Informed Consent for Tele-health and Notice of Privacy Practices

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PSYCHOTHERAPY INFORMATION DISCLOSURE STATEMENT NOTICE OF PRIVACY PRACTICES THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Your health record contains personal information about you and your health. This information about you that may identify you and that relates to your past, present, or future physical or mental health or condition and related health care services is referred to as Protected Health Information (PHI). This Notice of Privacy Practices describes how I may use and disclose your PHI in accordance with applicable law, including the Health Insurance Portability and Accountability Act (HIPAA) regulations promulgated under HIPAA include the HIPAA Privacy and Security Rules. I have complied with federal confidentiality rules (42 CFR part 2 and HIPAA) to ensure your confidentiality. It also describes your rights regarding how you may gain access to and control your PHI.

I am required by law to maintain your privacy with notice of my legal duties and privacy practices with respect to PHI. I am required to abide by the terms of this Notice of Privacy Practices. I reserve the right to change the terms of my Notice of Privacy Practices at that time. Any new Notice of Privacy Practices will be effective for all PHI that I maintain at that time. I will provide you with a copy of the revised Notice of Privacy Practices by posting a copy on my website, sending a copy to you via email upon request or providing one to you at your next appointment.

Changes to this Notice: We reserve the right to change the terms of our Notice of Privacy Practices at any time. Should we make a material change to our privacy practices, we will provide you with a copy of the revised Notice of Privacy Practices at your next appointment, in addition to posting a copy on our website, and/or sending a copy to you in the mail upon your request. We reserve the right to make any revised or changed notice effective for information we already have and for information that we receive in the future. Every privacy notice will be dated.

My Responsibilities to You as Your Therapist

Therapy is a relationship that works in part because of clearly defined rights and responsibilities held by each person. This frame helps to create the safety to take risks and the support to become empowered to change. As a client in psychotherapy, you have certain rights that are important for you to know about because this is your therapy. Ultimately, the goal is your well-being. There are also certain limitations to those rights that you should be aware of. As a therapist, I have corresponding responsibilities to you.

It is also my responsibility to keep you safe while you share about your life and circumstances surrounding it. There is some emotional and physical risk involved to sharing about your life. Emotional in the sense that it is painful to talk about certain subjects that may be influencing your need to come to therapy; and physical in the sense that emotional pain is manifested physically and when expressed it can create physical discomfort and pain. The benefit of opening up is that I am here to help you help yourself with those types of pain. A life with less pain could have a major benefit to your physical, emotional, social, and spiritual health.

MY TRAINING AND QUALIFICATIONS: I am a Licensed Clinical Social Worker (LCSW). I am trained in EMDR and Brainspotting. I have taken and met all the expectations of the necessary trainings to perform the services that I provide. All of the interventions that I do, I have done myself and with other clients. I am trained in different modalities and you may ask for further proof of my professional developments. I may also use psychological assessments that may help me gain a different perspective on you and your symptoms. I consider my approach to therapy to be eclectic. I borrow from both professional and personal experiences but also different philosophical and cultural backgrounds. I believe that the power of healing lies within you and I will use different ways to support you in accessing your healing nature. I can discuss with you any of the particulars about where I am coming from.

I. Confidentiality: With the exception of certain specific exceptions described below, you have the absolute right to the confidentiality of your therapy. I cannot and will not tell anyone else what you have told me, or even that you are in therapy with me without your prior written permission. The three incidents that I have tell someone about your engagement in therapy 1) you are a danger to yourself, 2) you are in danger of hurting someone else, and 3) since I am a mandated reporter, if there are reports of abuse to either elder adults or children. In the latter case, I am legally mandated to inform either Adult Protective Services (APS), Child Protective Services (CPS) or appropriate authorities. I may disclose PHI to law enforcement official, as required by law, in compliance with a subpoena (with your written consent), court order, public health agencies or in matters of public safety, administrative order or similar document, for the purpose of identifying a suspect, material witness or missing person, in connection with the victim of a crime, in connection with a deceased person, in connection with the reporting of a crime in an emergency, or in connection with a crime on the premises.

I may legally speak to another health care provider or a member of your family about you without your prior consent, but I will not do so unless the situation is an emergency. I may disclose your PHI in a medical emergency situation to medical personnel only in order to prevent serious harm. I will try to provide you a copy of this notice as soon as reasonably practicable after the resolution of the emergency.

