DEBRA N. BROSIUS, PSY.D.

LICENSED CLINICAL PSYCHOLOGIST

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STATEMENT OF PRACTICE
THERAPY

Welcome to my practice. This statement provides an overview of my practice and serves to provide information regarding the services provided. It is important to me that you receive quality care. Please read this document carefully. When you sign this document, it will represent an agreement between us. You have the right to revoke this agreement at any time in writing.

CREDENTIALS, EDUCATION AND EXPERIENCE

I am a clinical psychologist licensed by the Virginia Board of Psychology. I earned my doctoral degree from American School of Professional Psychology in Washington, D.C. I have worked as a psychologist in a variety of international and domestic settings including private practice, a medical hospital, inpatient psychiatric hospitals and Veterans Administration Hospitals. I have also worked in community outpatient clinics with children, adolescents and adults. I have specific training in assessment and cognitive remediation for brain injuries, memory impairment and working memory. I am also trained in psychotherapy with adolescents and adults. I typically employ a supportive cognitive behavioral approach in my work with clients. I welcome the opportunity to provide you with the highest quality psychological care.

It is important that you understand that psychology, similar to medicine, is not an exact science. Research over the past two decades indicates that as a result of therapy and mental health services, most individuals feel and function better in their lives after treatment.

Success in psychological treatment is dependent on many factors, some of which reside with the client (i.e., motivation for change), and some that reside in the professional (i.e., skills and techniques) and some from the interaction between the client and psychologist. I believe that a strong and trusting therapeutic relationship is paramount to success. Examples of a strong therapeutic relationship include but are not limited to: feeling understood and respected, viewing the relationship as a "good fit" and agreeing on the goals and tasks of the professional services.

Although positive results are likely, they are not guaranteed. Some clients feel worse before they feel better. This may be experienced as anxiety, depression or feelings of vulnerability. Rest assured, it is my goal to ensure that you receive quality care and often these feelings are resolved before the termination of the relationship. Collaboration and communication between client and therapist are paramount to treatment success.

Initials_____

TERMINATION: As set forth above, after the first couple of meetings, Dr. Brosius will assess if she can be of benefit to you. She does not accept clients who, in her opinion, she cannot help. In such a case, she will provide you with options of people whom you can contact. If at any point during psychotherapy, Dr. Brosius ascertains that she is not effective in helping you reach the therapeutic goals or that you are non-compliant, she is obligated to discuss it with you and, if appropriate, to terminate treatment. Dr. Brosius will assist you with referrals, and, if she has your written consent, she will provide the therapist with the essential information needed. You have the right to terminate therapy at any time.

SOCIAL NETWORKING AND INTERNET SEARCHES: Dr. Brosius not accept friend requests from current or former clients on social networking sites, such as Facebook. I believe that adding clients as "friends" on these sites and/or communicating via such sites is likely to compromise privacy and confidentiality. For this same reason, I request that clients **not communicate with me via any social networking web sites.** Texting is ok to confirm, change or request appointments but sensitive information should not be disclosed in texts.

Office organization, telephone and emergency coverage

My practice is located at 6845 Elm Street, Suite 507 in downtown McLean. Please kindly wait for me in the waiting lounge until I come for you at your scheduled appointment time. If services are provided for your child or adolescent, please escort your child to this office. I do request that you remain in the local area and be accessible by phone at all times. The session may be discontinued or we may finish early for a variety of reasons.

Your telephone calls are very important to me. If I am able, and not working with another client, I will answer your calls. I also have a remote assistant who can help you. Alternatively, I encourage you leave a confidential voicemail on my phone. I also welcome you to email me with any questions you may have about my services or practice in general. Please note that email is not considered secure so please limit the amount of information in your email, as I cannot ensure your privacy in this format. Also, **never email in an emergency situation**.

If you or your child is in crisis and you cannot reach me directly, seek immediate care at your nearest hospital or dial 911. The emergency staff that operate emergency services are always available.

Confidentiality and exceptions to confidentiality

Generally, all information related to you or your child is confidential and will be released only with your informed written consent. However, under particular circumstances private information may or is required to be released even without your consent. There are exceptions to confidentiality and please note that I follow the laws of these exceptions from the Virginia Board of Psychology. Under Virginia law, communication between a client and a licensed psychologist is considered privileged (confidential) and may not be disclosed without your consent. The limitations to confidentiality are listed in another section of this document. Please read it carefully.

FEES FOR SERVICES

My diagnostic intake fee is $225.00 for up to a 90-minute consultation. For counseling my fee is $175.00 per session. If, at the end of treatment, you require a therapy summary, the time needed to provide such a document will be billed at the hourly therapy rate.

Financial Agreement & Acknowledgement of Privacy Practices
NOTE: YOU MUST SIGN THIS CONTRACT TO BE SEEN BY: Dr. Brosius

Please note I am in-network with Carefirst, Anthem BlueCross BlueShield and Cigna. I will not submit claims for any other provider and I cannot guarantee complete coverage.

