Polo Jean-Louis LCSW

OFFICIAL WEBSITE: www.polojeanlouis.com

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612 GRAY ROAD, GORHAM, MAINE 04038

TELEPHONE: (207) 200-7050 & FAX: (207) 893-1865

CONSENT FOR TREATMENT

I, ____, authorize and request Mr. Polo Jean-Louis, MS, LCSW, provide treatment, and/or diagnostic procedures to myself (or if I am a parent/guardian to _______________________ - who is a minor) to which now or during the course of care as a client are advisable. I understand and agree the frequency and type of treatment will be decided between Mr. Jean-Louis, MS, LCSW and I.

I understand the purpose of these procedures will be explained to me and I will be subject to my verbal & written agreement. I understand there is an expectation that I (or the above-stated minor) will benefit from psychotherapy, but that there is no guarantee as to the outcome of the treatment.

Benefits of counseling have been shown in many well-researched studies. People who are depressed often find their mood lifting. Anxieties preventing good functioning can be mastered. Therapy can allow people to work through what is bothering them until their feelings are naturally resolved. Skills in relationships and communication often greatly improve. Counseling may help clients to develop and maintain a sense of balance in life followed by more lasting contentment, satisfaction, and skills for coping with inevitable challenges life presents.

Though I recognize the therapeutic process may at times be emotionally difficult, as the therapy process can sometimes be uncomfortable, Risks of counseling include feeling uncomfortable levels of sadness, guilt, anxiety, frustration, loneliness, helplessness or other negative feelings as a part of the process of healing and finding way to balance. I understand that the maximum benefit will occur with consistent attendance and active participation.

Termination of services is at will and available to both myself & my therapist to exercise at the discretion of both during treatment. If, however, your counselor feels that your leaving is not in your best interest, you will accept full responsibility for your termination.

I have read, fully understand, and agree to treatment.

Client Signature: __________________________________ Date: ______________

IF MINOR - CUSTODIAL PARENT(S) SIG: ______________________ _______________________

Staff: __________________________________ Date: ______________

612 GRAY ROAD, GORHAM, MAINE 04038
TELEPHONE: (207) 200-7050 & FAX: (207) 893-1865

CLIENT'S RIGHTS AND RESPONSIBILITIES

As a client of Polo Jean-Louis. LCSW, you have the following rights and responsibilities:

1. This private practice recognizes your rights as a citizen which entitles you to have the same civil, human and legal rights to which we are all entitled. You have the right to privacy, and to respectful and courteous treatment.

2. It is your responsibility to be sober when attending appointments. The clinician/private practice reserve the right to deny services on the day of a scheduled appointment if the clinician has reason to believe that you are under the influence of alcohol or drugs.

3. This clinician/private practice assures you of confidential treatment of your records. Your written approval is necessary for any information to be released to anyone outside this private practice, except as required by law, and by your insurance company or other party that pays for any part of your care. (See Confidentiality Statements for clarification regarding exceptions to confidentiality).

4. Your right to complain about any problem with this clinician/private practice is acknowledged and, if you wish to do so, you may in writing to the DHHS in Augusta or this clinician's licensing body with the Dept. of Professional & Financial Regulations/Board of Social Work Licensure. You may at any time request help from any public or private advocate. For assistance, contact the Office of Advocacy, State House Station 11, 3rd Floor, Marquardt Building, Augusta, Maine 04333 at 207-287-4228 or Disability Rights Center (formerly the Maine Advocacy Services), P.O. Box 2007, Augusta, Maine 04338-2007 at 1-800-452-1948.

5. You have the right to any appropriate level of treatment and a full understanding of all procedures being offered to you. At any time, you may say "yes" or "no", or choose to renegotiate, any treatment plans, suggestions, or procedures. You have the right to a written individualized service plan, developed by you and the counselor, based on your needs. No services or treatment can or will be provided to you against your will.