You are also protected under the provisions of HIPAA. This law ensures the confidentiality of all electronic transmission of information about you. Whenever I transmit information about

you electronically (for example, sending bills, emailing, or faxing information), it will be done with special safeguards to ensure confidentiality. Please be aware that email is not completely confidential. All emails are retained in the logs of your or my Internet service provider. While under normal circumstances no one looks at these logs, they are, in theory, available to be read by the system administrator(s) of the Internet service provider. Email communications between us may be stored in your electronic health record. Telecommunications are available through SimplePractice, which serves as a HIPAA compliant platform.

In all of these cases, if I am able to, I will inform you of my intent and need to inform the appropriate party. Your PHI may be used and disclosed by those who are involved in your care for the purpose of providing, coordinating, or managing your health care treatment and related services. This includes consultation with clinical supervisors or other treatment team members. I may disclose PHI to any other consultant only with your authorization. I will always act to protect your privacy even if you do release me in writing to share information about you. You may direct me to share information with whomever you choose, and you can change your mind and revoke that permission at any time. You may request anyone you wish to attend a therapy session with you. I may disclose information to close family members or friends directly involved in your treatment based on your consent or as necessary to prevent serious harm. Since I have a physical office in which I practice, I cannot ensure your confidentiality from pedestrians, others in the building or waiting area, neighbors, or outside observers. I have taken all necessary precautions to ensure your confidentiality. This may be discussed before our first session as to making sure that your confidentiality is protected.

HOW WE USE AND DISCLOSE HEALTH INFORMATION: Notice of Policy Practices

For Treatment. Your PHI may be used and disclosed to aid in your treatment or the coordination of your care. This includes consultation with clinical supervisors/consultants or other treatment team members. We may disclose PHI to any other consultant only with your authorization.

For Payment. We may use and disclose PHI to bill and collect payment for your treatment. Specifically, the therapist will maintain communication regarding your dates of service so that you can be appropriately billed. Other examples of payment-related activities are: making a determination of eligibility or coverage for out of network insurance benefits, processing claims with your insurance company, determining if a third party payor will make payment, getting prior approval, reviewing services provided to you to determine medical necessity, or undertaking utilization review activities. If it becomes necessary to use collection processes due to lack of payment for services, we will only disclose the minimum amount of PHI necessary for purposes of collection.

For Health Care Operations. We may use or disclose, as needed, your PHI in order to operate and manage our business activities including, but not limited to, quality assessment

activities, employee review activities, licensing, and conducting or arranging for other activities. For example, we may share your PHI with third parties that perform various business activities (e.g., pre-treatment, post-treatment/follow-up assessment, billing, payment processing, or typing services) provided we have a written contract with the business that requires it to safeguard the privacy of your PHI. Your written authorization would be obtained prior to disclosing any of your PHI for training or teaching purposes.

Required Disclosures. Under the law, we must disclose your PHI to you, or someone who has the legal right to act for you (your personal representative), upon your request. In addition, we must make disclosures to the Secretary of the Department of Health and Human Services, if necessary, for the purpose of Investigating or determining our compliance with the requirements of the Privacy Rule. This is to make sure that your privacy is protected.

Without Authorization. The following is a list of the categories of uses and disclosures permitted by HIPAA without an authorization. Applicable law and ethical standards permit us to disclose information about you without your authorization only in a limited number of situations.

Child Abuse or Neglect. We may disclose your PHI to a state or local agency that is authorized by law to receive reports of child abuse or neglect.

Judicial and Administrative Proceedings. We may disclose your PHI pursuant to a subpoena (with your written consent), court order, administrative order or similar processes.

Deceased Clients. I may disclose PHI regarding deceased clients as mandated by state law, or to a family member or friend that was involved in your care or payment prior to death, based on your prior consent. A release of information regarding deceased clients may be limited to an executor or administrator of a deceased person's estate or the person identified as next-of-kin. PHI of persons that have been deceased for more than fifty (50) years is not protected under HIPAA.

Medical Emergencies. We may use or disclose your PHI in a medical emergency situation to medical personnel only in order to prevent serious harm. Our staff will try to provide you a copy of this notice as soon as reasonably practicable after the resolution of the emergency.

Family Involvement in Care. We may disclose information to close family members or friends directly involved in your treatment based on your consent or as necessary to prevent serious harm.

Health Oversight. If required, we may disclose PHI to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies and organizations that provide financial assistance to the program (such as third-party payors based on your prior consent) and peer review organizations performing utilization and quality control.

