Lynne M. Treibel, LCSW

Emotional Nourishment.

I'm excited and honored that you've chosen me as your counselor. Welcome!

About me:

I'm passionate about counseling, and I have a wide range of strengths and trainings: Cognitive Behavioral therapy, Gottman Method couples therapy, Exposure Therapy, EMDR, and mindfulness techniques, to name a few. I will work with you on deciding what interventions or approaches might best fit for your individual needs. While I come from a client-centered and supportive perspective, I care enough to challenge your ideas and thought patterns when appropriate. After all, if you've come here, you're wanting to do something new—something that might work!

Risks and Benefits:

Research indicates that psychotherapy and counseling improves a wide range of social, relationship, and mental health issues. Still, there is inherent risk in all we do, and counseling is no exception. Risks commonly include (but are not limited to): secrets being told, painful decisions being made, uncomfortable realizations and discoveries, relationships faltering or ending, and emotionally challenging efforts that are likely necessary to make meaningful change. I cannot and will not make promises on how you will benefit or react from counseling treatments, and there is a chance that, despite our best efforts, your symptoms and relationships may stay the same or worsen. If I believe your will be best served by another provider or another treatment modality, I will tell you and help you get that care.

Availability:

I am usually available on non-holidays, Monday through Friday, 9:00am to 5:00pm. I do not take or return phone calls during client sessions, but if you leave a voicemail, I will return your call within the next business day.

I cannot promise you that, in the event of a crisis or mental health emergency, I will be available. If you have a mental health emergency, please call 911 or go to the nearest emergency room immediately. If you need access to clinical services outside of my office hours or availability, you are welcomed to call Agora at 505-277-3013.

In cases of extreme lateness (if client arrives greater than 20 minutes late for the appointment), the therapist reserves the right to cancel the appointment, deem it a "no-show," and bill the client for the full session ($100) no-show fee accordingly.

My Ethics, Confidentiality, Office Policies & Your Rights:

Client Name:
DOB:

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I am a clinical social worker, independently licensed by the New Mexico Board of Social Work Examiners, and I am governed by the rules of my profession. I only give clinical counseling advice and supportive mental health therapy.

My relationship with any and all clients is forever limited to our professional therapeutic relationship, and it can never extend to any social or business relationship beyond that of the professional therapeutic relationship.

If you ever become involved in a divorce or custody dispute, I want you to understand and agree that I will not provide evaluations or expert testimony in court. You should hire a different mental health professional for any evaluations or testimony you require. This position is based on two reasons: (1) My statements will be seen as biased in your favor because we have a therapy relationship; and (2) the testimony might affect our therapy relationship, and I must put this relationship first.

Your information is important to me. Please review the Notice of Privacy Practices to learn more specific details about HIPAA. Generally speaking, though, your protected healthcare information is kept confidential (just between us), except for times it is needed for treatment, to obtain payment (especially true if you use your health insurance benefits), and to maintain the operations of my office.

I will keep all records of your care in a confidential and safe place for at least 7 years after the date of your last therapy session, after which I will destroy the records appropriately and in accordance with HIPAA law.

If you need to share your healthcare information with a person outside of our therapeutic relationship, you will need to sign a Release of Information detailing the specific information required.

You are always welcomed to ask for an electronic copy of your records (in part or full). and you will receive the information within 30 days after your specific and written request for the information. Your patience is always appreciated.

You are always welcomed to make **a specific written request** to amend to the treatment records or to not share some information, although I am not responsible for how other parties use the information and cannot undo any past sharing of information used to obtain treatment, payment, or to maintain my healthcare practice operations. I will do my best to respect your wishes to all your requests.

You are always welcomed to review your clinical records, although if there is some information that is determined clinically harmful for you to review, I may choose to amend or otherwise withhold the potentially harmful information.

I am mandated to break confidentiality when: given a court order to break confidentiality, when law enforcement and government authority (see also: USA Patriot Act) compels it,

Client Name:
DOB:

when I am made aware of abuse of elders or children, if you are in an emergency, or I am made aware of a your intent or threats to harm or kill yourself or others. If I plan to break confidentiality, I will discuss the matter with you if it is safe and feasible.

Your therapy is about your path, and you may stop my treatment at any time. The only thing you will still be responsible for is paying for the services you have already received, sessions that you failed to cancel within 24 hours of the appointment time, "no-show" fees, and sessions for which you were extremely (greater than 20 minutes) late. You must understand that you may lose other services or may have to deal with other problems if you stop treatment. (For example, if your treatment has been court-ordered, you will have to answer to the court.)