6. You have the right to view any information in your treatment file, and may do so by consulting with your counselor. You may add written comments to your record to clarify information you believe is inaccurate or incomplete.

7. If any aspect of your assessment or treatment consists of experimental research, you will be notified and given the opportunity to refuse participation.

8. You have the right to terminate with this private practice at any time. If, however, your counselor feels that your leaving is not in your best interest, you will accept full responsibility for your termination.

9. Smoking is prohibited in the building of this private practice.

10. It is expected that you will treat your counselor with courtesy and respect. Inappropriate behavior towards your counselor will lead to termination of session or phone call and may result in termination of services.

11. It is your responsibility to pay for services and maintain an active retainer fee with the agency.

CLIENT'S RIGHTS AND RESPONSIBILITIES Continued

The above information has been explained to me and I understand it fully. A copy of this document has been offered to me.

Client Signature: ______________________________ Date: _____________

(Parent/Guardian) if minor: ______________________________ Date: ______________

Counselor Signature: ______________________________ Date: ______________

Summary of Rights of Recipients of Mental Health Services -
Department of Behavioral and Developmental Services

1. This is a summary of your rights as a recipient of outpatient services under The Rights of Recipients of Mental Health Services. You have a right to obtain a copy of the Rights from this private practice or from the Department of Health and Human Services, State House Station 40, Augusta, Maine 04330 (207) 287-4200, TTD # (207) 287-2000. If you are deaf or do not understand English, an interpreter will be made available to you so that you can understand your rights.

2. Basic Rights: You have the same civil, human, and legal rights, which all citizens have. You have a right to be treated with courtesy and full respect for your individuality and dignity.

3. Confidentiality and Access to Records: You have the right to have your records kept confidential and only released with your full informed consent. You have the right to review your record at any reasonable time. You may add written comments to your record to clarify information you believe is inaccurate or incomplete. No one else can see your record unless you specifically authorized him/her to see it, except in instances described in the complete Rights book.

4. Individualized Treatment or Service Plan: You have the right to an individualized plan, developed by you and your worker, based upon your needs and goals. The plan must be in writing and you have a right to a copy of it. The plan needs to specifically detail what everyone will do, the time frames in which the tasks and goals will be accomplished and how success will be determined. The plan must be based upon your actual needs and, if a needed service is not available, detail how your need will be met.

5. Informed Consent: No services or treatment can be provided to you against your will. If you have a guardian, he or she is authorized to make decisions without your consent. You have the right to be informed of the possible risks and anticipated benefits of all services and treatments, including medications, in a manner which you understand. If you have any questions, you may ask your worker or anyone else you choose before making decisions about treatment or services. If a guardian has been authorized to make decisions for you, the guardian has the right to be fully informed of all risks and benefits or proposed treatment or services.

6. Assistance in Protection of Rights: You have the right to appoint a representative of your choice to help you understand your rights, protect your rights or help you work out a treatment or service plan. If you wish a representative, you must designate this person in writing. You can have access to the representative at any time you wish and you can change or cancel the designation at any time.

7. Freedom From Seclusion or Restraints: You cannot be secluded or restrained in an outpatient setting.

8. Right to File a Grievance: You have the right to bring a grievance to challenge any possible violation of your rights or any questionable practices. You have the right to have your grievance answered in writing, with reasons for the decision. You may appeal any decision to the Department of Health and Human Services of the State of Maine. You may not be punished in any way for filing a grievance. For help with grievances, you may contact the Office of Advocacy, State House Station 11, 3rd Floor, Marquardt Building, Augusta, Maine 04333 at 207-287-4228 or the Disability Rights Center (formerly the Maine Advocacy Services), P.O. Box 2007, Augusta, Maine 04338-2007 at: 1-800-452-1948.