Law Enforcement. We may disclose PHI to a law enforcement official as required by law, in compliance with a subpoena (with your written consent), court order, administrative order or similar document, for the purpose of identifying a suspect, material witness or missing person, in connection with the victim of a crime, in connection with a deceased person, in connection with the reporting of a crime in an emergency, or in connection with a crime on the premises.

Specialized Government Functions. We may review requests from U.S. military command authorities if you have served as a member of the armed forces, authorized officials for national security and intelligence reasons and to the Department of State for medical suitability determinations, and disclose your PHI based on your written consent, mandatory disclosure laws and the need to prevent serious harm.

Public Health. If required, we may use or disclose your PHI for mandatory public health activities to a public health authority authorized by law to collect or receive such information for the purpose of preventing or controlling disease, injury, or disability, or if directed by a public health authority, to a government agency that is collaborating with that public health authority.

Public Safety. We may disclose your PHI if necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. If information is disclosed to prevent or lessen a serious threat it will be disclosed to a person or persons reasonably able to prevent or lessen the threat, including the target of the threat.

With Authorization. Uses and disclosures not specifically permitted by applicable law will be made only with your written authorization, which may be revoked at any time, except to the extent that we have already made a use or disclosure based upon your authorization. The following uses and disclosures will be made only with your written authorization: (i) most uses and disclosures of psychotherapy notes which are separated from the rest of your medical record; (ii) most uses and disclosures of PHI for marketing purposes, including subsidized treatment communications; (iii) disclosures that constitute a sale of PHI; and (iv) other uses and disclosures not described in this Notice of Privacy Practices.

Verbal Permission. We may also use or disclose your information to family members that are directly involved in your treatment with your verbal permission. Except for the uses and disclosures described and limited as set forth in this notice, we will use and disclose your PHI only with a written authorization from you. Once you give us authorization to release your health information, we cannot guarantee that the recipient to whom the information is provided will not disclose the information. You may take back or "revoke" your written authorization any time in writing, except if we have already acted based on your authorization. We will not be able to get back health information that we have already used or shared based on your permission.

II. Record-keeping: I keep brief records, noting that you have been here, what interventions happened in session, and the topics we discussed. If you prefer that I keep no records, you

must give me a written request to this effect for your file and I will only note that you attended therapy in the record. Under the provisions of the Health Care Information Act of 1992, you have the right to a copy of your file at any time. You have the right to request that I correct any errors in your file. You have the right to request that I make a copy of your file available to any other health care provider at your written request. I maintain your records in a secure location that cannot be accessed by anyone else. Required by law – Under the law, I must disclose your PHI to you upon your request. In addition, I must make discloses to the Secretary of the Department of Health and Human Services for the purpose of investigating or determining our compliance with the requirements of the Privacy Rule.

III. Billing: At this time I do not accept health insurance. If you have insurance, and out of network coverage is available to you, I will provide a superbill so you can submit it to your insurance company. If you have Medicaid or Medicare, by signing this informed consent agreement, you are waiving any responsibility, cases of fraud, or legal ramifications for Illuminate Licensed Clinical Social Work, PLLC and Leah Silverstein. Cash, check, and credit card are valid forms of payment. If you are paying by credit card, know that I have complied with HIPAA's and all major credit cards guidelines and rights to privacy. I cannot guarantee that credit card companies have taken appropriate measures to ensure your privacy. Your credit card bill may list the name Illuminate Licensed Clinical Social Work, PLLC. If a check or credit card is returned or denied, you will be charged any processing fees and the complete total bill of the session is still due. If there is a need for communication i.e. email, phone, or case coordination with you, then you could be charged $2.00 per minute for coordinating care that is over 15 minutes. Insurance does not cover this.

Final payment. If you drop out of therapy without notice, you are responsible for communicating that you are ending therapy. Your credit card information will be kept on file in order to ensure any outstanding payments. If you do not respond to my attempts to contact you, then your final payment will be charged to your credit card for the remaining balance. By signing this informed consent, you are consenting for me to charge you for final payment under these circumstances.

Health insurance waiver. We do not accept health insurance so by signing below you are willingly and voluntarily opting out of using your health insurance for mental health services at Illuminate Licensed Clinical Social Work, PLLC. By signing below you give consent for any organizational members to have access to billing information in order to process my payments or claims.

