Raquel Ferns Lefebvre
Licensed Psychologist-MA

3000 Williston Rd. Suite 2
South Burlington, VT 05403
Tel: 802-951-0498
Fax: 802-652-2008

Outpatient Contract

Sessions

The therapy "hour" consists of 45-50 minutes, beginning on the appointed hour and ending at 10-15 minutes to the next hour. For example, a 2:00 appointment begins at 2:00 and ends between 2:45-2:50. Your therapy hour is reserved and held for you. If you have to cancel, please give me at least 24 hours notice**.** If you no show or don't give a full 24 hours notice when canceling, you will be charged a $50 fee. Please be aware that your health insurance company will not pay for missed sessions, so you will be responsible for the entire charge and not just the co-payment. Repeatedly no showing or canceling with less than 24 hours notice may result in termination of your outpatient contract.

Fees

My hourly fee is $100.00. Payment (or co-payment) is due at each session. Clients are responsible for their co-pays and all unpaid balances. In addition to weekly sessions, it is my practice to charge this amount on a prorated basis for other professional services you may require, such as consultation with other professionals, telephone conversations that last longer than 15 minutes, court appearances or the time required to perform any other services you may request of me. If you require me to go to any court proceedings, all hours spent in preparation (including but not limited to time for written documentation on your behalf) and in appearances will be charged at my hourly rate. This is not covered by insurance and therefore, you will be responsible for the entire payment.

Contacting Me

I am often not immediately available by phone. When I am with a client**,** I do not answer the telephone. However, you may leave a message on my voice mail and I will make every effort to return your call within 24 hours, with the exception of weekends and holidays. When I am on vacation and you have an emergency, you are advised to call your local crisis line (For Chittenden County: First Call for children-802-488-7777 and for Adults 802-488-6400. For Franklin County: 1-800-834-7793) or dial 911. Email should not be used for emergencies. Email can be used if you have a question about scheduling an appointment and don't have phone access. Please do not put personal information in your emails as it is not secure.

Confidentiality

In general, confidentiality between a client and a psychologist is protected by law and I can only release information about our work to others with your permission (or parents' permission if you are a minor). However, there are the exceptions:

1.Both law and the standards of the my profession require that I keep appropriate treatment records. In most judicial proceedings, you have the right to prevent me from releasing your records or providing any information about your treatment. However, in some circumstances, such as child custody proceedings and proceedings in which your emotional condition is an important element, a judge may require my testimony or release of your records if he/she determines that resolution of the issues before him/her demands it.

2.If you are using insurance to pay for any part of my services, you should be aware that your insurance agreement has required you to authorize me to provide a diagnosis and clinical information about you, your treatment and our progress in therapy. All insurance companies claim to keep such information confidential; but once it is in their hands, I have no control over what they do with it.

3.If I believe that a child, an elderly person, or a disabled person is being abused, I am legally required to contact the

appropriate agency. If you report knowledge of an adult hurting a child in any way, including providing them with alcohol and/or drugs, I am required to report this to the proper authorities.

4.If I believe that a client is threatening serious bodily harm to another, I am legally required to take protective actions, which include notifying the potential victim, notifying the police or seeking appropriate hospitalization.

5.If I believe that a client is threatening to harm him/herself, I am legally required to seek hospitalization for the client, or to contact authorities or family members or others who can help provide protection.

These situations have rarely arisen in my practice. Should such a situation occur, I will make every effort to fully discuss it with you before taking any action.

I may occasionally find it helpful to consult about a case with other professionals. In these consultations, I do not reveal the identity of my clients. This consultant is also legally bound to keep the information confidential. Unless you object, I will not tell you about these consultations unless I feel that it is important to our work together.

Couples/Family Therapy

I believe honesty and openness is essential to healthy intimacy. Therefore, any information provided to me privately (for example, in a telephone conversation) by one partner will not be kept in confidence from the other partner. The rules and ethics of confidentiality do apply to the couple as a unit.

Minors

If you are under 18 years of age, please be aware that your parents have the legal right to examine your treatment records. It is my policy to request from parents that they give up access to your records. If they agree, I will provide them only with the general information on how your treatment is proceeding unless I feel that there is a high risk that you will seriously harm yourself or another, in which case I will notify them of my concern. Before I give them any information I will make every effort to discuss the matter with you and will do the best I can to resolve any objections you may have.