____________________________________ ____________________________________
Signature of Client Date Signature of Clinician Date

AUTHORIZATION TO DISCLOSE / OBTAIN CONFIDENTIAL INFORMATION

(PRINT) CLIENT'S NAME: ______________________________ **DATE:** ___________________

I,_________________________________, request ________________________(clinician's name) to release to & obtain from____, whose address is____ and phone number is ____________________ the following information regarding:

I authorize the disclosure (D) of or the obtaining (O) from information which is circled below:(check all that apply)

___D ___O Intake and assessment
___D ___O Diagnosis, brief description of progress
___D ___O Treatment/service plan
___D ___O Medical History
___D ___O Chemical dependency treatment
___D ___O Presence in treatment
___D ___O Prognosis
___D ___O Aftercare Plan
___D ___O Discharge Summary
___D ___O Other: _____________

Purpose of requested disclosure: (check all that apply)

___D ___O Development of treatment/service plan
___D ___O Ongoing treatment/care
___D ___O Coordination w/ treatment providers
___D ___O Other: ________________________
___D ___O Coordination w/ family friends
___D ___O Coordination with school
___D ___O Employment/gov't benefits

I understand that I can revoke at any time my consent to disclose the information listed above, except to the extent that action has already been taken in reliance on my consent. This release expires on __________________, when the purpose for which it was granted has been completed, or one (1) year from the date of signing.

I also understand that Federal Regulations prohibit the above named person(s) or agency(ies) from making any additional disclosure of information without my specific written consent.

1. ___I DO ___DO NOT authorize release/disclosure of information which refers to treatment or diagnosis of drug or alcohol abuse. _____________ Client's initials

2. ___I DO ___DO NOT authorize release/disclosure of information which refers to treatment or diagnosis of mental illness. __________ Client's initials

3. ___I DO ___DO NOT wish to review such information prior to release. __________ Client's initials

3. ___ I DO ___DO NOT authorize release/disclosure of information which refers to treatment or diagnosis of HIV infection, or AIDS. I understand that individuals about whom such disclosures have been made encountered discrimination from others in the areas of employment, housing, education, life insurance, health insurance, and social and family relationships. __________ Client's initials

______________________________ ___________________
Signature of Client or Parent/Guardian Date

______________________________ ___________________ **EXPIRATION DATE**: ______________
Signature of Clinician Date

Advisories:

You may refuse to sign the authorization to disclose some or all of your health care information, but you should be aware that refusal may result in improper diagnosis or treatment or other adverse consequences.

You may revoke this authorization at any time by a written revocation and by delivering it to the person or organization holding the release of information authorization. However, this revocation is subject to the right of any person who acted in reliance on the authorization prior to receiving notice of revocation.

You are entitled to a copy of this authorization form.

For Persons/Organizations Receiving Substance Abuse or Mental Health Information:

This information has been disclosed to you from records protected by Federal Confidentiality Rules (42 CFR Part 2). The federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

(52 FR 21809, June 9, 1987; 52 FR 41997, November 2, 1987)

For Persons/Organizations Receiving Mental Health Information:

This information has been disclosed to you from records protected by State confidentiality laws (34-B M.R.S.A. Section 1207; Rights of Recipients of Mental Health Services). This information remains confidential and should not be disclosed any further except as expressly permitted by the written consent to whom it pertains or as otherwise permitted by law.

CONFIDENTIALITY STATEMENT

The following statement of confidentiality shall be read to all clients at the time of application to this private practice, or at any other appropriate time.

The confidentiality of alcohol and other drug abuse client records maintained by this clinician/private practice program are protected by Federal law and regulations. Clients of mental health services are protected by professional ethics and state local regulations regarding the confidentiality of client records. Generally, this clinician/ private practice may not disclose to anyone outside this private practice a client is receiving services, or disclose any information identifying a client as an alcohol or other drug abuser, recipient of mental health services or HIV/ AIDS status unless:

1. The client consents in writing;
2. The disclosure is mandated by court order;
3. The disclosure is made to medical personnel in a medical emergency or to police in the event of client threatening self-harm or harm to others with refusal to contract for safety;
4. Client data is requested by State authorities for purpose of audit or program evaluation;
5. The client is receiving services from an agency which has an written agreement to exchange information regarding his/her participation in the program; or
6. A review is being conducted by an accrediting licensing body.