IV. Other Rights Regarding Therapy: You have the right to ask questions about anything that happens in therapy. I'm always willing to discuss how and why I've decided to do what I'm doing, and to look at alternatives that might work better. You can feel free to ask me to try something that you think will be helpful. You can ask me about my training for working with your concerns, and can request that I refer you to someone else if you decide I'm not the right therapist for you. You are free to leave therapy at any time.

V. Tele-Health: SimplePractice is HIPAA compliant and the video conferencing platform that will be used for sessions. I have a BAA signed with them to do so. Your obligation to tele-health is to ensure the following; that no one else is in the room, you are in New York State or in the state that you say you are in, you have dedicated the agreed upon time and length of session and to limit possible interruptions, your technology is functional, you have a dedicated emergency contact, you have emergency medical and mental health services available, you are aware that by doing Tele-Health you have taken on the responsibility to take care of your immediate needs if anything were to happen during session. Lastly, you understand that I will break confidentiality to ensure your safety.

VI. Communications: I utilize texting to help with scheduling. I cannot send you PHI via text or email. In an email I can indirectly link PHI to you. When emailing or texting me, please do not send any personal information and/or by signing below you are consenting for me to do so. Do not put your full name in the title of an email. Communicating PHI to me via text or e-mail is advised against, as those forms of communication are not secure.

Your Responsibilities as a Therapy Client
You are responsible for coming to your session on time and at the time we have scheduled. Individual sessions last for 1 hour, but can be adapted to shorter or longer sessions based on your needs, per your hourly rate. If you are late to any appointment, we will end on time and not run over into the next person's session unless we arrange otherwise. All payments are for the scheduled session unless otherwise arranged, meaning you will be charged for the full session if you are late or have to leave early. If you miss a session without canceling, or cancel with less than *48 hours notice, you must pay a late cancellation/no-show fee of $75.00 by our next regularly scheduled meeting. The voicemail/email has a time and date stamp which will keep track of the time that you reached out to cancel. The only exception to this rule about cancellation is if you would endanger yourself by attempting to come (for instance, driving on icy roads without proper tires), or if you or someone whose caregiver you are has fallen ill suddenly. However, online sessions are available. If you no-show for two sessions in a row and do not respond to my attempts to reschedule, I will assume that you have dropped out of therapy and will make the space available to another individual. You are responsible for paying for your session weekly unless we have made other firm arrangements in advance. Fees are reviewed yearly and may be adjusted, but I will inform you accordingly, depending upon your course of treatment.

Your responsibilities are to be honest with yourself. To be honest with yourself, is to be honest with me. If there is an issue that is manifesting itself in your need to seek therapy, it would best be taken care of before it progresses further and you have greater consequences. My expectations are that you can explore your medical, psychological, substance use, family, and social history honestly and in a forthcoming manner.

*Please be aware that New York State Law (Educational Law and Regents Rules) requires that you have a medical evaluation (yearly physical) as a part of your care, particularly if you are have been medically diagnosed with schizophrenia, schizo-affective disorder, bi-polar,

major depression disorder, panic disorder, obsessive-compulsive disorder, attention-deficit hyperactivity disorder, or autism.

Court Clause: If a court case requires your therapist to attend court then you are liable for all of your therapist legal fees and any other expenses (travel expenses, travel time, housing, emotional preparation). The fees are $3500 for a day and a full-day is the minimum for each day required to be in court (because I will have to cancel my appointments for the day). The same hourly rate is applied to coordinating court cases and emotional time is also charged at this rate as well. Pro-rating is not available.

YOUR RIGHTS
You have the following rights regarding PHI we maintain about you. To exercise any of these rights, please submit your request in writing to our Privacy Officer at illuminatelcsw@gmail.com.