I will never intentionally discriminate based upon race, age, color, ethnicity, religion, ability, marital or family status, sexual orientation, gender identity, veteran status, or criminal record unrelated to current dangerousness.

If you were court-ordered to therapy or sent to therapy by your employer, they expect a report from me. Please discuss with me before telling me what you would not want your employer or the court to know. You have a right to tell me only what you are comfortable telling me.

Grievance Policy:

I try my very best to treat others the way I would want to be treated. With that said, I am human and make mistakes. If you ever feel dissatisfied with our work, you've been discriminated against, treated unfairly, or that I have broken a professional rule, please let me know, and I'll give my best effort at hearing your complaint. We'll talk about it to see what solutions and efforts we can make to resolve the issue.

If you are still dissatisfied after my efforts to resolve the issue you present, you may then register a complaint to the New Mexico Board of Social Work Examiners at 505-476-4890.

Financial Issues:

Payment, (including all copayment, coinsurance, deductible payments, etc), is due at the time of service.

Any no-shows, extreme lateness (arriving more than 20 minutes after the scheduled appointment time), and cancellation with less than 24 hours notice prior to the scheduled appointment time will all result a charge in the full out-of-pocket fee for the missed session: $100.

My out-of-pocket fee, for those who choose to not use their insurance coverage, is $100 per session. I accept all major credit cards, although cash and checks are particularly

Client Name:
DOB:

welcomed, as they do not have an associated transaction fee.

In certain situations, telephone therapy or telephone consult (with you or another professional to coordinate care) may be necessary or desired, but as insurance typically will not cover services that do not involve face-to-face interaction, you (the client) are responsible for paying for sessions and professional consult prorated at the $100 per hour fee.

Requested paper copies of protected health information in excess of 10 printed pages will result in a charge of $1 per page. You, (the client) are responsible for these fees.

I will not charge you for time spent: billing, making clinical notes, or for short phone calls to schedule therapy sessions.

I am contracted with a number of health insurance companies, but it is *your* responsibility to ensure that I am an in-network provider under your specific plan *before* you receive services with me, as individual plans within the same insurance companies may vary widely.

Certain services (for instance, couples therapy) may not be covered under your specific plan, and it's your responsibility to understand your insurance coverage *prior* to having the service, to avoid the insurance company's denial and refusal to pay the claim for services rendered.

Unpaid or denied claims and out-of-network provider care fees are typically more expensive than in-network provider care fees, and you (the client) are responsible for the balance of any unpaid or denied claims.

In the event that you accumulate a unpaid balance greater than $100 and that balance is not paid for at least two weeks, you will be terminated from services. If the amount greater than $100 is unpaid for more than two months, the balance may be sent to a collection agency.

Client Name:
DOB:

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Your (and/or your legal healthcare decision maker's) signature and initials below indicates you agree to and understand the following:

1. Consent to Treatment Agreement: _____

Initial Here

I, the client (or client's guardian), have read and agree to all portions of this brochure.

I am (or have obtained the written consent of) my legal healthcare decision maker.

I/We understand that no promises have been made to me about the results of therapy and counseling. I/We deem the risks of therapy and counseling acceptable, and I/We choose to engage in counseling services with Lynne M. Treibel, LCSW despite knowing those risks.

2. Agreement to Use and Disclose PHI (Protected Health Information): _____

Initial Here

I/We have read all parts of this brochure, read the unabridged HIPAA Notice of Privacy Practices, and have had all my/our questions answered.

I/We agree that the client's protected health information may be used and shared for: the client's treatment, to obtain payment for my services, and to maintain the healthcare operations of the office of Lynne M. Treibel, LCSW.

3. Agreement of Financial Responsibility: _____

Initial Here

My/Our payment information is listed here, and I/We agree to be responsible for all payments (copayments, coinsurance, late cancellation fees, out-of-pocket fees, etc) listed in this brochure.

Check one:

❑ Out-of-pocket Fees for service payment ($100.00) ❑ Insurance benefits for service payment

Insurance Company: _____ Copay/Coinsurance Amount: _____

Name of Main Policy Holder (if not the client):_____

Member ID#:_____ Group ID#:_____

Effective Date: _____ Session Limitations: _____

_____

Client Signature and/or Legal Healthcare Decision Maker Date

_____

Therapist Signature Date

I, the therapist, believe this person to be competent to give consent to treatment, and I have answered their questions fully and to the best of my ability.
Date of NPP: _____

Client Name:
DOB: