Meghan Sasso, LMHC
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Therapist Experience and Licensure: I, Meghan Sasso, am a fully licensed practitioner in the Commonwealth of Massachusetts. State Laws and the Code of Ethics of the American Mental Health Counselors Association (AMHCA) govern my work. A copy of the Code of Ethics of the AMHCA is available on request.

Ethical Standards: The nature of the counseling relationship is unique, and I provide services that is guided by ethical standards. Because of the need to protect clients from harm or confusion, mental health and substance abuse therapists must establish and maintain appropriate professional boundaries with present or past clients, including avoiding any client contact where the counseling role may be compromised. For this reason, therapists are prohibited from developing friendships, social relationships, or having sexual contact with any individual receiving services.

Confidentiality: Under Massachusetts law, communications between a client and a licensed psychotherapist are privileged (confidential) and may not be disclosed without the authorization of the client or the client's legal guardian except under specific, limited circumstances. For example, client information may be shared with others only with written permission, through a court order, or when otherwise required by law. Records may also be subject to audit by regulatory authorities. Records and information pertaining to alcohol and/or drug treatment are protected under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 C.F.R Part 2 and cannot be disclosed without written consent unless otherwise provided for in the regulations. Your file contains written information about our work with you and your family, including an initial assessment, progress notes, signed releases of information, and summary information. You have the right to access and review your records upon request. Requests for paper copies are fulfilled at a rate of $.15 per page.
I, as your therapist, if needed, seek supervision and case consultation when necessary. In these situations, we do not disclose the identity of our clients, and are legally bound to confidentiality. **By signing this document, you are acknowledging that you understand that I may discuss your case in consultation and/ or supervision and do not object to my doing so.**

Confidentiality and the Treatment of Minors: The treatment of a minor must be authorized by a parent or guardian (with limited exceptions). If you are under eighteen years of age and not emancipated, please be aware that the law provides your parents/guardians with the right to examine your treatment records. **If treatment is for drug dependency, parents/guardians may examine the records of children under 12. This is a legal mandate set forth by the state of MA.** A summary of your treatment may also be provided to your parents. Before such action is taken, it will be discussed with you, and all efforts will be made to resolve any objections you may have about what is to be discussed prior to disclosure.

Although parents have the right to know what is occurring in therapy sessions, we must also comply with the law. A recent Supreme Court decision prohibits a therapist from waiving a minor's privilege of confidentiality to provide information when there may be a case that involves custodial or other matters that may be averse to the interests of the minor or one or both parents. In the case of a minor, I will only release the records in response to a signed court order. **Please note:** neither an agreed upon stipulation in a parenting plan nor a proposed order qualifies. This court-imposed requirement is designed to protect the minor's confidentiality and client-therapist relationship. If you have any questions, or if you would like a copy of the court decision, please let me know.
When a child turns 18, control of treatment, file information, and records reverts to the child.

Confidentiality and the Treatment of Groups: Unlike individual treatment, the confidentiality of group therapy is not protected by law. Group members must sign and abide by a written confidentiality agreement prior to participating in group. Clients with concerns about confidentiality should discuss them prior to beginning treatment.

Confidentiality and Electronic Communications: I, Meghan Sasso, cannot guarantee the confidentiality of electronic communications, including but not limited to, faxing necessary information to third party providers and insurance payers, web-based services, or e-mail communications. If you have additional questions or concerns, please let me know. If you do not consent to electronic communications, please inform me before beginning treatment, so I can determine how to proceed.

Exceptions to Confidentiality/Mandated Reporting Requirements/Duty to Warn: There are some situations in which a therapist is required by law to take actions to protect you and others from harm, even though that requires revealing information about a client's treatment:

- If it is suspected that a child, elderly, or incapacitated adult is being abused or neglected, a report will be filed with the appropriate protective agency.
- If it is believed that a person is threatening bodily harm to another person or threatening to damage another's property, protective action is required. This action will include notifying the potential victim(s), notifying the police, and/or seeking appropriate hospitalization for the client. If necessary, a therapist may contact the client's emergency contact(s) in order to gain information in order to warn the intended victim(s).
- If someone threatens to harm him/herself, a therapist may contact the person's emergency contact(s), family members, or others who can help provide protection and/or seek appropriate hospitalization.
- If a government agency is requesting the information for health oversight activities, we may be required to provide it.
- If a client files a complaint or lawsuit against his/her therapist, she/he may disclose relevant client information in order to defend her/himself.

Conflicts of Interest: From time to time, actual or potential conflicts of interest may arise. In the event that your therapist becomes aware of a conflict of interest in providing treatment to you, it will be discussed with you. We may be required to refer you to another therapist. Regardless of the existence of a conflict of interest, you can be assured that any information will remain confidential.

