

**HARRIET ENTIN, MSW, LCSW**  
**2821 N. Ballas Rd. #37**  
**St. Louis, MO. 63131**  
**314-993-4745**

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**PRACTICE INFORMATION AND INFORMED CONSENT**

Welcome to my practice. I look forward to being of assistance to you. Please carefully read through the information below and sign and date one copy. The 2<sup>nd</sup> copy is for you records. If you have any questions, please let me know.

**Appointments**

Sessions are by appointment only, and run 50 minutes unless otherwise scheduled.

**Canceling or Rescheduling Appointments**

If you need to cancel or reschedule an appointment, please call my office # and give me 24 hours' notice or you will be charged the full fee for the time held for you. Hazardous weather or illness do not apply. Please leave me a voice message at 314-993-4745 about any appointment related information.

**Contacting Me**

You may reach me at 314-993-4745. Please leave your name, message and phone number, and I'll return your call as soon as I am available. Non-emergency calls over the weekend will be returned on Monday morning.

**Email communication**

If you email me, please use email address [harriet@harrietentin.com](mailto:harriet@harrietentin.com). Since there is a lot of room for misunderstanding in email, I prefer communication be in person or by phone.

**Emergencies**

If you have an urgent situation and need to speak with me after hours or on a weekend or holiday, please call my cell #314-750-8305. Please note that I do charge for after hour emergency calls at the same rate as office visits. If you have a life-threatening situation, call 911.

**Fees**

Fees are collected at the start of each session. This clears the clinical space for our work together. My fee for a 50 minute session is \$180. and may be paid by cash, check, credit, or debit card. This fee applies to office sessions, as well as time that I spend working on your behalf outside of sessions, such as consultations, responding to emails, and phone calls of over 15 minutes. If you are in therapy with me or have terminated therapy with me, and I am legally ordered to submit records, provide testimony, or appear in court, you will be charged a fee of \$250.per hour for all of my time (including travel) in these matters. There is a \$20 fee for returned checks.

**Insurance**

My policy is that clients pay me at the time of service. You will automatically receive an insurance-ready statement to submit to your insurance company that will have all the information they need to process your claim. If your insurance company needs further information from me in order to process your claim, I must have you sign a written release allowing me to speak with them about your therapy, and will then send your insurance company what they request. I will also inform you what I share with them.

**Confidentiality**

All information that you share with me in session, by phone or in writing (including emails) is strictly confidential and cannot be shared by me with anyone without your written permission, except as follows:

1. **Child abuse** – If I have reasonable cause to suspect that a child has been or may be subjected to abuse or neglect, or if I observe a child being subjected to conditions which could reasonably result in abuse or neglect, I am legally mandated to report such information to the Missouri Division of Family Services. I must also report sexual abuse or molestation of a child less than 18 years of age to Family Services. I may also report child abuse or neglect to a law enforcement agency or juvenile office.
2. **Adult and domestic abuse** – If I have reasonable cause to suspect that an eligible adult presents a likelihood of suffering from physical harm or is in need of protective services, I am legally mandated to report this to the MO Department of Social Services. “Eligible adult” means any person 60 years of age or older, or an adult with a handicap (substantially limited mental or physical impairment) between the ages of 18 and 59 years old who is unable to protect his/her own interests or adequately perform or obtain services necessary to meet his/her essential human needs.
3. **Judicial and administrative proceedings** – If you are involved in a court proceeding and a request is made for information about your diagnosis or treatment and the records thereof, such information is privileged under state law, and I will not release this information without written authorization from you or your personal or legally-appointed representative, or a court order. This privilege does not apply when an evaluation is court-ordered. I will inform you in advance if this is the case.
4. **Serious threat to health or safety-** When I judge that disclosure is necessary to protect against a clear and substantial risk of imminent serious harm being inflicted by you on yourself or another person, I must disclose your relevant confidential information to the appropriate professional workers, public authorities, the potential victim, his or her family, or your family.
5. **When I judge it appropriate therapeutically,** I reserve the right to consult with professional colleagues. In these consultations, your name will not be used.

I look forward to being helpful to you, and thank you for giving me this opportunity to be of service. Your signature below indicates that you have read this agreement and agree to its terms. Your signature also serves as an acknowledgement that you have received the HIPAA (Health Insurance Portability and Accountability Act) information described above.

\_\_\_\_\_  
Client(s) signature

\_\_\_\_\_  
(Date)

\_\_\_\_\_  
Parent/guardian signature

\_\_\_\_\_  
(Date)

*Harriet Entin, MSW*  
Witness, Harriet Entin, MSW

\_\_\_\_\_  
(Date)