to practice counseling in 2007 from the state of Texas (61945), and my 2nd counseling license from PA in 2010 (PC006083). My special areas of training include Cognitive Behavioral therapy (CBT), Attachment theories, Certified EMDR therapist (Eye movement desensitization and reprocessing), DBT (Dialectical Behavioral therapy) Solution focused therapy (for EAP), Parenting using the Step Curriculum, CBITS (Cognitive Behavior Intervention for Trauma in Schools), Trauma, Grief and Loss, and Stress, relaxation and healthy living (holistic) along with the latest in neurological approaches and researched based best practices. My approach to therapy is CBT, EMDR therapy, attachment theories, emotional focused, Narrative therapy, Reality therapy, and DBT (dialectical behavior therapy). My philosophy of psychotherapy looks at the thinking patterns and history behind our behavior and focuses on finding solutions to your past to present experiences and how it forms you. Techniques I will incorporate are likely to include dialogue, interpretation, cognitive reframing, demonstrating and role playing, self-awareness exercises, self- monitoring experiments, visualization, journal keeping, drawing, reading books and even using Apps on your cell phone. If I propose a specific technique that may have special risks involved, I will inform

you of that, and discuss with you the risks and benefits of what I am suggestion. I may suggest that you consult with a physical health care provider regarding somatic treatments that could help your problems; I refer both to traditional and nontraditional (homeopathic and Eastern medicine practices), and will be involved in a therapy or support group as part of your work with me. If another health care person is working with you, I will need a release of information from you so that I can communicate freely with that person about your care. You have the right to refuse anything I suggest. I follow the required code of Ethics by the American Counseling Association, Pennsylvania Certification Board, National Board of Certified Counselors and EMDR International Association and am instructed to receive consultation, when doing so your case may be discussed with no personal details, in order for me to provide you the best treatment of care, and will always follow the ethics of my profession.

Therapy also has potential emotional risks. Approaching feeling or thoughts that you have tried not to think about for a long time may be painful. Making changes in your beliefs or behaviors can be scary, and sometimes disruptive to the relationship you already have. You may find your relationship with me to be a source of strong feelings, some of them painful at times. If is important that you consider carefully whether these risk are worth the benefits to you changing. Most people who take these risks find that therapy is helpful and freeing in the long run.

We will decide together, while in treatment when therapy will end, with three exceptions. If we have contracted for a specific short-term piece of work, we will finish therapy at the end of that contract. If I am not in my judgment able to help you, because of the kind of problem you have or because my training and skills are in my judgment not appropriate, I will inform you of this fact and refer you to another therapist who may meet your needs. If you do violence to, threaten, verbally or physically, or harass myself, the office, or my family, I reserve the right to terminate you unilaterally and immediately from treatment. If I terminate you from therapy, I will offer you referrals to other sources of care, by cannot guarantee that they will accept you for therapy.

I am away from the office a few times in the year for holidays/ vacations or to attend professional trainings. I will do my best to work with you to schedule your appointments before and after my absences, and if need be, to arrange for someone to cover my practice. I will tell you in advance of any anticipated lengthy absences, and give you the name and phone number of the therapist who will be covering my practice during my absence. I am available for brief between session phone calls during normal business hours. If you are experiencing an emergency when I am out of town, or outside of my regular office hours, please call Resolve Crisis Network at 1-888-796-8226. If you believe that you cannot keep yourself safe, please call 911, or go to the nearest hospital emergency room for assistance.

Signature of understanding________________________________ **Date**______________________

Your Responsibilities as a Therapy Client: You are responsible for coming to your session on time and at the time we have scheduled. Sessions lasts 45-60 minutes. If you are late, we will end on time and not run over into the next person's session. If you miss a session without canceling or cancel with less than twenty-four hours' notice, you must pay for that session at our

next regularly scheduled meeting. The voice mail service has a time and date stamp which will keep track of the time that you called me to cancel. I cannot bill your missed or late sessions to your insurance. The only exception to this rule is if you would endanger yourself by attempting to come (for instance, driving on icy roads without proper tires), or if you or someone whose caregiver you are has fallen ill suddenly and needs emergency immediate care. You will be given an option to receive a reminder for your scheduled session time up to 2 days in advance, via text or email please follow the prompts for confirmation. You are responsible for paying for your sessions weekly unless we have made other firm arrangements in advance. My fee for a 45-60 minute session is up to $150.00. If we decide to meet for a longer sessions, I will bill you prorated on the hourly fee. Emergency phone calls of less than ten minutes are normally free. However, if we spend more than twenty minutes on the phone throughout the week, there will be a charge of $20.00 for every twenty minutes we spend on a phone session. My fees go up $10.00 every two years. If a fee raise is approaching I will remind you of this well in advance. If you have insurance, you are responsible for providing me with the information I need to send in your bill. You must pay me your deductible at the beginning of each calendar year if it applies and any copayment at the beginning of each session. You must arrange for any pre-authorization, if necessary. I will bill directly to your insurance company via electronic means for you. You must provide me with your complete insurance identification information, and the complete address of the insurance company. If a check is mailed to you to cover your balance due, you are responsible for paying me that amount at the time of our next appointment. If the insurance overpays me, I will credit it to your account or refund it to you if you would prefer that. I am with most major insurances, if I am not with yours, I may be able to bill yours as an out of network provider. I am not willing to have clients run a bill with me. I cannot accept barter for therapy; and do not take medical coupons. Please make payment at the beginning of each session with me and it will eliminate our closing time after each session ends.