Record Maintenance and Documentation: I will maintain both clinical and business records for each person/family for whom I provide services, that is stored in a locked file cabinet and/or in a HIPAA-compliant Electronic Health Record. These records are maintained for a minimum of seven years following the last activity and include, but are not limited to, intake information, progress notes, assessments, treatment plans, releases of information, insurance and billing information, and information and/or documents provided by or about you before, during, and after the treatment. You, or anyone that you authorize by a written authorization for release of information, have the right to access and review your records. If requested, I will provide you with a copy of your records within thirty days of the request, at a rate of $.15 per page.

Insurance/ Managed Care: I do not work with any insurance panels or insurers as of 2/16/23. I can provide clients a receipt for services rendered in the form of a Superbill, but as I am not affilliated with the insurers. It is the client's responsibility to file their claim, wait for reimbursement & be responsible for the full payment at the time of service to their therapist.
Also, a mental health provider I am legally not obligated to complete any form or document from an insurance company unless I have agreed I will do so. This includes any insurance related paperwork related to treating the clients I see, other than a completed Superbill.

Risks and Benefits of Therapy: Participating in psychotherapy can have risks and benefits. As part of your treatment, your therapist will discuss with you your diagnosis, assessment, and my proposed treatment focus. Since participation in therapy services often involves discussing unpleasant aspects of your life, you might experience uncomfortable feelings like sadness, anger, guilt, anxiety, frustration, loneliness, and helplessness that are not always resolved by the end of a therapy session. On the other hand, participating in psychotherapy can also have benefits. It can lead to more positive relationships and a better understanding of oneself and others. Therapy can also provide solutions to specific problems and reduce feelings of distress. Your therapist will work with you to identify areas of strength, expand your coping strategies, build on competencies and develop a treatment plan with your active involvement. Please share with me both your positive feelings about your therapy and any concerns you may have.

Grievances: I am committed to providing high quality services. You are encouraged to discuss any concerns or complaints with your therapist, Meghan Sasso, LMHC. You can also access the MA Board of Allied Mental Health Professionals at 1000 Washington St. Suite 710. Boston, MA 02118; (617) 727-0054; www.mass.gov

<u>Cost and Payment for Services:</u> **Please refer to Meghan Sasso's Published Rates. Payment (including co-payment and co-insurance) is expected at the time of service, and is accepted in the form of cash, credit/ debit or personal check. Receipts for services can be provided upon request. All fees are subject to change.**

With regard to minors with divorced parents, the financially responsible guardian(s) agrees to pay for services rendered to their child regardless of any disagreements with the other parent.
You may stop treatment at any time; however, you will still be responsible for paying for services you have already received. In the case that your account is delinquent and my attempts to obtain the unpaid balances are unsuccessful, I reserve the right to submit your account to our collection agency for enforcement of collection. If your account goes to collection agency, you agree to pay any and all charges associated with the collection of your account.

<u>Scheduling and Cancellations:</u> For your convenience, I provide day and evening appointments. I understand the value of time, so we work very hard to avoid scheduling delays. We appreciate the same consideration in return.
I do request a 48 hour advanced notice for a cancellation. Failure to provide 48 hours notice could result in a missed appointment fee to the client of the cost of a full psychotherapy session. Payment for missed or cancelled appointments is the responsibility of the client, as insurance companies do not pay for missed appointments. Exceptions may be made for emergencies or extenuating circumstances by talking with your therapist. Should you and your therapist reschedule your missed appointment within the same week, you will not be charged. Please note that your therapist may not have availability to accommodate this.

<u>Emergency Services:</u> I am an outpatient-only facility, and I may not be able to be available for emergency situations that occur outside of your scheduled session time.
In the event of an emergency (you or a family member may cause harm to self or others) call **911**, your local police department, or in Essex County, you may contact Lahey Behavioral Health Center's 24-hour/7 days-a-week Emergency Services number by calling **(978) 744-1585**. You may also go directly to your local emergency room for evaluation.

ACKNOWLEDGEMENT AND ACCEPTANCE

I acknowledge that I have received and reviewed this agreement in its entirety. My signature below indicates my acceptance of, and agreement to, all of its terms.

Client/ Guardian Signature (kindly include both signatures if conjoint) Date

Meghan Sasso, LMHC

Credit Card Payment Authorization Form

I strive to make your appointments convenient for you. By signing this form, you give me permission to automatically debit your account for any costs for my services not paid by your insurance, including deductible fees, co-payments, cancellation fees and no-show fees.

Please complete the information below:

Billing Address:____________________________________

City, State, Zip:-____________________________________

Phone#_______________________________

Email:________________________________

Account Type: ___Visa ___MasterCard ___AMEX ___Discover Cardholder
Name:____
Account Number:____
Expiration Date:________________
CVV2 (3 digit number on back of Visa/MC, 4 digits on front of AMEX):________________

Card Holder's Signature:____
Date:____________

I authorize the above named business to charge the credit card indicated in this authorization form according to the terms outlined above. I certify that I am an authorized user of this credit card and that I will not dispute the payment with my credit card company; so long as the transaction corresponds to the terms indicated in this form.