Meagan Rae Segal, LCSW-R
1055 Stewart Avenue
Bethpage NY 11714
(516) 903-9624
Meagan@letchangebegintherapist.com

Informed Consent

Sessions:

Therapy should be considered an investment in your future and long term wellbeing. That being said, for therapy to be most effective and for optimal results, it is recommended that you be seen consistently/weekly for therapy. Weekly sessions are 45-60 minutes based on your level of need and insurance options. In addition, please be on time for your appointment. A late arrival will not warrant additional time past the session's normal end time.

Cancellation Policy:

You are asked to kindly cancel your appointment 24 hours in advance unless unable to do so due to an emergency. Please realize that your appointment could have utilized for someone else and your cooperation is appreciated. **Cancellations will result in being charged a fee of $100 to you NOT your insurance company.**

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Client Signature Today's Date

Payments:

Fees are due in full at the time the service is rendered. **I accept cash or checks for payment only unless you have an HSA credit card.** Bank fees apply for returned checks.

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Client Signature Today's Date

Insurance

Co Pays are due at the time services are rendered. It is the responsibility of the client to be knowledgeable about their benefits, deductible, etc.

If you are using **Out Of Network Benefits** payment is due at the time services are rendered and you will be provided a receipt or claim form to submit to your insurance company for reimbursement.

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Client Signature Today's Date

Confidentiality:

Information shared with the therapist during session is confidential and privileged to the therapist/client relationship. However there are some circumstances in which information cannot be kept confidential, including but not limited to: (a) clients insurance company (if billing insurance) requests diagnosis and dates of service to collect payment (b) the physical or sexual abuse of children is reported or suspected (c) client makes threat of suicide or homicide (d) the client signs a release of information (in accordance with HIPAA Notice of Privacy Practice) (e) the law requires the release of information. If you would like your treatment coordinated with another provider (i.e. a primary care physician or psychiatrist, please sign a release to allow information to be shared). Please note, it is the client's choice to release information to other providers and the client reserves the right to decline such or rescind consent at any time.

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Client Signature Today's Date

Emergency/Crisis:

*****If client is in imminent danger, a danger to themselves/others, and/or requires emergency response or assistance, please contact 911 or go to your nearest emergency room*****

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Client Signature Today's Date

Consent For Treatment:

I,_____, consent to receive services from Meagan Rae Segal, LCSW-R. I have read and understand the information included in these documents. I also understand that I have the right to ask for clarification of any of the information provided at anytime, and that therapy is voluntary, unless court ordered, and I have the right to terminate services at any time.

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Client Signature Today's Date