

**Clinical Counselors, PA**  
**Mona Rubenfeld, M. A., LCPC**  
**11447 Cronhill Drive – Suite L, Owings Mills, MD 21117**  
**Phone: (410) 960-3954 Fax: (410) 581-3504 Email: [MRubefeld@ClinicalCounselors.com](mailto:MRubefeld@ClinicalCounselors.com)**

Dear Client:

Enclosed are some required forms that will need to be signed and returned prior to your child's scheduled initial consultation. These forms include the Treatment Consent + Office Policies and Guidelines, New Child Information, Financial Policy and Insurance Information, the Notice of Privacy Practices, and any questionnaire that may be included in your packet. Please read them over and sign where required. Please bring the signed forms to your initial consultation. In addition, I will need a copy of both sides of your insurance card. Deductibles, co-payments and full self payments are required before the start of each session. Cash or check will be accepted.

Feel free to contact me with any questions or concerns prior to our scheduled appointment. I look forward to meeting you.

Thank you,

Mona Rubenfeld, M.A., LCPC



**Clinical Counselors, PA**

**Mona Rubinfeld, M. A., LCPC**

**11447 Cronhill Drive – Suite L, Owings Mills, MD 21117**

**Phone: (410) 960-3954 Fax: (410) 581-3504 Email: [MRubinfeld@ClinicalCounselors.com](mailto:MRubinfeld@ClinicalCounselors.com)**

**Areas of Concern:** In the following list, place a check mark next to each item which identifies an area of concern to you. **Place two checks by those items which are most important.**

- |  |  |
|--|--|
| <input type="checkbox"/> Anger/Temper                                  | <input type="checkbox"/> Sexual Concerns       |
| <input type="checkbox"/> Depression                                    | <input type="checkbox"/> Thoughts of Suicide   |
| <input type="checkbox"/> Educational/School Work                       | <input type="checkbox"/> Weight loss or gain   |
| <input type="checkbox"/> Family Problems/Fighting with Siblings        | <input type="checkbox"/> Use of Alcohol        |
| <input type="checkbox"/> Fearfulness/Phobias                           | <input type="checkbox"/> Use of Drugs          |
| <input type="checkbox"/> Insecure/Timid/Lack of Self Confidence        | <input type="checkbox"/> Work                  |
| <input type="checkbox"/> Marital Problems/Parental Conflicts           | <input type="checkbox"/> Worry                 |
| <input type="checkbox"/> Problems with accepting discipline            | <input type="checkbox"/> Traumatic Stress      |
| <input type="checkbox"/> Problems in relationships with other children | <input type="checkbox"/> Stress                |
| <input type="checkbox"/> Religious/Spiritual Concerns                  | <input type="checkbox"/> Physical Problems     |
| <input type="checkbox"/> Unhappy most of the time                      | <input type="checkbox"/> Other (Specify) _____ |

Is there anything else which you believe might be important for your counselor to know about your child?

\_\_\_\_\_

Describe any method of discipline used with your child and how the he/she reacts to such discipline:

\_\_\_\_\_

Current Medications:

Dosage

Prescribed by:

\_\_\_\_\_

Primary Care Physician \_\_\_\_\_ Phone: \_\_\_\_\_

Psychiatrist \_\_\_\_\_ Phone: \_\_\_\_\_

Referred by: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Phone: \_\_\_\_\_

Past hospitalizations or surgeries: \_\_\_\_\_

**Significant Family Medical History and Mental Conditions:**

Please list all medical concerns (including mental/emotional health) in your family.

Medical Problem

Family member

\_\_\_\_\_

\_\_\_\_\_

Have any family members had previous counseling/therapy? \_\_\_Y\_\_\_N If so, explain:

\_\_\_\_\_

\_\_\_\_\_

Describe the experience?

