

**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

Participation in therapy is voluntary and you may terminate treatment at any time. Your therapy appointment is reserved 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 (For example, if your appointment is at 2pm on Friday you must call before 2pm on Thursday to avoid fee) 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 fee and not just the co-payment. Clients with medicaid insurance legally cannot be charged this fee. Repeatedly no showing or canceling with less than 24 hours notice may result in termination of your outpatient contract.

Fees

My hourly fee for an initial intake is \$130.00 and \$120 for therapy sessions. Payment (self pay, high deductible payments or co-payment) is due at the start of each session. Clients are responsible for their co-pays and all unpaid balances. Payment can be made in the form of cash or check. A \$20 fee will be charged for any checks returned for insufficient funds. 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. 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 you have a clinical emergency and I'm not immediately available, you are advised to call your local crisis line (For Chittenden County: First Call 802-488-7777, Franklin County: 1-800-834-7793, Addison County: 802-388-6751, Washington County: 802-229-0591) or dial 911. Email should not be used for emergencies. Email should only be used if you have a question about scheduling an appointment. You should only email my professional email account: raquel@raquelfernslefebvre.com. Please do not put personal information in your emails as it is not secure. It is my policy not to accept requests from clients on social media (Facebook, LinkedIn, etc.) in order to protect your confidentiality.

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.

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

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.

If you believe your privacy rights have been violated, you may file a complaint with the Secretary of the Department of Health and Human Services. They can be contacted through their regional office at:

Office of Civil Rights, U.S. Department of Health and Human Services, Government Center, J.F. Kennedy Federal Building – Room 1875, Boston, Massachusetts 02203, voice phone (800) 368 1019, fax (617) 565-3809, TDD (800) 537 7697.

#### Office of Professional Regulation Notice

The Office of Professional Regulation provides Vermont licensees, certification, and registrations for several professions, including psychologists. Each profession is governed by laws defining professional conduct. Consumers who have inquiries or wish to obtain a form to register a complaint may do so by going to <https://www.sec.state.vt.us/professional-regulation/file-a-complaint.aspx>, calling (802) 828-2875, or by writing to the Vermont Secretary of State, Office of Professional Regulation, 89 Main Street, 3rd Floor, Montpelier, Vermont 05620-3402. Upon receipt of a complaint, an administrative review determines if the issues raised are covered by the applicable professional conduct statute. If so, a committee is assigned to investigate, collect information, and recommend action or closure to the appropriate governing body. All complaint investigations are confidential. The case is either closed or charged. Where a case is closed without charges, the investigative details and identity of the respondent remain confidential, and a brief report is sent to the complainant, respondent, and relevant board. Where the prosecuting attorney files disciplinary charges, those charges and any subsequent proceedings, findings, and orders are public. Charges are adjudicated. Charges may be resolved by an agreement, called a stipulation, or may proceed to a hearing before the relevant board or before an administrative law officer. A sanction may be imposed. The professional disciplinary process focuses on the competence, conduct, and fitness of a licensee to practice. If there is a finding of

unprofessional conduct, available sanctions range from a warning, to practice supervision, to remedial coursework, to suspension for a period of time, to permanent revocation of a license. The Office does not have authority to order restitution to an aggrieved complainant. Complainants seeking restitution should consult an attorney, consult the Consumer Protection Division of the Office of the Attorney General, or pursue a claim in small claims court.

### Vermont Statutes regarding Unprofessional Conduct for Psychologists

3016. Unprofessional conduct means the conduct listed in this section and in 3 V.S.A. § 129a:

- (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 that 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) In the course of practice, failure to use and exercise that degree of care, skill, and proficiency that 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 that 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 that violates the "ASPPB Code of Conduct-1990" of the Association of State and Provincial Psychology Boards, or its successor code.
- (11) Use of conversion therapy as defined in 18 V.S.A. § 8351 on a client younger than 18 years of age. (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; 2013, No. 27, § 34; 2015, No. 138 (Adj. Sess.), § 5.)

### 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 have been licensed by the State of Vermont as a Master's Level Psychologist since 2007 (#047000731).

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
- Perinatal Mood Disorders
- Play Therapy
- Dialectical Behavioral Therapy
- Motivational Interviewing
- Solution Focused Therapy
- EMDR Certificate I and II (July 2008)

Please initial:

I consent to treatment with Raquel Ferns Lefebvre and terms stated in this contract. \_\_\_\_\_

I understand that my participation in therapy is voluntary and I may terminate treatment at any time.  
\_\_\_\_\_

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 and agree to the HIPAA policy 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 and insurance card 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: \_\_\_\_\_

Client Name (Printed): \_\_\_\_\_

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

Client's First Name: \_\_\_\_\_ Client's Last Name: \_\_\_\_\_

DOB: \_\_\_\_\_ Age: \_\_\_\_\_ Gender: \_\_\_\_\_ Pronouns: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Mailing Address (if different from above): \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Permission to leave message: Y or N

Cell Phone: \_\_\_\_\_ Permission to leave message: Y or N

Permission to text about scheduling only when efforts to reach you by phone and/or email fail: Y or N

Employer: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Permission to leave 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's number: \_\_\_\_\_ Who referred you? \_\_\_\_\_

Primary Insurance Provider: \_\_\_\_\_

Address: \_\_\_\_\_

ID #: \_\_\_\_\_ Group #: \_\_\_\_\_

Subscriber's Name: \_\_\_\_\_ Subscriber's DOB: \_\_\_\_\_

Relationship to you: \_\_\_\_\_ Authorization Number (if required): \_\_\_\_\_

Secondary Insurance Provider: \_\_\_\_\_

Address: \_\_\_\_\_

ID #: \_\_\_\_\_ Group #: \_\_\_\_\_

Subscriber's Name: \_\_\_\_\_ Subscriber's DOB: \_\_\_\_\_

Relationship to you: \_\_\_\_\_ Authorization Number (if required): \_\_\_\_\_

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Email: raquel@raquelfernslefebvre.com

Release to Exchange Information

I \_\_\_\_\_ (Client name) born on this date \_\_\_\_\_ hereby authorize the reciprocal exchange of my information via letters, email, in person meetings, 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.

\_\_\_ Other:

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: \_\_\_\_\_