My Qualifications

I have a Bachelor of Arts Degree (Psychology Honors Program) from McGill University and a Master's Degree in Clinical Psychology from the University of Hartford. Since 2002, I have provided outpatient counseling to children, adolescents and adults. I am licensed by the State of Vermont as a Master's Level Psychologist (#731). I have training in a variety of mental health areas including:

Anxiety Disorders
Depression
Mood Disorders
Grief Counseling
PTSD
Trauma
Domestic Violence
ADHD
OCD
Family Therapy
Play Therapy
Dialectical Behavioral Therapy
Motivational Interviewing
Solution Focused Therapy
Aurasoma Level 2 Practitioner (September 2006)
EMDR Certificate I and II (July 2008)

Please initial:

If a life-threatening crisis should occur, I agree to immediately contact a crisis hotline, call 911, or go to a hospital emergency room. _____

I have read the ethical violations form and understand how to file a complaint. _____

I have read the HIPAA form and understand how to file a complaint _____

I hereby authorize my insurance benefits to be paid directly to Raquel Ferns Lefebvre, MA, and acknowledge that I am financially responsible for any unpaid balance. I also authorize the release of my information needed to verify the medical necessity for my evaluation and treatment to my insurance. _____

I acknowledge and agree to Raquel Ferns Lefebvre's use of a billing service to bill for those charges issued to my insurance company. When technology permits, these claims may be submitted electronically. I acknowledge that the billing service will be given a copy of my registration form in order to process these claims and/or maintain a record of my account. If necessary, I authorize the billing service to contact my insurance company to check on claims submitted for payment for services. _____

I acknowledge that I understand that while Raquel Ferns Lefebvre's practice is located in the same suite as NFI (Northeastern Family Institute) it is not affiliated with NFI and Raquel Ferns Lefebvre is not an employee of NFI.
_____

Your signature below indicates that you have read this therapy contract and agree to abide to its terms during our professional relationship.

Client Signature: _____

Parent/Legal Guardian Signature if under 18: _____

Date:_____

Optional:

I would like to receive Raquel Lefebvre's email newsletter which comes out 3 times a year. Y or N

Upon completion of treatment, I am willing to fill out a short survey about my experience. Y or N

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Registration Form

Date: _____ DOB:_____ Age:_____ Gender:

First Name:_____ Middle Initial: _____ Last Name: _____

Address:_____

City: _____ State:_____ Zip:_____

Mailing Address (if different from above):_____

Home Phone:_____ Permission to leave message: Y or N

Cell Phone:_____ Permission to leave message: Y or N

Employer: _____Work Phone:_____Leave a message: Y or N

Email(optional): _____Permission to contact via email: Y or N

PCP Provider:_____Phone number:_____Permission to contact: Y or N

Emergency Contact:_____ Relationship to you:_____

Contact Number:_____ Who referred you? _____

Primary Insurance Provider:_____	Secondary Insurance Provider:_____
Address:_____	Address:_____
Phone Number:_____	Phone Number:_____
ID #:_____	ID #:_____
Group #:_____	Group #:_____
Subscriber Name:_____	Subscriber Name:_____
Subsciber's DOB:_____	Subscriber's DOB:_____
Relationship to you:_____	Relationship to you:_____
Authorization # (if required) _____	Authorization # (if required) _____

Consent and Agreement to the Use and Disclosure of Health Information For Treatment, Payment or Health Care Operations

I understand that as part of my care, my therapist maintains records describing my health history that may include symptoms, examinations, test results, diagnoses, treatment and any plans for future care or treatment. I understand that this information serves as:

-A basis for planning my care and treatment
-A means of communication among the professionals who contribute to my care
-A source of information for applying my diagnosis and appointment information to my bill
-A means by which third party can verify that services billed were actually provided
-And a tool for routine health care operations such as assessing quality of care and services offered

I have reviewed my outpatient contract with my therapist and understand the situations in which my therapist might need to disclose my protected health information. I understand that my therapist has the right to change her disclosure agreement but that she would notify me prior to making any changes.