\_\_\_\_\_

\_\_\_\_\_

**Clinical Counselors, PA**

**Mona Rubinfeld, M. A., LCPC**

**11447 Cronhill Drive – Suite L, Owings Mills, MD 21117**

**Phone: (410) 960-3954 Fax: (410) 581-3504 Email: [MRubinfeld@ClinicalCounselors.com](mailto:MRubinfeld@ClinicalCounselors.com)**

**Financial Policy**

Clinical Counselors, PA is committed to providing caring and professional mental health services. As part of the delivery of mental health services, a financial policy has been established to clarify the payment policies and options available at Clinical Counselors, PA.

- Your insurance policy, if any, is a contract between you and the insurance company; we are not part of the contract with you and your insurance company.
- Clinical Counselors, PA will bill insurance companies and other third-party payers, but cannot guarantee such benefits or the amounts covered, and is not responsible for the collection of such payments. In some cases, insurance companies or other third-party payers may consider certain services as not reasonable or necessary or may determine that services are not covered. In such cases the Person Responsible for Payment of Account is responsible for payment of these services. Clients are responsible for payments regardless of any insurance company’s arbitrary determination of usual and customary rates, or for fees that are denied or not paid by your insurance company (for any reason).
- The Person Responsible for Payment will be financially responsible for payment of such services. The Person Responsible for Payment of Account is financially responsible for paying funds not paid by insurance companies or third-party payers. Payments not received after 30 days are subject to collections. A 2% per month interest rate is charged for accounts over 30 days.
- Insurance deductibles and co-payments are due at the beginning of each session. Although it is possible that mental health coverage deductible amounts may have been met elsewhere, this amount will be collected by the office until the deductible payment is verified by the insurance company or third-party provider.
- All insurance benefits will be assigned to this office (by insurance company or third-party provider) unless the Person Responsible for Payment of Account pays the entire balance at each session.
- Clients are responsible for payments at the beginning of each session. The adult accompanying a minor (or guardian of the minor) is responsible for payments for the child at the time of service. Unaccompanied minors will be denied nonemergency service unless charges have been preauthorized to an approved credit plan or payment at the time of service.
- Missed appointments and cancellations less than 24 hours prior to the appointment will be billed to you directly, not to your insurance company or third-party provider.
- Telephone sessions lasting more than 10 minutes, will be charged at the hourly session fee.
- Filling out required forms or writing letters will be billed to you (not your insurance) at an hourly rate of \$130.00.
- There is a \$39 fee on all returned checks. A delinquency fee will be assessed on accounts which require additional collection action.
- Payment methods include check or cash.
- Every effort will be made to inform you of all charges in advance. Questions regarding the financial policies can be answered by a staff person.

I (we) hereby certify that I (we) have read, understand, and agree with the provisions of the Office and Financial Policy. I (we) consent to treatment and will comply with the policies and guidelines set forth by Clinical Counselors, PA.

Person responsible for account: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Co-responsible party: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

**Insurance Information**

**Person Responsible for Counseling Payment (or Co-Payment)**

First Name \_\_\_\_\_ MI \_\_\_\_ Last Name \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_  
Home Phone \_\_\_\_\_ Work \_\_\_\_\_ Cell \_\_\_\_\_

**Medical Insurance**

Policy Holder \_\_\_\_\_  
Relationship to Client \_\_\_\_\_  
Birth date: \_\_\_\_\_  
SSN: \_\_\_\_\_  
Gender: \_\_\_\_\_ M \_\_\_\_\_ F  
Marital Status \_\_\_\_\_ S \_\_\_\_\_ M \_\_\_\_\_ D \_\_\_\_\_ W  
Employer \_\_\_\_\_

Insurance Name \_\_\_\_\_  
Type of Policy \_\_\_\_\_  
Policy ID \_\_\_\_\_  
Group Number \_\_\_\_\_  
Phone Number \_\_\_\_\_

**Release of Information Authorization to Third Party**

I (we) authorize \_\_\_\_\_ to disclose required treatment plans, a mental health diagnosis, case notes, or other requested material) to the above listed third-party payer or insurance company for the purpose of receiving payment. I (we) understand that access to this information will be limited to determining insurance benefits, and will be accessible only to persons whose employment is to determine payments and/or insurance benefits. I (we) understand that I (we) may revoke this consent at any time by providing written notice, and after one year this consent expires. I (we) have been informed what information will be given, its purpose, and who will receive it. I (we) certify that I (we) have read and agree to the conditions and have received a copy of this form.

