Marisa Campanella-Harris, LPC LLC
NJ License: 37PC00620300

I am looking forward to working with you. I will make a reasonable effort to accommodate your needs. So that you may be fully informed about the services you are receiving, please take the time to read the following information about practice policies. Please do not hesitate to ask any questions if any of the following seems unclear.

CONFIDENTIALITY:
I would like you to be aware of your right to confidentiality and my commitment to safeguard that right. The patient-therapist relationship is a confidential and privileged one and is thus protected by law and ethical code. However, there may be limits to confidentiality depending on your particular circumstance. Notice of Privacy Practices will be provided to you outlining how Protected Health Information is used and disclosed.

If you participate in group, family, or couples therapy, I insist that you do not discuss the contents of those sessions with any other person who is not a fellow client also undergoing treatment with you in the same sessions. Also, you must agree not to hold the therapist responsible for any group, family, or couples therapy member's behavior. In the case of minors, it is important that parents/guardians understand the need of their children to develop trust in their therapists. Thus, we ask that parents/guardians limit their desire for specific details of treatment. However, I will be sure to address any concerns parents may have regarding treatment of their children.

THERAPEUTIC PROCESS:
If you choose to engage in psychotherapy, please be aware that the process of psychotherapy involves change and can be an exciting process. At times, it may seem frustrating and may bring about strong, difficult emotions. The experience may change how you perceive the world and also how you see your past, present and future. It may also change how you relate to others. Therapy will require your work and commitment. My goal is to help you make progress in your work towards reaching the goals you have identified. I will strive at all times to utilize my best clinical skills and professional judgment in this endeavor.

SCHEDULING:
Sessions are usually scheduled to last 45-60 minutes unless otherwise indicated. I will make every effort to begin sessions on time would likewise ask for your consideration in being timely for sessions. Frequency of sessions will be arranged between you and I based on recommendations and needs and can be changed over the course of treatment. You are free to end the therapeutic relationship at any time. Termination is usually a mutual goal planned for by both therapist and patient. If at any time you feel therapy is not meeting your needs, please present such concerns to me as soon as possible so that they can be addressed.

FEES/PAYMENT:
Regarding billing, payment in full is due at the time that services are rendered. Patients using insurance plans for services are required to pay co-pays or co-insurance at time of services. At this time only cash and checks and direct transfers through Zelle are accepted in the practice. For any accounts greater than 30 days overdue, interest of 1.5% will be charged per month. Any checks returned will be charged a fee of $25. In cases in which the patient has neglected an account and there has been no show of good faith despite repeated attempts to resolve, accounts will be turned over to collections. In hardship circumstances, I am available to discuss other payment arrangements including payment plan. I reserve the right to charge you for any missed appointments or appointments that are cancelled with less than 24 hours notice. In the case of a bona fide emergency, the charge will be waived. This charge will be assessed as reimbursement rate of your insurance carrier or 50% of full-fee for non-insurance patients.

OUTSIDE OF SESSION:
I am available by telephone at other times than your scheduled appointment if there is a matter that cannot wait until the next session. For any telephone calls that last longer than 15 minutes, I reserve the right to charge you a fee proportionate to the individual psychotherapy rate. If you have a true emergency, and you call after regular business hours or cannot reach me, please go to your local emergency room immediately.

HEALTHCARE COVERAGE:
I am not responsible for your health care coverage. I strongly encourage you to clarify the extent of any coverage with your carrier. Please be advised that what your insurance provider/representative advises you or me over the phone may not always be correct or clear. Changes to co-pays or co-insurance fees may be revised on receipt of Explanation of Benefits form. Ultimately you are responsible for payment of the services rendered to you.

After you have read this form, please print (2) copies, sign your name and date below indicating you have understood and accepted what you have read. By signing this form, I am providing consent to my treatment (or treatment of a minor). I acknowledge that this consent includes all future outpatient appointment and outpatient care rendered and that Marisa Campanella-Harris, LPC need not obtain other consent for outpatient care, diagnosis, or treatment unless I revoke this consent in writing.

Please keep one copy of this document for your records. Thank you.

Print Patient Name Patient Signature Date

_____

Signature of Parent/Guardian if patient is under 18 years of age Date

_____

Signature of Other Parent if Joint Custody of Minor Date

_____