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## CLIENT INFORMED CONSENT TO TREATMENT

The following information is provided to offer you a clear understanding of my services, office policies, and your rights. Please read the information carefully and feel free to ask me any questions.

**Initial Sessions and Therapy Process:** Our first few sessions will involve gathering information about your concerns, taking personal and family history, completing necessary forms, deciding whether to continue working together, and setting initial therapy goals. The therapy process is a collaborative agreement to explore, observe, and problem-solve your current difficulties and related issues. In working towards your therapy goals, material may be discussed which brings up uncomfortable feelings. There is no guarantee that a specific result will emerge from the therapy process; however, that is our mutual goal. Therapy usually ends after mutual agreement about readiness and goal completion. However, your participation in therapy is voluntary, and you have the right to terminate at any time.

**Confidentiality:** The information you provide will be treated confidentially and will not be made available to individuals or agencies without your written consent. If the client is less than 18 years of age, a parent or guardian must provide written consent. There are instances in which confidential information can or must be released without your consent. These instances are as follows:

- (1) If you pose a serious danger to yourself or others.
- (2) If neglect or abuse of a child or an incapacitated adult is suspected.
- (3) If a court issues a subpoena concerning your records.
- (4) If you file a worker's compensation claim.
- (5) If I become the focus of a Virginia Board of Psychology inquiry, and the Board subpoenas the records.

In cases in which information must be released without your consent, every attempt will be made to notify you before hand. Please read the attached HIPAA Notification Form for more information on your rights and privacy.

**Scheduling, Fees, and Payments:** Upon deciding to work together to meet your therapeutic goals, we will identify a schedule of meeting times. These sessions are reserved for you and only you. With the exception of inclement weather conditions, observed holidays, or my absence, you will be billed for sessions on a continuing basis until termination, including missed or cancelled sessions. The fee for a missed or cancelled session will be waived if, either we are able to schedule a "make-up" session (generally within the same week), I am able to fill the missed session with another client appointment, or we have agreed ahead of time the

circumstances dictate a fee waiver. If you are using insurance, note that your insurance company may not be billed for missed appointments.

All individual, couples, and family sessions are 45 minutes long. The fee for each session is \$135.00 per session, and fees are collected at the time of service. The fee for psychological testing is \$165.00 per hour. Extended telephone contacts or preparation of written reports will be billed on a prorated basis. A statement of all services billed will be provided on a monthly basis. Balances over 90 days may be sent to a third party for collection. Fees are reviewed on a yearly basis and may be adjusted, with notice.

Please note that I do not bill insurance companies directly or accept payment from insurance companies. If you are expecting to file a claim for services with your insurance company, I recommend that you contact your insurance company so that you are aware of the deductibles (if any), co-payments/co-insurance, and limits to your coverage. Limits to coverage may include, but are not limited to: the number of sessions that are covered per calendar year, the need for pre-authorization of services, exclusion of reimbursement for out-of-network providers, and exclusions of coverage based on pre-existing conditions. It is important to note that insurance companies require information regarding your diagnosis and treatment, and that most insurance companies cover only those services that are considered “medically necessary” (i.e., provided to treat a diagnosable mental condition).

**Telephone Contact, Coverage, and Emergencies:** Telephone messages are checked regularly and routine telephone calls are returned within a 24-hour period. My office voice-mail greeting provides a number at which to contact me in an emergency. If a situation is urgent but not life threatening, please leave a detailed message and I will return your call as soon as possible. If a situation requires immediate attention, and you can not await my return call, please call 911 or go directly to your nearest emergency room. Please contact me and notify me of the emergency as soon as possible so that I may assist you with follow-up. Coverage by a colleague will be provided during vacations and absences.

**I have read the above information and fully understand and consent to the policies described above. I understand I will be financially responsible for any fees not covered by my insurance company. I have reviewed the accompanying HIPAA Notification Form and understand and fully consent to the policies on the HIPAA Notification Form.**

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Signature of Client/Parent

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Date

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Signature of Client/Parent

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Date