Person(s) responsible for account: _____	Date: ____/____/____
Person(s) receiving services: _____	Date: ____/____/____
Person(s) or guardian(s): _____	Date: ____/____/____

We suggest you confirm mental health benefits with your insurance company. The Person Responsible for Payment of the Account shall make payment for services which are not paid by your insurance policy, all co-payments, and deductibles. We will also attempt to verify these amounts with the insurance company. Your insurance company may not pay for services that they consider to be not medically or therapeutically necessary, or ineligible (not covered by your policy, or the policy has expired or is not in effect for you or other people receiving services). If the insurance company does not pay the estimated amount, you are responsible for the balance. Payments, co-payments, and deductible amounts are due at the time of service. There is a 2% per month interest charge on all accounts that are not paid within 30 days of the billing date. Payments, co-payments, and deductible amounts are due at the time of service. There is a 2% per month interest charge on all accounts that are not paid within 30 days of the billing date. Cancellations less than 24 hours in advance or missed appointments are billed directly to the Person Responsible for Payment and not to your insurance or third party provider.

I HEREBY CERTIFY that I have read and agree to the conditions as described above.	
Person responsible for account: _____	Date: ____/____/____

## Treatment Agreement Regarding Minors

The involvement of children and adolescents in therapy can be highly beneficial to their overall development. Very often, it is best to see them with parents and other family members; sometimes, they are best seen alone. I will assess which might be best for your child and make recommendations to you. Obviously, the support of all the child's caregivers is essential, as well as their understanding of the basic procedures involved in counseling children.

The general goal of involving children in therapy is to foster their development at all levels. At times, it may seem that a specific behavior is needed, such as to get the child to obey or reveal certain information. Although those objectives may be part of overall development, they may not be the best goals for therapy. Again, I will evaluate and discuss these goals with you.

Because my role is that of the child's helper, I will not become involved in legal disputes or other official proceedings unless compelled to do so by a court of law. Matters involving custody and mediation are best handled by another professional who is specially trained in those areas rather than by the child's therapist.

The issue of confidentiality is critical in treating children. When children are seen with adults, what is discussed is known to those present and should be kept confidential except by mutual agreement. Children seen in individual sessions (except under certain conditions) are not legally entitled to confidentiality (also called privilege); their parents have this right. However, unless children feel they have some privacy in speaking with a therapist, the benefits of therapy may be lost. Therefore, it is necessary to work out an arrangement in which children feel that their privacy is generally being respected, at the same time that parents have access to critical information. This agreement must have the understanding and approval of the parents or other responsible adults and of the child in therapy.

This agreement regarding treatment of minors has provisions for inserting individual details, which can be supplied by both the child and the adults involved. However, it is first important to point out the exceptions to this general agreement. The following circumstances override the general policy that children are entitled to privacy while parents or guardians have a legal right to information.

- Confidentiality and privilege are limited in cases involving child abuse, neglect, molestation, or danger to self or others. In these cases, the therapist is required to make an official report to the appropriate agency and will attempt to involve parents as much as possible.
- Minors may independently enter into therapy and claim the privilege of confidentiality in cases involving abuse or severe neglect, molestation, pregnancy, or communicable diseases, and when they are on active military duty, married, or officially emancipated. They may seek therapy independently for substance abuse, danger to self or others, or a mental disorder, but parents must be involved unless doing so would harm the child.
- Any evaluation, treatment, or reports ordered by, or done for submission to a third party such as a court or a school is not entirely confidential and will be shared with that agency with your specific written permission. Please also note that I do not have control over information once it is released to a third party.