Insurance reimbursement is a contract between you and your insurance company. It is essential that you understand which services and procedures are covered by your insurance plan and obtain any necessary authorizations or referrals prior to your appointment with me. ***It is your responsibility as the patient to understand the limits and restrictions affecting coverage of services you receive.*** The patient is responsible for all co-pay, deductibles, and coinsurance amounts not covered by your insurance policy.
Initial:

Charges for all visits, treatments and procedures are due at the time of service. If you have any outstanding balances with me, they must be paid in full before your next date of service.
I accept cash, check, and all major credit cards. For NSF checks, a $50 NSF charge will be billed to your account. If proof of insurance is not provided at the time of service, you are responsible for the entire amount of the visit, treatment and/or procedure at the time of service.
Initial:

For all appointments not cancelled 24 hours before your scheduled appointment, a $100 "No Show Fee" will be billed to your account.
Initial:

In the event it is necessary to refer your account to collections, you will be responsible for all charges accrued including attorney fees, court costs and all administrative, late and
interest fees.
Initial:

By signing below, you authorize the release of any medical or other information necessary to process claims related to medical services received by yourself or your dependent. You assign all medical payment on your behalf or that of your dependent for services provided to be issued to Dr. Debra Brosius, Psy.D., LLC 6845 Elm Street, Suite 507 in McLean VA 22101.

I am required by law to provide you with a copy of our Notice of Privacy Practices and Financial Agreement.
Initial:

By signing this form you acknowledge that you have received and read a copy of our Notice of Privacy Practices and dully understand and accept the terms of Dr. Debra Brosius, Psy.D., LLC Notice of Privacy Practices and Financial Agreement.
Initial:

**In the case of an account overpayment, the amount will be applied to your account as a credit unless you request otherwise. Updated January 1, 2017

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PROFESSIONAL RECORDS

The laws and standards of my profession require that I keep protected health information about you in your client record. Most of my records are kept in electronic format and encrypted with multiple passwords. You do have the right to examine your records or receive a copy of your clinical record if you request it in writing. Because these are professional records, the information should be reviewed with each patient individually rather than just providing the persons with a written copy.

SCHEDULING AND CANCELLATION OF APPOINTMENTS

We will schedule appointments at our mutual convenience. Your time will be kept for you alone and we will only be interrupted for emergencies. If you must cancel an appointment, please be sure to call at least 24 hours in advance. Otherwise, you will be billed a $100 cancellation fee and insurance does not cover these charges. If a personal emergency prevents cancellation, please let me know as soon as possible.

Thank you for choosing my practice. I look forward to working with you.

AUTHORIZATION, AGREEMENT AND SIGNATURE

Having read, understood and agreed to the above, I authorize Debra N. Brosius, Psy.D. to provide services for:_____.

Date:_____ Signatures_____

I HAVE received the HIPAA Privacy policy (Notice of Privacy Practices)

_____ _____
Client Signature Date

I understand the missed appointment policy and that I am responsible for a fee of $100 if I do not provide 24 hours of cancellation.

_____ _____
Client Signature Date

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LIMITATIONS TO CONFIDENTIALITY

Note: All references to "you" or "your" as the client also apply to your minor child.

As a general rule, I will not disclose the information obtained from your contacts with me, or the fact that you are my client, except with your written consent. However, there are some important exceptions to this confidentiality rule, as described below or as otherwise specified by law. Some of these circumstances are what I determine to be best practice while others are dictated by my professional ethics and/or are required by law.

It is my policy to provide information to others ***without*** your consent in circumstances:

1. **You are in imminent danger of harming yourself or if you express intent to hurt someone else.**
2. There is suspicion of child abuse or neglect.
3. There is suspicion of elder abuse or neglect.
4. There is suspicion of abuse or harm to a disabled individual.
5. There is suspicion of an inappropriate sexual relationship with another health-care provider.
6. If legal action is brought which specifies mental health damages.
7. If I receive a valid subpoena or court order to release records.
8. If the Virginia Department of Health Professions is conducting an investigation and need access to your records.
9. If you are under 18 years old your parents request access to your records.
10. **National Security**: Under the Patriot Act, certain circumstances allow for disclosure of health information to authorized federal officials. Typically these involve intelligence, counterintelligence, and other national security activities. I may be prohibited by the terms of the order from notifying you of the disclosure.

ADOLESCENTS: Virginia law allows your parents to obtain information and/or records related to your treatment. Parents: In general, I ask that you transfer your right to privacy to your child; you will, however, be kept informed of the important goals of therapy and how you can be helpful. Any specifics that are important for you to know, I will encourage your child to discuss with you, with my help if necessary.

Information to be provided to a third party payor only with your consent: If you wish to obtain third party reimbursements for mental health services, certain information must be provided. Typically that involves providing information about the dates of treatment, the type of treatment, and your diagnosis. You will process your own insurance claims and this information will be listed on the receipt I provide you for that purpose. If you wish for me to provide more extensive information to your insurance company, you must pro-

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vide authorization. It is my policy to provide you a copy of the information being submitted to your insurance company.

I understand that if I receive mental health services from Debra N. Brosius, Psy.D., the above limitations may be imposed on confidentiality. I herby accept those limits of confidentiality and consent to receive service under those conditions.

Client signature: _____ Date: _____

Client name: _____ DOB _____

If the client is under age 18, both parent signatures are required:

Mother: _____ Date: _____

Father: _____ Date: _____

Initials_____