• Right of Access to Inspect and Copy. You have the right, which may be restricted only in exceptional circumstances, to inspect and copy PHI that is maintained in a "designated record set". A designated record set contains mental health/medical and billing records and any other records that are used to make decisions about your care. Your right to inspect and copy PHI will be restricted only in those situations where there is compelling evidence that access would cause serious harm to you or if the information is contained in separately maintained psychotherapy notes. We may charge a reasonable, cost-based fee for copies. If your records are maintained electronically, you may also request an electronic copy of your PHI. You may also request that a copy of your PHI be provided to another person.
• Right to Amend. If you feel that the PHI we have about you is incorrect or incomplete, you may ask us to amend the information although we are not required to agree to the amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us. We may prepare a rebuttal to your statement and will provide you with a copy. Please contact the Privacy Officer if you have any questions.
• Right to an Accounting of Disclosures. You have the right to request an accounting of the disclosures that we make of your PHI. We may charge you a reasonable fee if you request more than one accounting in any 12-month period.
• Right to Request Restrictions. You have the right to request a restriction or limitation on the use or disclosure of your PHI for treatment, payment, or health care operations. We are not required to agree to your request unless the request is to restrict disclosure of PHI to a health plan for purposes of carrying out payment or health care operations, and the PHI pertains to a healthcare item or service that you paid for out of pocket. In that case, we are required to honor your request for a restriction.
• Right to Request Confidential Communication. You have the right to request that we communicate with you about health matters in a certain way or at a certain location. We will accommodate reasonable requests. We may require information regarding how payment will be handled or specification of an alternative address or other method of contact as a condition for accommodating your request. We will not ask you for an explanation of why

you are making the request.
• Breach Notification. If there is a breach (defined as the acquisition, access, use or disclosure of PHI in violation of the HIPAA Privacy Rule) concerning your unsecured PHI, we are required to notify you of this breach, including what happened and what you can do to protect yourself against potential harm. You also have a right to be notified if that PHI has not been encrypted to government standards and/or the risk assessment fails to determine that there is a low probability that your PHI has been compromised.
• Right to opt out of Fundraising Communications. We may send you fundraising communications at one time or another. You have the right to opt out of such fundraising communications with each solicitation you receive.
• Right to a Copy of this Notice. You have the right to a copy of this notice.
*Requests, except for additional copies of this notice, must be made in writing.

Statement of Personal Liability: By signing below, you are releasing Illuminate Licensed Clinical Social Work, PLLC, Leah Silverstein (or any subcontractor or landlord) from any legal and personal responsibility as a result of your treatment. In consideration for being allowed to participate in this event, I hereby RELEASE, WAIVE, DISCHARGE AND COMMIT NOT TO SUE Illuminate Licensed Clinical Social Work, PLLC or Leah Silverstein, any sub-contractors, organizers and/or participants for any and all liabilities, claims, demands arising from or related to the event, including any loss, damage, or injury sustained by me or to any property belonging to me whether caused by the negligence of release or otherwise while participating in, on or upon the premises where the treatment/event is being conducted or any other treatment/event related to the organization. To the best of my knowledge, I am in good physical condition and I am not aware of any physical and physiological infirmity, which would place me at risk to participate in any way within therapy or ceremony activities. I am fully aware of the risk and hazards connected with this treatment/event. I voluntarily assume full responsibility for any risk of loss, property damage or personal injury, that may be sustained by me, or any loss or damage to property owned by me as result of being engaged in the treatment/event activities whether caused by the negligence of release, or otherwise.

Illuminate Licensed Clinical Social Work, PLLC does not and will not sell or rent your personal information to anyone. Illuminate Licensed Clinical Social Work, PLLC may disclose your information to third-party service providers for purposes of service delivery, payment processing, or other account-related activities. Such third-party processors are contractually restricted from using or disclosing such information for any other purpose.

Infectious Disease Statement: Due to the current situation, COVID-19 has changed the landscape of how therapy is done. However, there are times when meeting in person is necessary. This waiver absolves Leah Silverstein and Illuminate Licensed Clinical Social Work, PLLC from any legal obligations and/or medical responsibilities, resulting from COVID-19 or any contagious infectious illness. By signing below you are relinquishing and forfeiting any rights that you, any family member, person, or entity may have in pursuing any legal action

or medical responsibility on the part of Leah Silverstein and/or Illuminate Licensed Clinical Social Work, PLLC.

Good Faith Cost Estimate: I am required by law to share the expected cost of therapy, diagnosis, length of treatment, and good faith estimate. A basic formula for cost is: hourly rate times how many sessions. For some, it will be 2x a week, weekly, 2x a month, or monthly. Session Coding (CPT Codes) are as follows: 16-37 min: 90832; 38-52 min: 90834; 53-60 min: 90837. Length: People who utilize extended sessions for the purpose of trauma resolution will cut down on the length of treatment but the costs are relatively the same (*even though actively recovering from illness is usually a lifelong process, for which I provide on-going care). Diagnosis: Most people are going to have an underlying unresolved trauma or dissociative aspect of their trauma that is impacting their current mental health presentation, so more than likely, a trauma and stressor-related disorder (DSM coding: F43.10, F43.23, F43.8) is going to be applicable. As I am a trauma and dissociation specialist, people who seek me out typically fall into this diagnostic category. Good faith estimate: Your history, age, diet, exercise, severity of traumas (amount and scale), level of bond/addiction to current coping strategy, severity of symptomology and the level of impact that your mental health is having on your life are factors that impact how long your treatment will last. Your (conscious and unconscious) willingness to change, and at what level you are willing to address your mental health are also factors. If you are reenacting an unresolved relationship with a caregiver from childhood, then this tends to extend your length in treatment. The typical range is $3,000 to $7,000 a year for treatment, although this will vary based on the individual and their needs.

