VERITAS PSYCHOTHERAPY
Individual, Couple & Family Counseling

Maureen Newberg, LCSW-C

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STATEMENT OF POLICIES

Welcome! I salute you for pursuing the path that has led you to counseling. I would like to take this time to familiarize you with my practice. I am goal-directed and interactive in my approach to therapy. Together we will set goals and be attentive to achieving them. Periodically through therapy, we will re-evaluate where we are in this process and whether those goals are being appropriately addressed.

I believe we are all capable of changing our lives for the better. While change can be difficult and at times may make you feel like quitting, if you can endure it, I believe you'll reap the benefits of your efforts. Change however is not guaranteed. Due to the subjective nature of behavioral sciences and the fact that multiple factors go into any one problem, no guarantee is being offered that you will obtain the changes you seek. It will be your responsibility to take that which is learned during counseling and make any appropriate applications. I for my part will make every attempt to study and understand your particular issue. I am required by law to participate in ongoing continuing education and I always choose my course work based on the needs of my clients.

In my years of practice I have seen evidence that one's spiritual life can greatly enhance healing. For one to embrace fully who they are requires that they be at peace with their Creator. I will encourage you to be open in this area of your life.

Appointments are scheduled so as to allow each client a 45-minute session with a 5-minute summary and closure period. Every attempt will be made to run on schedule. Please note that clients who arrive late for their appointment will not receive the entire 50-minute session but will receive whatever time is still left for them in their time slot.

EMERGENCIES

I am available for emergencies outside of sessions and can be accessed by dialing 301-873-9556. This number can also be found on my business card. When leaving messages, please indicate the level of urgency. If I cannot be reached please call **Montgomery County Crisis Center at 240-777-4000** or proceed to your local emergency room.

If at any time during treatment I believe you to be truly suicidal or homicidal, as a health officer for the State of Maryland, I will be required to elicit the immediate help of the Police.

CONFIDENTIALITY

The laws in the State of Maryland require that all information shared within the counseling room be confidential. There are situations in which any mental health worker is required to share information outside of counseling. Those situations are as follows:

- If you threaten bodily harm or death to yourself or another
- If you reveal information relative to sexual abuse or significant physical abuse or neglect of a child or vulnerable adult
- If a court of law issues a legitimate order or you are being tested by court order

OTHER CONFIDENTIALITY ISSUES

- Consultation with other professionals may be deemed necessary. Those consultants are obligated to follow the same standards of preserving the confidentiality of your case
- In group therapy, participants are expected to honor the privacy and confidentiality of other group members
- In marital therapy, case records or summaries cannot be released without the consent of both partners unless a lawful subpoena is issued

Please refer to the notice of my Privacy Practices for more detail about these matters.

TERMINATION OF SERVICES

Termination of services is at the discretion of either the client or the counselor. It is recommended that we mutually discern this process. If you decide to go elsewhere, I would request a final termination session at which time I will provide you with the names of other professionals. You have a right to end therapy without moral, legal or financial obligations other than those already accrued.

PAYMENT POLICIES AND FEES

Listed below are my policies and fee information. In office rates:

$150.00		75 Minute Initial Intake Interview
$125.00		50 Minute Psychotherapy
$ 50.00		90 Minute Group Psychotherapy
$ 20.00	per 10 minutes	Phone Management
$ 55.00		Missed Appointment/Late Cancellation Fee (24 hr notice required)
$ 25.00		Fee On All Returned Checks

I agree to a fee of _____ per session

If time permits, extended sessions may be made available and fees will be prorated according to the standard rate.

Cancellations must be made 24 hours in advance. If an appointment is canceled with less than the 24 hours notice and is not an emergency, you will be charged a cancellation fee.

All fees are due at the time of visit unless otherwise negotiated in advance. I will provide you with a receipt at the time of service which can be directly submitted to your insurance company.

I am covered by most insurance companies that allow you to go outside your plan in selecting a provider. I do not participate directly with any one insurance plan. **It is the sole responsibility of the client to determine your own benefits and coverage and to submit your claim to your insurance company.**

DISCLAIMER

I understand that I have presented myself for psychotherapy in an attempt to remedy some issues in my life. Psychotherapy is one means of achieving potential personal growth. Psychotherapy is not an exact science and problem resolution requires changes on multiple levels.

I understand fully that Maureen Newberg does not guarantee that the growth I desire will occur.

If any other specialized form of help is indicated at any time, I understand that a proper referral will be made.

Maureen Newberg assumes no liability and shall not he held responsible for accidents or injuries sustained in her office or elsewhere on the premises. Attempts have and will be made to minimize hazards and provide a safe environment. The client acknowledges that psychotherapy involves a degree of risk and hereby agrees to assume personally that risk and any possible consequences.

I have read and agree with the above and acknowledge so by my signature.

_____ _____ _____

(Please Print) CLIENT'S NAME (or Representative) ***CLIENT'S SIGNATURE (or Representative)*** ***DATE***

_____ _____

THERAPIST'S SIGNATURE *DATE*

I also acknowledge that a copy of the Privacy Practices of Maureen Newberg, LCSW-C is available to me to read and that I have received a copy or waive my right to such a copy. Received_____ Waived _____

_____ _____ _____

(Please Print) CLIENT'S NAME (or Representative ***CLIENT'S SIGNATURE (or Representative)*** ***DATE***

_____ _____

THERAPIST'S SIGNATURE *DATE*