Signature of Understanding______________________________ **Date**________________

Complaints

If you're unhappy with what happening in therapy, please don't hesitate to talk about it with me so that I can respond to your concerns. I will take such criticism seriously, and with care and respect. If you believe that I've been unwilling to listen and respond, or that I have behaved unethically, you may schedule a special session to discuss these concerns, and hopefully we can resolve all your concerns. You are also free to discuss your complaints about me with anyone you wish, and do not have any responsibility to maintain confidentiality about what I do that you don't like, since you are the person who has the right to decide what you want kept confidential.

Name ____
(Printed)

Signature: ____ **Date**: ____________________

Witness: _______________________________ Date: ___________________

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1000 Cliff Mine Road Suite 130, Park West One
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(Therapist providing service)

STATEMENT OF FEE POLICY

It is important that you understand the Fee Policy. Please read then complete the section which states your insurance and your copay then Sign and Date. If you are a cash pay client, you and your therapist will complete the section relative to fee.

Francine D Pritt, MS, LPC, NCC, provides psychotherapy, educational, and consultation services. I am requesting that you read and sign this statement to acknowledge your understanding of my policy. Your signature does not bind you to therapy. It does make you responsible for charges incurred.

Insurance Billing: This will be handled on a case by case basis. You are asked to contact your insurance company relative to your benefits. This office has made every effort to be a provider for a variety of managed care companies. As a service to you, Francine D Pritt, MS, LPC, NCC or Francine D Pritt, may bill Client's insurance company on Client's behalf. **If for any reason a claim is denied, it is the Client's responsibility to contact the insurance company and clear up any reasons for its denial. Client is responsible for verifying insurance coverage, obtaining any necessary pre-authorization, and resolving any claim denials.** If Client fails to do so, Client will pay provider's full customary fee for all services rendered. For managed care claims and EAP referrals, we will bill as per the agreement with the managed care company. (Example: United Behavioral, Highmark, Cigna, UPMC, etc.) Because Francine D Pritt is a licensed professional counselor, most insurance companies will accept claims.

Co-Pay: If your managed care policy requires a co-pay, it is the individual's responsibility to bring the co-pay to each session or make other arrangements. *This office does NOT send out statements for co-pay.*

Deductible: Your health insurance may also have a deductible. If it is applied by your insurance company to any claim I submit, you are responsible for these amounts also. You should check with your insurance to see if a deductible applies**.**

Auxiliary Service: Occasionally, requests are made for mental health evaluations and other reports. A fee will be charged for these reports. I do not make a practice to go to court for any reason, if I am ordered to you will be charged and must pay the day of court, $500.00/ each day along with any additional costs for paperwork and time exceeding a normal work day, up to my discretion.

Telephone Calls, Texts and E-mail: There is no charge for telephone calls, texting, and e-mail unless we have prearranged a formal session. Please keep in mind text and emails are not protected means of communication and in most cases, are not recommended. Due to the nature of the therapeutic relationship I do not accept friend requests or interactions on any online social groups or websites, or purchase items you sell or provide.

Cancellations: The time of your scheduled appointment is reserved for you. It is the policy to charge $50 when the appointment is canceled within 24 hours of the appointed time. It is the policy to charge for the entire session for a no show. I understand that circumstances arise that make it difficult to keep an appointment, at that time will assess.

Length of Session: A session is generally **45-60** minutes. This can be lengthened up to 90 minutes if notice is given in advance or my next appointment cancels and/or I do not have another client scheduled or consulting with someone else. If you do not show for sessions and do not call to reschedule after 2 attempts via our agreed upon communication a letter of No Contact will be sent to the address you provided and you will be given a deadline date where I will have to discharge you and charge you for services previously agreed upon.

Emergencies: I am generally available on a 24 hour basis. Clients, however, seen in out outpatient psychotherapy are assumed to be responsible for their day to day functions. You may reach me in the following ways:
Office: (412) 265-4574 to make an appt. or cancel your scheduled appointment.
I will attempt to return your call within 24 hours, though this is not always possible as I may be in session with another person, speaking to a group of people, or traveling from one destination to another.
If a life threatening situation arises, please go immediately to the nearest hospital Emergency Room or contact the Emergency Psychiatric services in your area.

E-mail: You may also write to me at becalm4u@gmail.com. If you request a reply please note that in your e-mail. The reply may come in approximately 24 to 48 hours. Email is not considered a protected means of communication.

Fees: *I do not have a sliding fee,* though it is my desire to work with you as much as possible as to payment.
Fees are payable to **Francine D Pritt.** Insurance will be billed when requested.

I give my consent and authorization to Francine D Pritt, MS, LPC, NCC and Francine D Pritt to bill my insurance company_________________________ and I further acknowledge that my co-pay is ____________________________________ to be paid at the time of the session or at the time otherwise arranged.
My signature also represents my understanding of the above fee policies.

Signature: ____ Print: __________________________________
Date_______________________