CONTACT AND EMERGENCY CONTACTING

In case of an emergency please use email or my phone number provided to contact me. Please be mindful that email and text communications are not secure when choosing what information to include, and note that I may not be readily available or accessible in an emergency or crisis. If it is a medical or psychological emergency that requires immediate attention, please go to your nearest emergency room or hospital or call 911. Mobile Crisis (in Albany County, the Mobile Crisis team is reachable at 518-549–6500, and should be available 24 hours/day, 7 days/week) and the National Suicide Hotline (988) can also be utilized. By signing below you are authorizing me to utilize Mobile Crisis or emergency services for a wellness check-up, if applicable.

Complaints

If you're unhappy with what's happening in therapy, I hope you'll talk about it with me so that I can respond to your concerns. I will take such criticism seriously, and with care and respect. If you believe that I've been unwilling to listen and respond, or that I have behaved unethically, you can complain about my behavior to the New York State Office of Professions at 1-800-442-8106 or conduct@nysed.gov. You are also free to discuss your complaints about me with anyone you wish, and do not have any responsibility to maintain

confidentiality about what I do that you don't like, since you are the person who has the right to decide what you want kept confidential.

Rights Regarding Your PHI: You have the following rights regarding PHI I maintain about you. To exercise any of these rights please submit your request in writing to our Privacy Officer, Leah Silverstein, at 200 Trillium Lane, Albany, NY 12203 or illuminatelcsw@gmail.com.

All consumers of services offered by New York State licensed professionals have the right to: receive competent professional services; verify the credentials of licensed professionals and to know the names and titles of licensed professionals who provide services; receive clear explanations of the services being offered or provided and how much they cost; refuse any services offered; know what patient records will be maintained and how to obtain copies; personally identifiable information normally cannot be revealed without the patient's consent; file a complaint with the State Education Department or Office of Professions about a licensed professional or an unlicensed practitioner; and request and be provided a reasonable accommodation to access professional services if they have a disability. You have the right of access to inspect and copy, right to amend, right to an accounting of disclosures, right to request restrictions, right to request confidential communication. If there is a breach of unsecured PHI concerning you, I may be required to notify you of this breach, including what happened and what you can do to protect yourself. You also have the right to a copy of this notice. A reasonable filing fee may be charged for more than one accounting, case notes, communications or records request in any 12-month period. Also, a reasonable filing fee may be required if any request cannot be fulfilled electronically, i.e. email or flash drive.

Client Consent to Psychotherapy
In signing this consent, I acknowledge and represent that I have read and understood the above and signed voluntarily, had sufficient time to be sure that I considered it carefully, asked any questions that I needed to, and understand it. I understand the limits to confidentiality required by law, statement of personal liability, record keeping, billing procedures, health insurance waiver, infectious disease waiver, tele-health, communication guidelines, court clause, MCAT wellness program, good faith estimate, and I understand my responsibilities and rights as a client.

I consent to the use for release of my information to Illuminate Licensed Clinical Social Work, PLLC and other information necessary to complete the billing process. I agree to pay the fee of:
$150 for 1 hour (53-60 minute) individual session
$125 for 45 minute (38-52 minute) individual session
$100 for 30 minute (16-37 minute) individual session
unless a separate form has been reviewed, sent by Leah Silverstein, and signed by the client with an alternative agreement for payment.

I understand my rights and responsibilities as a client and my therapist's responsibilities to me. I understand the content of this informed consent and have received a copy. I am agreeing to undertake therapy with Leah Silverstein, LCSW. I know I can end therapy at any time I wish and that I can refuse any requests or suggestions made by Leah Silverstein.

By electronically signing your name below you are acknowledging the terms above, including that you have received, reviewed, and accept the content of this Informed Consent, 48-hour cancelation policy, court clause, and case management clause, and that the Good Faith Estimate has been provided.