I understand that my records are subject to confidentiality imposed by state and federal regulations. I also understand that any information pertaining to drug and/or alcohol use is protected by federal substance abuse privacy regulations (42 CFR part 2) and that those records may not be released or disclosed without my written consent except in a life threatening emergency situation.

I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or health care operations. I understand that my therapist is not required to agree to these restrictions requested, however if she does agree to the requested restrictions, she is bound by our agreement.

By signing this form, I consent to my therapist's use and disclosure of my protected health information about me for treatment, payment and health care operations. I understand that I may revoke this consent in writing, except to the extent that my therapist has already taken action based upon my prior consent.

*For children: This consent expires when the client reaches the age of 18 or when a change in guardianship occurs.

_____ _____

Client Signature or Authorized Representative Date

_____ _____

Witness Date

§ 3016. Unprofessional conduct

Unprofessional conduct means the conduct listed in this section and in section 129a of Title 3:

(1) Failing to make available, upon written request of a person using psychological services to succeeding health care professionals or institutions, copies of that person's records in the possession or under the control of the licensee.

(2) Failing to use a complete title in professional activity.

(3) Conduct which evidences moral unfitness to practice psychology.

(4) Engaging in any sexual conduct with a client, or with the immediate family member of a client, with whom the licensee has had a professional relationship within the previous two years.

(5) Harassing, intimidating, or abusing a client or patient.

(6) Entering into an additional relationship with a client, supervisee, research participant or student that might impair the psychologist's objectivity or otherwise interfere with the psychologist's professional obligations.

(7) Practicing outside or beyond a psychologist's area of training or competence without appropriate supervision.

(8) Notwithstanding the provisions of 3 V.S.A. § 129a(a)(10), in the course of practice, failure to use and exercise that degree of care, skill and proficiency which is commonly exercised by the ordinary skillful, careful and prudent psychologist engaged in similar practice under the same or similar conditions, whether or not actual injury to a client or patient has occurred.

(9) Conduct which violates the "Ethical Principles of Psychologists and Code of Conduct" of the American Psychological Association, effective December 1, 1992, or its successor principles and code.

(10) Conduct which violates the "ASPPB Code of Conduct-1990" of the Association of State and Provincial Psychology Boards, or its successor code. (Added 1975, No. 228 (Adj. Sess.), § 2; amended 1981, No. 241 (Adj. Sess.), § 1; 1993, No. 98, § 7; 1993, No. 222 (Adj. Sess.), § 3; 1997, No. 145 (Adj. Sess.), § 50; 1999, No. 52, § 26; 1999, No. 133 (Adj. Sess.), § 24.)

HIPAA COMPLAINT REQUIREMENTS - Your complaint must:

1. Be filed in writing, either on paper or electronically, by mail, fax, or email;
2. Name the covered entity involved and describe the acts or omissions you believe violated the requirements of the Privacy Rule; and
3. Be filed within 180 days of when you knew that the act or omission complained of occurred. OCR may extend the 180-day period if you can show "good cause."

In Vermont, mail to:

Office of Civil Rights,DDHS
JFK Federal Building-Room 1875
Boston, MA 02203
Phone: 617-565-1340
TDD: 617-565-1343
Fax: 617-565-3809

For further information, please visit: http://www.hhs.gov/ocr/office/index.html

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Release to Exchange Information

I _____(Client name) born on this date _____ hereby authorize the reciprocal exchange of my information via letters, email, phone or fax between

Raquel Ferns Lefebvre

and:

Name: _____
Address: _____
Phone number: _____
Fax:_____

_____I agree to authorize disclosure of my entire treatment record.

Or

_____I only agree to authorize disclosure about my treatment attendance.

_____I only agree to authorize disclosure about my diagnosis.

_____I only agree to authorize disclosure of my treatment plan/discharge summary.

I understand that I can revoke this authorization at any time.

Client Name: (Please print):_____

Client Signature:_____

Parent/Legal Guardian Signature: _____

Date: _____

Authorization revoked on: _____

Client Signature: _____

Parent/Legal Guardian Signature: _____

Date: _____