

CHLOE ZINGARO, LCSW
ADULT AUTHORIZATION AND CONSENT
FOR MENTAL HEALTH TREATMENT

Welcome to my practice. This document contains important information about my professional services and business policies. Please read it carefully and jot down any questions you might have so that we can discuss them at our next meeting. When you sign this document, it will represent an agreement between us.

Client Name: _____

Birth Date: _____

Gender: _____

Home Address:

Home Number: _____ Voice messages and texts Yes No

Cell Number: _____ Voice messages and texts Yes No

Work/Other: _____ Voice messages and texts Yes No

Professionals Include: Chloe Zingaro, LCSW. Chloe is an independent practitioner.

PSYCHOLOGICAL SERVICES

I offer a wide variety of counseling services, including individual, couples, family and group services. Effective psychotherapy is founded on mutual understanding and good rapport between client and therapist. My primary theoretical perspectives include Cognitive Behavioral Therapy (CBT), Rational Emotive Behavioral Therapy (REBT), Dialectical Behavioral Therapy (DBT), DBT prolonged exposure therapy (DBT-PE), and DBT for Complex PTSD (DBT-CPTSD).

Psychotherapy is not like a medical doctor visit. Instead, it calls for a very active effort on your part. In order for the therapy to be most successful, you will have to work on things we talk about both during our sessions and at home. Psychotherapy can have benefits and risks. Because therapy often involves discussing unpleasant aspects of your life, you may experience uncomfortable feelings like sadness, guilt, anger, shame, frustration, loneliness, and helplessness. On the other hand, psychotherapy has also been shown to have benefits for people who go through it. Therapy often leads to better relationships, solutions to specific problems, and significant reductions in feelings of distress. But, there are no guarantees as to what you will experience.

Our first few sessions will involve an evaluation of your needs. By the end of the evaluation, I will be able to offer you some first impressions of what our work will include and a treatment plan to follow, if you decide to continue with therapy. You

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should evaluate this information along with your own opinions about whether you feel comfortable working with me. At the end of the evaluation, I will notify you if I believe that I am not the right therapist for you and, if so, I will give you referrals to other practitioners whom I believe are better suited to help you.

Therapy involves a large commitment of time, money, and energy, so you should be very careful about the therapist you select. If you have questions about my procedures, we should discuss them whenever they arise. If your doubts persist, I will be happy to help you set up a meeting with another mental health professional for a second opinion.

SESSIONS

I normally conduct an evaluation that will last from 2 to 4 sessions. During this time, we can both decide if I am the best person to provide the services you need in order to meet your treatment goals. If we agree to begin psychotherapy, I will usually schedule one 45-minute session per week, at a time we agree on, although some sessions may be longer or more frequent. Clients who are participating in Dialectical Behavioral Therapy (DBT) will be required to attend one 45-minute session per week and one 60-minute skills group training per week. Parents of adolescents in DBT MUST attend the Parent/Caregiver Skills Group once weekly as part of the treatment model. Once an appointment hour is scheduled, you will be expected to pay for it unless you provide 48 hours advance notice of cancellation. If it is possible, I will try to find another time to reschedule the appointment.

PROFESSIONAL FEES

\$220 Individual Sessions (45 minutes)

\$240 Individual Sessions (60 minutes)

\$240 Couple or family sessions (60 minutes)

\$240 Intake Evaluation (60 minutes)

\$360 90 Minute sessions (indicated for Gottman Couples, DBT-C and prolonged exposure sessions)

\$80 Group Sessions (60 minutes)

\$880 Cost of DBT Pretreatment sessions (Four orientation sessions prior to being accepted into DBT program)

In addition to weekly appointments, I charge an hourly rate of \$180 for other professional services you may need, though I will prorate the hourly cost if I work for periods of less than one hour. Other professional services include report writing, telephone conversations lasting longer than 10 minutes, attendance at meetings with other professionals you have authorized, preparation of treatment summaries, and the

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time spent performing any other service you may request of me. **If you are in DBT, I do not charge for DBT coaching calls.** If you become involved in legal proceedings that require my participation, you will be expected to pay for any professional time I spend on your legal matter, even if the request comes from another party. I charge \$180 per hour for professional services I am asked or required to perform in relation to your legal matter. Also if we meet more than the usual time 45-minute time frame, I will charge accordingly.

BILLING AND PAYMENTS

You will be expected to pay for each session at the time it is held unless we agree otherwise. Payment schedules for other professional services will be agreed to when such services are requested. In circumstances of unusual financial hardship, I may be willing to negotiate a fee adjustment or payment installment plan. If your account has not been paid for more than 60 days and arrangements for payment have not been agreed upon, I have the option of using legal means to secure the payment. This may involve hiring a collection agency or going through small claims court. If such legal action is necessary, its costs will be included in the claim. In most collection situations, the only information I will release regarding a patient's treatment is his/her name, the dates, times, and nature of services provided, and the amount due. **Please provide payment in the form of CASH, CHECK or CREDIT CARD. If requested, a statement of services rendered can be provided.**

INSURANCE REIMBURSEMENT

In order for us to set realistic treatment goals and priorities, it is important to evaluate what resources you have available to pay for your treatment. **I am an out of network provider and do not take health insurance. If you wish to file with your insurance company in order to seek reimbursement, I will give you a receipt with diagnosis and billing codes for the times of service. You will be responsible for submitting these to your insurance and any further communication insurance might require for processing your claim.**

You should carefully read the section in your insurance coverage booklet that describes mental health services. If you have questions about the coverage, call your plan administrator. Of course, I will provide you with whatever information I can based on my experience and will be happy to help you in understanding the information you receive from your insurance company.

You should also be aware that most insurance companies require that I provide them with your clinical diagnosis. Sometimes I have to provide additional clinical information, such as treatment plans, progress notes or summaries, or copies of the entire record (in rare cases). This information will become part of the insurance company files. Though

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all insurance companies claim to keep such information confidential, I have no control over what they do with it once it is in their hands. In some cases, they may share the information with a national medical information databank. I will provide you with a copy of any records I submit, if you request it. You understand that, by using your insurance, you authorize me to release such information to your insurance company. I will try to keep that information limited to the minimum necessary.

CONTACTING ME

I am often not immediately available by telephone. I will not answer the phone when I am with a patient. I will make every effort to return your call on the same day you make it and will respond as quickly as possible if you are a DBT client calling for coaching. At the start of treatment, clients will be given their therapist's preferred mode of contact for emergencies and coaching calls. If you are unable to reach me and feel that you cannot wait for me to return your call, dial 911 or go to the nearest emergency room. If I will be unavailable for an extended time, I will provide you with the name of a colleague to contact, if necessary and make arrangements for you to see another colleague in my absence.

THERAPIST INCAPACITY OR DEATH

I understand that, in the event of death or incapacitation of the undersigned therapist, it will be necessary to assign my case to another therapist and for that therapist to have possession of my treatment records. By my signature on this form, I hereby consent to another licensed mental health professional, selected by the undersigned therapist, to take possession of my records and provide me copies at my request, and/or to deliver those records to another therapist of my choosing.

ELECTRONIC COMMUNICATION POLICY

In order to maintain clarity regarding our use of electronic modes of communication during your treatment, I have prepared the following policy. This is because the use of various types of electronic communications is common in our society, and many individuals believe this is the preferred method of communication with others, whether their relationships are social or professional. Many of these common modes of communication, however, put your privacy at risk and can be inconsistent with the law and with the standards of my profession. Consequently, this policy has been prepared to assure the security and confidentiality of your treatment and to assure that it is consistent with ethics and the law.

EMAIL AND TEXTS

I use email communication and text messaging only with your permission and only for administrative purposes unless we have made another agreement. That means that email exchanges and text messages with my office should be limited to things like

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setting and changing appointments, billing matters and other related issues. Be advised that communicating clinical matters via email is not a secure way to contact to me and could put your privacy at risk. I do use a secure HIPPA compliant email platform. If you need to discuss a clinical matter with me, please feel free to call me so we can discuss it on the phone or wait so we can discuss it during your therapy session. The telephone or face-to-face context simply is much more secure as a mode of communication. For telehealth services, I use a secure HIPPA compliant telehealth platform through Therapynotes. If you will be attending sessions via telehealth you will sign the attached telehealth consent form.

SOCIAL MEDIA

I do not communicate with, or contact, any of my clients through social media platforms like Twitter and Facebook. In addition, if I discover that I have accidentally established an online relationship with you, I will cancel that relationship. This is because these types of casual social contacts can create significant security risks for you. I participate on various social networks, but not in my professional capacity. If you have an online presence, there is a possibility that you may encounter me by accident. If that occurs, please discuss it with me during our time together. I believe that any communications with clients online have a high potential to compromise the professional relationship. In addition, please do not try to contact me in this way. I will not respond and will terminate any online contact no matter how accidental.

WEBSITES

I have a website that you are free to access. I use it for professional reasons to provide information to others about me and my practice. You are welcome to access and review the information that I have on my website and, if you have questions about it, we should discuss this during your therapy sessions.

WEB SEARCHES

I will not use web searches to gather information about you without your permission. I believe that this violates your privacy rights; however, I understand that you might choose to gather information about me in this way. In this day and age there is an incredible amount of information available about individuals on the internet, much of which may actually be known to that person and some of which may be inaccurate or unknown. If you encounter any information about me through web searches, or in any other fashion for that matter, please discuss this with me during our time together so that we can deal with it and its potential impact on your treatment.

Recently it has become fashionable for clients to review their health care provider on various websites. Unfortunately, mental health professionals cannot respond to such comments and related errors because of confidentiality restrictions. If you encounter such reviews of me or any professional with whom you are working, please share it with me so we can discuss it and its potential impact on your therapy. Please do not rate my

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work with you while we are in treatment together on any of these websites. This is because it has a significant potential to damage our ability to work together.

CONFIDENTIALITY

In general, the privacy of all communications between a patient and therapist is protected by law, and I can only release information about our work to others with your written permission. But there are a few exceptions. In most legal proceedings, you have the right to prevent me from providing any information about your treatment. In some legal proceedings, a judge may order my testimony if he/she determines that the issues demand it, and I must comply with that court order. There are some situations in which I am legally obligated to take action to protect others from harm, even if I have to reveal some information about a patient's treatment. For example, if I believe that a child, elderly person, or disabled person is being abused or has been abused, I am required to make a report to the appropriate state agency. If I believe that a patient is threatening serious bodily harm to another, I have the right to contact the police or seek hospitalization for the patient. If the patient threatens to harm himself/herself, I may be obligated to seek hospitalization for him/her or to contact family members or others who can help provide protection. If a similar situation occurs in the course of our work together, I will attempt to fully discuss it with you before taking any action.

DUTY TO WARN/PROTECT

If my therapist believes that I (or my child if child is the client) am in any physical or emotional danger to myself or another human being, I hereby specifically give consent to the therapist to contact any person who is in a position to prevent harm to me or another, including, but not limited to the person in danger. I also give consent to my therapist to contact the following persons in addition to any medical or law enforcement personnel deemed appropriate:

Name _____ Contact Number _____
Name _____ Contact Number _____
Name _____ Contact Number _____

CONSENT FOR DBT CONSULTATION TEAM

For clients in DBT your information may be shared in consultation team in an effort to give you the most adherent and effective treatment possible. DBT is a team approach therefore each therapist has the support of their consultation team. Team helps increase the competence of the therapist as well as ensure the therapist is staying within the DBT framework. Dallas DBT meets weekly and at times consults with an outside consultant through the Linehan Institute/Behavioral Tech. I make every effort to avoid revealing information that is not pertinent to your treatment. The consultant is also legally bound to keep the information confidential. Ordinarily, I will not tell you about these consultations unless I believe that it is important to our work together. Professionals on

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my consultation team include: Laura Cooper, Ph.D, Julie Euseppi, LCSW, Tammy Hyde, LPC, Linda O'Toole, LPC, and Susan Shiring, LCSW. By signing this consent you agree that I may share information about you with my consultation team in order to deliver the most adherent and effective treatment possible. By signing this consent, you are also agreeing to be treated by the consultation team in the event that a team member is co-leading group, substituting for me in my absence, or taking phone coaching calls during my vacations. This consent will remain in effect while you are receiving treatment from the above providers and myself and for thirty days following termination of treatment unless you provide earlier written notice of its revocation.

PLEASE SIGN:

Your signature below indicates that you have read the information in this document and agree to abide by its terms during our professional relationship.

Patient Signature _____

Date _____

Therapist Signature _____

Date _____

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CREDIT CARD PAYMENT AUTHORIZATION

I, _____, hereby authorize Margaret Chloe Zingaro, LCSW, PLLC to keep my credit card information and signature on file and to automatically charge my credit card account for: confirmation of initial evaluation appointments, appointments, missed/cancelled appointments including the initial evaluation without 48 hours notice (will be charged at full fee), late fees (invoices past 30 days due), chargeback fees, and the full check(s) amount that is/are not cleared by the bank plus a \$30 returned check charge per incident, and will not dispute the charges with my credit card company. This authority is to remain in full force and effect until Margaret Chloe Zingaro, LCSW, PLLC has received notification from me in writing in such time and in such manner as to afford Margaret Chloe Zingaro, LCSW, PLLC a reasonable opportunity to act on it.

