Larry Epstein Mental Health PLLC

**302 Willis Avenue**

**Mineola NY 11553**

**(O) 516-325-5617 (F) 516-741-8456**

**Client Rights:**

1: You will be treated with dignity and respect. The counselor will do his best to respect your gender, age, race, religion, national origin, sexual orientation, and any other pertinent demographics you or he finds applicable to your case. Should you feel you are part of a demographic which is not being addressed, or is important to you, please let him know.

2: You will be treated for what you are coming to see the counselor for.

3: You get a say in therapy, if you don’t like a technique or don’t wish to discuss a specific topic, you don’t have to. You don’t have to do anything the counselor suggests.

4: Your privacy as applicable to Health Insurance Portability and Accountability Act (HIPPA) of 1996 will be upheld. Unless a release of information is given to the counselor in writing and you are legally an adult, the counselor shall not provide any information or a 3rd party including family, children, spouse, or legal authorities unless the counselor is forced to do so from a legal authority. A written release can be rescinded verbally and a note will be included in your file. A new release will need to be signed should you wish for one to be enacted once again.

5: You should know in advance what services will cost. Should a session continue past the predetermined time limit and the counselor did not notify you of this, you will not be charged for additional time in session.

6: If you have a grievance against this counselor, there are two governing bodies for which you may contact.

1. NYS Office of Alcohol and Substance Abuse Services: **1-800-482-9564**
2. NYS Office of the professions: call **1-800-442-8106** or email [conduct@mail.nysed.gov](mailto:conduct@mail.nysed.gov)

7: You have the right to discharge yourself at any time. The counselor cannot force you to come to therapy, nor force you to stay in therapy.

8: You may see your counselor’s credentials, license, proof of insurance, or other documentation that he proports to have that enables him to practice mental health. This paperwork is stored at the treatment facility at all times.

9: You may see your handwritten notes which counselor will use to document your session if you wish.

Client Responsibilities:

1: Show up, on time, and participate in treatment.

2: Pay for services rendered after each session. Should a balance accrue, please pay within 30 days. The counselor may send debits to a collection agency.

3: If homework is assigned, please consider doing it. If techniques require practice, consider practicing them.

4: As a courtesy, the counselor will try to send you a text reminder of an upcoming session 24 hours prior to the agreed upon time and date. He is not obligated to do so. If you cannot make your appointment, please give him 24 hours or more notice. If you get a text and either agree to the appointment and still do not show, or fail to respond to his text, or you do not receive a text, and baring medical or psychiatric emergency still do not make it to your session, you will be charged the full fee of the session. Should you not respond to his text, you will receive one more after the session time would have ended. If you do not respond to that text and I do not hear from you within 2 weeks, I will mail you a letter of intent to discharge you from services. If I do not hear back from you within a week of that date, I will consider you discharged, your file will be closed and should you require treatment, a new assessment will be conducted.

5: Social media and reviews: Should you choose to post, like, review, comment, etc., on any online or print forum/platform, anything related to myself or my practice, please understand you may be publicly giving up your confidentiality as a client of mine.

6: Please put your phone on vibrate or silent unless you know you are expecting a message or call. Part of many people’s therapy is practicing staying present in the moment. This is hard for many people to do if they allow electronics to distract them.

7: If you wish to invite family or friends into a session, a release of information will need to be signed in advance. Please give the counselor notice prior to brining others into a session with you so he can have the appropriate paperwork ready for you.

8: You’ll work towards established goals set at the beginning of treatment. If your goals change, please let the counselor know.

The counselor has explained my rights and responsibilities to me. By signing below, I acknowledge any questions I have about this have been explained. I also understand I can obtain a copy of these forms with at least 24 hours’ notice.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Client signature Counselor Signature

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Pay Structure as of 1/1/2015

Individual/couple

Assessment: 75-90 minutes $125

30-minute individual session $50

45-minute individual session $75

60-minute individual session $100

Each additional 15 minutes $25

Non- Crisis Phone Calls:

15 minutes $15

30 minutes $50

45 minutes $100

Initial phone screening- no cost

Crisis calls that involve police or medical attention- no cost

Calls made on your behalf to other professionals: Same costs as individual sessions. Counselor will provide you proof of call durations should you ask for it.

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### Release of Information for an Emergency contact

I hereby authorize Larry Epstein LMHC CASAC to exchange information with:

Name: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

The information requested or authorized for release or exchange pertains to:

* Emergency contact

Confirm appointments

Share and discuss diagnosis

Progress of Treatment/counseling

Answer drug/alcohol abuse questions

Admit date

Discharge date

Discharge status

Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

This authorization is valid for 1 year from the date provided below or **\_\_\_\_\_\_\_\_\_\_\_**, whichever is earlier. I may cancel this authorization by signing, dating, and writing “CANCEL” on this original form, by sending a written, signed and dated request to the counselor above indicating my desire to cancel or verbally informing him of my desire to rescind this release. I understand that once my information has been released, the recipient might re-disclose it, my counselor has no control over it and privacy laws may no longer protect it. The purpose of this authorization is to improve the quality of my mental health evaluation or treatment.

I understand that my substance use disorder records are protected under the Federal regulations governing Confidentiality and Substance Use Disorder Patient Records, 42 C.F.R. Part 2, and the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”), 45 C.F.R. pts 160 & 164, and cannot be disclosed without my written consent unless otherwise provided for by the regulations.

I understand that I may revoke this authorization at any time except to the extent that action has been taken in reliance on it. Unless I revoke my consent earlier, this consent will expire automatically as follows:

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

##### Client’s Name Date of Birth

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

##### Client’s Signature Today’s Date

Larry Epstein Mental Health PLLC

**302 Willis Avenue**

**Mineola NY 11553**

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### Release of Information to third party insurance company

I hereby authorize Larry Epstein LMHC CASAC to exchange information with:

Name: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship: Insurance provider

The information requested or authorized for release or exchange pertains to:

Confirm Appointments

Toxicology Results

Progress of Counseling

Admit Date

Discharge Date

Discharge Status

Provide/Discuss Diagnosis

Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I understand that my records are protected under the Federal regulations governing Confidentiality and Substance Use Disorder Patient Records, 42 C.F.R. Part 2, and the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”), 45 C.F.R. pts 160 & 164, and cannot be disclosed without my written consent unless otherwise provided for by the regulations.

I understand that I may revoke this authorization at any time except to the extent that action has been taken in reliance on it. Unless I revoke my consent earlier, this consent will expire automatically as follows: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.   
 *[describe date, event, or condition upon which consent will expire, which must be no longer than reasonably necessary to serve the purpose of this consent]*

I understand that I might be denied services if I refuse to consent to a disclosure for purposes of treatment, payment, or health care operations, if permitted by state law. I will not be denied services if I refuse to consent to a disclosure for other purposes.

I have been provided a copy of this form.

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

##### Client’s Name Date of Birth

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##### Client’s Signature Today’s Date