# ANDREA GALIETTE SKOGLUND, MSW, LCSW
# Counselor/Therapist

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Welcome and thank you for considering Andrea Skoglund, MSSW, LCSW for your mental health needs.

I am a Licensed Clinical Social Worker (TX #52381), which allows me to bill your insurance for mental health services provided in an office setting.

## OFFICE POLICIES:

**Appointments**
Appointments are made by calling 832-247-8066 or emailing skoglundlcsw@gmail.com

The frequency of appointments and the length of service vary depending on the client's needs.

The time scheduled for your appointment is assigned to you and you alone. You are responsible for coming to your session on time; if you are late, your appointment will still conclude at the scheduled end-time.

**Insurance**
At the present time, I am an in-network provider with the following insurance plans:

- Aetna
- BlueCross/BlueShield
- Optum/United Behavioral Health
- CIGNA
- UTEAP
- Interface EAP

Prior to your first appointment, I will obtain relevant insurance information which will allow me to verify your insurance coverage as well as to identify what your out-of-pocket responsibility will be for mental health services. If you have a co-payment, fees will be collected at the beginning of each session. I accept cash, check or credit card.

At the end of each month, I will bill your insurance company on your behalf.

If you **do not** have one of the insurances listed above, I will provide a receipt, which you may submit to your insurance company to request reimbursement for services from an out-of-network provider.

**Fees**
Hour-long sessions are billed at $125.

If you have an HSA account, I can provide you with a monthly invoice summarizing your payments, which you can submit for reimbursement.

You are expected to pay for services at the time they are rendered unless other arrangements have been made. Please notify me ahead of time if any problem arises regarding your ability to make timely payment.

**Cancellation**
Since an appointment reserves time specifically for you, 24-hour notice is required for rescheduling or canceling of an appointment. Beyond an agreed upon emergency or accident, your credit card will be charged $125, the full fee for an hour-long session. Most insurance companies do not reimburse for missed sessions so you will be responsible for the bill.

**Credit Card**
At your first appointment, I will ask that you provide a credit card number. I will retain this information if I need to charge your account for a missed appointment/last minute cancellation.

Credit card information will be stored in password protected Cloud storage. The original document where you provide this information will be shredded.

## THERAPEUTIC CONTRACT:

**Clients' Rights**
Treatment is entirely voluntary, and you have the right to terminate treatment at any time.

I have the right to terminate therapy with you under the following conditions:

- I believe that therapy is no longer beneficial to you.
- You fail to follow recommended treatment repeatedly.
- I believe that you will be better served by another professional.
- You have not paid for at least two sessions, unless special arrangements have been made.
- You have failed to attend your last two therapy sessions without a 24-hour notice.

**Risks of Services**
As with any change in your life, you should be aware that outcomes of therapy can be unpredictable. However, it has been my experience that the overwhelming majority of willing clients improve their situations through therapy. Treatment is intended to induce change in your life, and when this change occurs it may disrupt your accustomed manner of living and your relationships with others. You should also know that positive change takes work and you may be asked to try things that are difficult for you. Some people

reach their goals fairly quickly and without much discomfort, while others need more time and feel more stress through the process. The experience of each individual is impossible to predict as each person has their own unique strengths and problems.

**Notice of Confidentiality**
The law protects the relationship between a client and a psychotherapist, and information may not be disclosed without written permission of the client. Exceptions include:

- Suspected child abuse or dependent adult or elder abuse. I am required by law to report this abuse to the appropriate authorities immediately.
- If a client is threatening serious bodily harm to another person/s, I must notify the police and inform the intended victim.
- If a client intends to harm him/herself, I will make every effort to engage the client to ensure their safety. If the client does not cooperate, I will take further measures that are provided to me by law in order to ensure their safety. This will be done without the client's permission.

I can release all or portions of your records to any person or entity you specify. I will inform you whether or not I think releasing that information to that agency or person might be harmful to you. **This release must be stipulated in writing**.

If a court of law issues a subpoena or an order, I am required by law to comply with the subpoena or order.

**Records**
Your clinical file will consist of:
(a) legal forms such as this document
(b) a record of visits and payments
(c) clinical progress notes. These progress notes will contain enough information about your treatment to justify it, should such justification ever become an issue.

*You have the right to view your records at any time. I have the right to provide you with the complete records or a summary of their content.

**After Hour Emergencies**
Please know that I do not provide twenty-four (24) hour crisis or emergency therapy services. Should you experience an emergency necessitating immediate mental health attention, immediately call 911 or if you are able to safely transport yourself, go to the nearest hospital emergency room for assistance.

# CONSENT TO TREATMENT

I, _____ agree to be legally responsible for any charges that said persons listed below may incur during * (please print name of responsible party) psychotherapy with Andrea Skoglund. _____ (initial here)

I understand that I, personally, will be billed for any missed or cancelled appointments (without 24-hour notice) and that insurance companies do not typically reimburse for missed sessions. _____ (initial here)

Consent for Treatment: please print all names of any person or persons participating in therapy then have each member over the age of 12 sign below

I _____

_____

_____

_____

authorize and request that Andrea Skoglund, LCSW, carry out psychotherapeutic examinations, diagnostic procedures, and/or treatment for me/us while I/we am her client. I understand that the purpose of any procedure will be fully explained and be subject to my agreement.

I have read, understand and fully agree with the "Office Policies" and the "Therapeutic Contract".

_____ _____

Client's Signature Date

_____ _____

Andrea Skoglund, LCSW Date

## CREDIT CARD

_____
Name as it Appears on Your Credit Card

_____
Type of Credit Card

_____
Credit Card Number

_____ _____
Expiration Date mm/yyyy 3-Digit Security Code