Client Name: _____

Cardholder Name (as on card): _____

Credit Card Number: _____

CVV Code (3 digits): _____

Credit Card Type (please circle one): Visa / Master Card/ Discover/ Amex

Expiration Date: ____/____/____

Cardholder Billing Address (Street Number, Address, City, State, Zip Code) :

Cardholder Phone Number: _____

Cardholder's Signature: _____ Date: ____/____/____

**NOTICE OF PRIVACY PRACTICES:
RECEIPT AND ACKNOWLEDGMENT OF NOTICE**

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If you would like a copy of the Notice of Privacy Practices it will be provided to you at your appointment and it can also be found on my website: www.cztherapy.com

I hereby acknowledge that I have received and have been given an opportunity to read a copy of Margaret Chloe Zingaro, LCSW, PLLC Notice of Privacy Practices. I understand that I can access the Notice of Privacy Practices on Chloe's website. I understand that if I have any questions regarding the Notice or my privacy rights, I can contact Chloe Zingaro, LCSW.

Signature of Patient/Client _____ Date _____

Signature of Guardian of Patient/Client _____ Date _____

AUTHORIZATION TO CONTACT BY TELEPHONE/VERBALLY IN EVENT OF BREACH OF PHI

I, _____ [Insert Name of Patient/Client], authorize Margaret Chloe Zingaro, LCSW, PLLC to provide notice to me by telephone or verbally in the event of a breach of my protected health information (PHI) by Margaret Chloe Zingaro, LCSW, PLLC. Such conversation shall be documented by Margaret Chloe Zingaro, LCSW, PLLC. Pursuant to the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Final Rule modifying the HIPAA Privacy, Security, Enforcement and Breach Notification Rules, the verbal or telephonic notice provided to me pursuant to this authorization shall not be simply for the administrative convenience of Margaret Chloe Zingaro, LCSW, PLLC.

Signature of Patient/Client _____ Date _____

Signature of Guardian of Patient/Client _____ Date _____

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Please read the following and initial each statement indicating your understanding of and agreement with its contents and implications. Chloe Zingaro, LCSW is unable to provide treatment without these terms being agreed upon in advance.

___ I understand that I will be paying the following fees for clinical services:

- ___ \$180 Individual Sessions (45 minutes)
- ___ \$200 Couple or family sessions (60 minutes)
- ___ \$200 Intake Evaluation (60 minutes)
- ___ \$300 90 Minute sessions (indicated for Gottman Couples, DBT-C and prolonged exposure sessions)
- ___ \$80 Group Sessions (60 minutes)
- ___ \$880 Cost of DBT Pretreatment sessions (Four orientation sessions prior to being accepted into DBT program)
- ___ Other \$_____

___ You will be charged for 15 minute increments for additional time on sessions, telephone consultations, case management, document review, and e-mail correspondence (excluding appointment scheduling). These charges will be automatically charged to the active credit card on file.

___ This office does not carry balances. We will be happy to provide you with receipts for you to submit to your insurance at your request. These forms are generated monthly but can be provided at other times per your request. Please email to request a receipt or ask at the end of your session.

___ I understand that I am responsible for payment of any missed session unless I have provided a minimum of 48 hours in advance of the appointment. Cancellations must occur by phone call or text to 214-966-0040.

___ I understand that I will forfeit my session if I am 15 minutes late without notification to Chloe Zingaro, LCSW. If Chloe has not received notification by me within 15 minutes that I am arriving late, she will bill me for the session and the session will be forfeited.

___ I have received a copy of the Texas Notice Form that explains the use and disclosure of my mental health record maintained by this office. A copy of the Texas Notice Form can be found on my webpage cztherapy.com

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___ I understand that Chloe Zingaro, LCSW does not take any cases that involve legal disputes where it is the intention of the client to receive documentation to provide to a court or attorney.

___ If Chloe Zingaro, LCSW deems it necessary that my child/adolescent participate in DBT therapy then I as the parent understand that my participation in the parent DBT skills group is mandatory. Chloe will not work with parents who do not take an active role in their child's treatment and the family will be given referrals.

___ I understand that if I need to communicate with Chloe Zingaro, LCSW regarding my treatment or my child/adolescent's treatment I will schedule a session in the office. Chloe Zingaro, LCSW is happy to read emails with updates concerning the child/adolescent and time taken to reply to emails will be charged in 15-minute increments.

___ I understand that if my adolescent is driving to and from session AND misses an appointment, Chloe Zingaro, LCSW will NOT notify parent of the missed session and parent will be charged according to the cancellation policy.

___ I understand that Chloe Zingaro, LCSW does NOT send out appointment reminders but will be happy to confirm your appointment time by text if you have forgotten.

Client Signature/Parent Signature if minor

Date

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