Federal, state and local laws and regulations do not protect any information relating to a crime committed at this private practice or its premises, or against any person who works for this private practice, or any threat to commit such a crime.

Federal, state and local laws and regulations do not protect any information relating to suspected child abuse or neglect from being reported to the appropriate state or local authorities. This private practice/ clinician is mandated to report any knowledge or suspicion of abuse or neglect of a child, the developmentally delayed, and/or the elderly.

Violation of federal, state and local laws and regulations by any provider is a crime. Suspected violations may be reported to appropriate authorities in accordance with federal and state regulations as well as to the appropriate licensing body.

I understand that I have a legal right to report any violations to this clinician/private practice, to the Department of Health and Human Services, and/or to the professional licensing board.

The above information has been explained to me, and I understand it. A copy of this document has been offered to me.

______________________________ ________________
Client Signature Date

______________________________ ________________
Clinician Signature Date

HIPAA NOTICE OF PRIVACY PRACTICES
Acknowledgement of Receipt and Acceptance

I acknowledge that I received a copy of client's rights & responsibilities and client confidentiality provided by Polo Jean-Louis, LCSW LLC and that I had opportunity to review this document and can discuss it with my therapist.

I understand that I can receive a copy of this document at any time upon request, and I agree to the terms contained in the HIPAA Notice of Privacy Practices.

____________________________________ ____________
Client/Guardian Signature Date

AGENCY POLICIES AGREEMENT

I understand and agree to follow all the information as outlined in the "Agency Policies" statement.

____________________________________ ____________
Client/Guardian Signature Date

____________________________________ ____________
Clinician Signature Date

DIVORCE AND CUSTODY

I ask all my clients waive right to subpoena me to court. This policy is set in order that I can best preserve the **efficacy and integrity of my therapeutic progress and relationship with you and/or your child(en). It is my experience that my appearance in court often damages my therapist-client relationship and it is my ethical duty to make every reasonable effort to promote the welfare, autonomy and best interests of my clients. By signing this agreement, you are waiving right to have me subpoenaed and agreeing in fact not to have me or any of my records subpoenaed.**

In the case I am subpoenaed to appear in court even with this waiver – whether I testify or not – I charge my full standard fee for court related work of $250/hour of my professional time. Any of my time dedicated to any court-mandated appearance including preparing documentation, discussions with lawyers and/or the guardian ad litem in connection with the court appearance, and any time spent waiting at the court house in addition to time on the stand as well as any travel time will be billed at $250 per hour.

I understand these policies and hereby waive any and all rights to subpoena Polo Jean-Louis, LCSW and any of his clinical record(s) on any current or future legal proceedings.

Printed Name: ______________________

Signature: ______________________ Date______

Printed Name: ______________________

Signature: ______________________ Date______

AGREEMENT TO PARTICIPATE IN PROGRAM EVALUATION

In an effort to provide you with the highest quality of service, this clinician/private practice conducts random surveys of clients to find out about your level of satisfaction with its services. To promote participation, Client Survey forms are mailed with self-addressed stamped envelopes enclosed for ease of return of the form. These surveys are anonymous. Your participation is requested, but not mandatory. If you would like to participate in a survey, please sign and date below.

I understand that my participation in the private practice's program evaluation is completely voluntary. By signing below, I agree to receive a Client Survey and non-identified, self-addressed stamped return envelope. I may revoke this agreement at any time.

I agree to have the survey sent to my home address or alternative address provided below.

Address to Send Survey:
____
____

Client or Parent/Guardian: ______________________________ **Date:** ________________
Print Name: ____

AGENCY POLICIES

Revised: January 2015

BILLING AND PAYMENTS

Standard Service Fee Schedule:

Individual:
$75 per 25 minute session.
$150 per 50-minute session.
Couples:
$195.00 per 50 minute session.

