Mary Ellen West, LCSW

4007 Marathon Boulevard Austin, Texas 78756
512.201.2995 Telephone
Texas License #41415

Outpatient Services, Policies and Procedures

Welcome to my practice. This form contains important information about my professional services and policies. Please read it carefully and note any questions or concerns you have so we may discuss them. Your signature at the end of this form indicates that you agree to my policies for services.

Therapist: I am a licensed clinical social worker (LCSW) engaged in independent private practice providing direct mental health care services to clients. I provide all services through Mary Ellen West, LCSW, PLLC. While I share office space with other professionals, our practices are not integrated and we are not associated in a partnership or other legal entity.

Nature of Services: I provide individual, group, and family psychotherapy and parent coaching for toddlers, preschoolers, children and adolescents referred for behavioral, emotional and social concerns. Follow-up consultation may be provided to assist in implementing recommendations in school, home, or other settings. I do not provide forensic assessments or assessments for custody trials.

The approach, goals, and duration of therapy depend on many factors and will be discussed with each family on an individual basis. At the end of the initial evaluation process, I will provide you with first impressions of what therapy may include and we will develop goals and an initial treatment plan to follow should we agree to work together in therapy.

Length of Sessions: The initial appointment includes an interview with you and/or your child and usually lasts approximately 60 minutes. Subsequent appointments are typically 45 minutes once a week at a time we agree on; Some sessions may be longer or more or less frequent.

Appointments: Appointments are scheduled with me directly by phone or email. Appointments are generally scheduled between the hours of 9:00 a.m. and 6:00 p.m. on a weekday.

My schedule for seeing clients closely follows the academic year. During summer months, I take extended time off from my practice (typically 6-8 weeks). If I will be unavailable for an extended time, I will provide a referral to other professionals and/or community resources if necessary.

Cancellations: Once an appointment is scheduled, you will be expected to pay for it unless you cancel at least 24 hours in advance. To cancel or reschedule, please contact me directly at 512-201-2995. Late cancellations or missed appointments will be charged at my full rate, except in the case of an emergency or prior arrangement. Please note that insurance companies will not pay for missed sessions. If you miss two appointments in a row without notifying me, it will be assumed that you have terminated your services. To re-establish treatment after it has been terminated, you may call me.

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Fees: Fees for services are required to be paid at the time of the service. Cash, check, and credit card are accepted for payment. My current fee structure is as follows: Individual and Family Sessions (45-50 minutes): $130; Late Cancel/No Show Fee: $130. Fees for additional services (e.g., school or home visits, consultations, letters, longer sessions) will be discussed on a case-by-case basis. There is a $25 charge for all returned checks. These fees are subject to change upon sixty (60) days' advance notice to you. If, after receipt of such notice, you are unable or not willing to pay the higher fee, you will be given referrals to other providers and services will be terminated. I reserve the right to terminate services for balances outstanding for more than fifteen (15) days.

Insurance: I do not accept insurance. Upon request, I can provide the necessary documentation (receipt with billing codes) for you to submit to your insurance company for possible out-of-network reimbursement. Please call your insurance company before entering into treatment to determine your benefits and reimbursement procedures. Please note that insurance providers may require disclosure of a psychiatric diagnosis and/or other treatment information.

Contacting Me: My direct telephone number is 512-201-2995. When I am unavailable, my telephone is answered by voice mail that I monitor frequently. If you are difficult to reach, please inform me of times when you will be available in your message. While I am often not able to answer telephone calls immediately, I will make every effort to return your call within 24 hours, with the exception of nights, weekends and holidays.

In the event that I am not able to return your call within a reasonable amount of time, or I am unavailable for a longer period of time (e.g., on vacation), you are responsible for seeking help from community resources or the local emergency room. Should you need assistance with a mental health situation outside of my availability, you may contact the Austin Travis County Integral Care 24/7 Crisis Hotline: 512-472-HELP (512-472-4357).

To protect privacy, I do not communicate with clients or family members via text message. As electronic mail (e-mail) is not considered a secure form of communication, I prefer to limit its use to administrative matters like scheduling and billing. Please do not send confidential or sensitive information via e-mail, as privacy cannot be guaranteed. (For more information, and to note your preferences, please see my Email and Texting Consent form.)

Emergencies: I do not provide any emergency mental health services. For medical emergencies, situations where a child or family member is believed to be a danger to self or others, or other emergencies necessitating immediate mental health attention, you should call 911 or go directly to the nearest hospital emergency room for assistance.

