

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

PRACTICE INFORMATION AND INFORMED CONSENT

Welcome to my practice. I look forward to being of assistance to you. Please read through the information below and sign and date one copy. The 2nd copy is for your 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 give me 24 hours notice or you will be charged the full fee for the time held for you. Hazardous weather or illnesses do not apply. Please leave any appointment related messages on my phone number, not email.

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

Since I am talking with clients most of the day, I do not check email frequently. So I prefer contact to be by phone or in person. However, I will receive your email and read it. My licensing board and professional liability insurance do not allow me to provide any online "advice". In addition, email leaves a lot of room for misunderstanding, since at least 80% of communication is non-verbal. I also cannot guarantee the confidentiality of incoming or outgoing emails, so confidentiality may also be compromised. Again, please phone rather than email to schedule, cancel or reschedule appointments.

Emergencies

If you have an urgent need to speak with me after hours or on a weekend or holiday, please call 314-750-8305 and I'll be notified. If you have an emergency that is life-threatening, call 911 or go to the nearest emergency room and ask for the mental health professional on call. When I am on vacation and a colleague is covering for me, that person's name and phone number will be on my voice mail.

Fees

Fees are collected at the start of each session. This clears the clinical space for our work together. Your fee for a 50 minute session is \$170., 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, conferences, 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 \$175. per hour for all of my time in these matters. I reserve the right to apply any refunds, reimbursements or any payments received from any third party to any outstanding balance due me by a client. There is a \$30 fee for any 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 reimburse you. If your insurance company needs further information from me in order to process your

claim, I will have you sign a 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 shared 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 may also share information about you, including your name, with the colleague providing emergency coverage if I am on vacation, and you have been in distress or crisis.

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)