Clinical Supervision:
Sliding Scale per 50 minute/weekly Individual Session
$30.00 per 50 minutes/weekly Group (Maximum number: 5/group)

Consulting:
$200.00 Consultation Assessment/Referral fee
$800.00 a half day /4 hours+travel
$1600.00 a full day /8 hours+travel

Out-of-office consultations - hospital visits, home visits, court appearances, or other types of consultations (which require the therapist to leave the office to provide private counsel or consultation) can be provided to the client at a fee of $250 per session hour. Travel time to and from will be billed at the same rate.

Annually, service fees may be increased. Clients will always be informed in advance of any changes in fees. Should there be any issues due to service rate increase, they should discuss it with their therapist.

Personal/Business checks, money orders, and/or cash are welcome. We do not accept credit cards at this time. Make checks payable to Polo Jean-Louis, LCSW. I hereby agree to directly pay Polo Jean-Louis, LCSW, for the provision of outpatient substance abuse and/or therapy services.

FOR INDIVIDUAL & COUPLES COUNSELING: An agency service retainer fee of $150.00 is required prior to each appointment which must be reconciled prior to each session. The retainer fee will be used as deposit for any now shows or cancellation policy violation Please review our cancelation policy in its entirety.

FOR CLINICAL CONSULTING : An agency service retainer fee - $30 for group supervision & full individual fee session is required prior to each appointment which must be reconciled prior to each session. The retainer fee will be used as deposit for any now shows or cancellation policy violation Please review our cancelation policy in its entirety.

FOR PROFESSIONAL CONSULTING : All payments must be paid at the time of booking. All bookings are final. There will be no refunds for any cancellations or no shows.

Checks not honored by your financial institution will be assessed a returned check fee of either $35 or the maximum amount allowed by law, whichever is greater, upon replacement. More than one dishonored check will place your account into a “cash only” status with the agency.

_______________________Signature Date: _____________

NO-SHOW/CANCELLATION POLICY An agency service retainer fee is required prior to each appointment which must be reconciled prior to each session. The retainer fee will be used if you cancel a scheduled appointment without a minimum 48 hour notice, we will not be able to use this time for another client. You will be billed for the entire cost of your missed appointment and the retainer fee will be used as payment. Within 48 hours of the next scheduled session, the retainer fee and the service fee must be reconciled in full.

RETAINER FEES: $150.00 -FOR INDIVIDUAL, $195.00 - FOR COUPLES,
$30.00 - FOR GROUP/CLINICAL SUPERVISION,
SLIDING SCALE FEE SESSON AS AGREED UPON - FOR INDIVIDUAL CLINICAL SUPERVISION.

If it is assessed necessary to file court charges due to non-payment and payment arrangements have not been agreed upon, client will be assessed full court, legal, filing cost fees, and other appropriate fees in addition to the original owed balance. All 3 major credit bureaus may be of notified debt and/or sent to a collection agency. In most collection situations, client's name, nature of service debt, and amount owed is released to the collector.

CONFIDENTIALITY All information disclosed within sessions, including that of minors, is confidential and may not be revealed to anyone without written permission, except where disclosure is permitted or required by law. Disclosure may be required in the following circumstances:

- when there is a reasonable suspicion of child abuse or abuse to a dependent or elder adult
- when the client communicates a threat of bodily injury to others
- when the client is suicidal
- when there is a threat of physical injury or violence
- when disclosure is required pursuant to a legal proceeding

CONTACT INFORMATION I may be contacted by telephone or by mail at 612 Gray Road, Gorham, ME, 04038. Note that this telephone number, (207) 200-7050, has voicemail, where you can leave a message. Messages left in my voicemail are confidential and are only accessed by me as I check messages on a regular basis during business hours. If you have an emergency that requires immediate help, please call 774-HELP for immediate crisis supportive assistance.

________________________Signature Date: _____________