Confidentiality: I respect the importance of the privacy of information that you and your family share with me. In general, the law protects the privacy of all communications between a patient and providers of mental health services. I will not release any information about treatment to anyone, including other family members, schools, physicians, or other therapists, without written

authorization from the parent/guardian (minors under age eighteen) or client (over age eighteen). There are a few important exceptions to confidentiality including but not limited to:

- If you (or your child or family member) reveal plans to harm yourself or someone else, I am required to disclose this information as necessary to ensure your safety and the safety of others.
- If you (or your child or family member) reveal information about past or current abuse or neglect of a minor, elderly person, or disabled individual, abuse of patients in treatment facilities, or sexual exploitation by another mental health professional or member of the clergy, I am required by law to report this to an appropriate state agency.
- In certain legal proceedings, such as child custody disputes, mental malpractice suits, and other lawsuits concerning damages to mental health, the court may subpoena your records.

If your child is under eighteen years of age, you have the right to examine your child's treatment records. Generally, for best treatment, it is desired that confidentiality between the therapist and child client be respected. Parents/Guardians will be kept informed about the progress and issues in the treatment of their child. I strive to do this while still preserving the confidentiality between the therapist and child that is essential for the best outcome.

At times I may consult with other respected mental health professionals on treatment plans and progress. During consultation, I make every effort to avoid revealing the identity of my clients. Anyone providing consultation or supervision on your child's treatment is also legally bound to keep information about patients confidential.

In the event of my death or permanent disability, it will become necessary for another licensed mental health professional selected by me to take possession of your file and records. By signing this form, you give your consent for the designated therapist to take possession of your file and records, contact you, and deliver your records to the therapist of your choice or provide you with copies upon your request.

For further information regarding privacy and confidentiality, please review the HIPAA Notice of Privacy Practices document provided in conjunction with this form.

Audio and Video Recordings: No recording of any sessions will occur without the express and prior written consent of the client and therapist.

Professional Relationship: Personal and/or business relationships can undermine the effectiveness of the professional, therapeutic relationship. I am not able to have social or personal relationships with clients. I do not accept personal friend or contact requests from current or former clients for social networking sites (e.g., Facebook, Twitter, etc.) as this can compromise client confidentiality and privacy. In order to respect client and family privacy, if I encounter you in a public setting, I will not acknowledge our acquaintance unless addressed by you first.

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Potential Negative Effects: Mental health services can have many positive benefits; however, receiving psychotherapy may involve some risks or discomforts for the client and family. Therapy often involves discussing problems that may lead to unpleasant feelings. You or your child may experience some discomfort when talking about these problems or experiences. Also, although each treatment is designed to help youth with emotional and behavior problems, there is no guarantee that your child will improve. In any of these events, you and your child have the right to withdraw from services at any time without penalty.

Court Involvement: It is important to note that I do NOT provide the following services: court-related evaluations (including assessments when litigation is pending or anticipated), determination of custody or visitation privileges, testimony in court, and advocacy services. Therapy will not be provided if there is a reasonable expectation that testimony in court will be required. Referral to other professionals in the community providing these services is available upon request. If disclosure of records or testimony is requested by you or compelled by law, regardless of who is responsible for compelling the production or testimony, you will be responsible for and shall pay the costs related to my preparation and participation, including fees charged by legal consultants. The current fee for court-related matters is $400/hour with a half-day minimum. A deposit may be required for anticipated court appearances or preparation.

Complaints: Please do not hesitate to discuss concerns with me. Open and honest communication between client and therapist regarding frustrations and upsets in the treatment context can provide opportunities for benefit. I take client concerns seriously and endeavor to respond with care and respect. If you have a question or complaint that you cannot resolve with me, you have the right to call the Texas State Board of Social Worker Examiners toll-free at 1-800-232-3162.

Termination: Ending relationships can be difficult. Having a healthy goodbye can be therapeutic. Therefore, it is important to have a termination process in order to achieve closure. The appropriate length of the termination depends on the length and intensity of the treatment. I may terminate treatment after appropriate discussion with you, if I determine that the psychotherapy is not being effectively used or if you are in default on payment. I will not terminate the therapeutic relationship without first providing the reasons and purpose of terminating.

Should you miss two scheduled appointments in a row or fail to schedule an appointment for three consecutive weeks, unless other arrangements have been made in advance, for legal and ethical reasons, I must consider the professional relationship discontinued. To re-establish treatment after it has been terminated, you may call me.

Alternative Services: You have the right to withdraw from my services at any time and I will assist you with finding an appropriate referral. You may also choose someone on your own or from another referral source.

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HIPAA Privacy Policy: Please read my HIPAA Notice of Privacy Practices and note that you have read it at the bottom of this form.

Your signature indicates that you have read, understand, and agree to the policies and procedures of the office of Mary Ellen West, LCSW.

Signatures:

_____ _____
Parent or Guardian printed name Relationship to Client

_____ _____
Signature Signature Date

☐ I have read the HIPAA Notice of Privacy Practices form and received a copy for my files.

_____
Printed name

_____ _____
Signature Signature Date

Received:

_____ _____
Mary Ellen West, LCSW Date
Therapist Signature