Now that the various aspects surrounding confidentiality have been stated, the specific agreement between you and your child/children follows:

I, (name) \_\_\_\_\_ (relationship to child) \_\_\_\_\_  
I, (name) \_\_\_\_\_ (relationship to child) \_\_\_\_\_

I (we) agree that my /our child/children:

(name) \_\_\_\_\_  
(name) \_\_\_\_\_  
(name) \_\_\_\_\_

should have privacy in his/her/their therapy sessions, and I agree to allow this privacy except in extreme situations, which I will discuss with the therapist. At the same time, except under unusual circumstances, I understand that I have a legal right to obtain this information. To increase the effectiveness of the therapy, I agree to the following:

Parents' Goals of Therapy:

Child's Goals of Therapy:

- |          |          |
|----------|----------|
| 1. _____ | 1. _____ |
| 2. _____ | 2. _____ |
| 3. _____ | 3. _____ |
| 4. _____ | 4. _____ |
| 5. _____ | 5. _____ |

I (we) will do my best to ensure that therapy sessions are attended and will not inquire about the content of sessions. If my child prefers/children prefer not to volunteer information about the sessions, I will respect his/her/their right not to disclose details. Basically, unless my child has/children have been abused or is/are a clear danger to self or others, the therapist will normally tell me only the following:

- whether sessions are attended
- whether or not my child is/children are generally participating
- whether or not progress is generally being made

The normal procedure for discussing issues that are in my child's/children's therapy will be joint sessions including my child/children, the therapist, and me and perhaps other appropriate adults. If I believe there are significant health or safety issues that I need to know about, I will contact the therapist and attempt to arrange a session with my child/children present. Similarly, when the therapist determines that there are significant issues that should be discussed with parents; every effort will be made to schedule a session involving the parents and the child/children. I understand that if information becomes known to the therapist and has a significant bearing on the child's/children's well-being, the therapist will work with the person providing the information to ensure that both parents are aware of it. In other words, the therapist will not divulge secrets except as mandated by law, but may encourage the individual who has the information to disclose it for therapy to continue effectively.

### **Authorization and Consent to Treatment**

**I declare that I am the custodial parent or legal guardian of \_\_\_\_\_,  
as described in this document, and that I have the legal authority to bring him or her for treatment.**

**I authorize treatment to be administered by Mona Rubinfeld, LCPC and Clinical Counselors, PA to  
\_\_\_\_\_ as described in the Treatment Agreement Regarding Minors.**

**Signature: \_\_\_\_\_**

**Date: \_\_\_\_\_**

**(Parent/Legal Guardian)**

# Privacy of Information Policies

**This form describes the confidentiality of your medical records, how the information is used, your rights, and how you may obtain this information.** Effective 4-14-03

## **Our Legal Duties**

State and Federal laws require that we keep your medical records private. Such laws require that we provide you with this notice informing you of our privacy of information policies, your rights, and our duties. We are required to abide these policies until replaced or revised. We have the right to revise our privacy policies for all medical records, including records kept before policy changes were made. Any changes in this notice will be made available upon request before changes take place.

The contents of material disclosed to us in an evaluation, intake, or counseling session are covered by the law as private information. We respect the privacy of the information you provide us and we abide by ethical and legal requirements of confidentiality and privacy of records.

## **Use of Information**

Information about you may be used by the personnel associated with this clinic for diagnosis, treatment planning, treatment, and continuity of care. We may disclose it to health care providers who provide you with treatment, such as doctors, nurses, mental health professionals, and mental health students and mental health professionals or business associates affiliated with this clinic such as billing, quality enhancement, training, audits, and accreditation.

Both verbal information and written records about a client cannot be shared with another party without the written consent of the client or the client's legal guardian or personal representative. It is the policy of this clinic not to release any information about a client without a signed release of information except in certain emergency situations or exceptions in which client information can be disclosed to others without written consent. Some of these situations are noted below, and there may be other provisions provided by legal requirements.

## **Duty to Warn and Protect**

When a client discloses intentions or a plan to harm another person or persons, the health care professional is required to warn the intended victim and report this information to legal authorities. In cases in which the client discloses or implies a plan for suicide, the health care professional is required to notify legal authorities and make reasonable attempts to notify the family of the client.

## **Public Safety**

Health records may be released for the public interest and safety for public health activities, judicial and administrative proceedings, law enforcement purposes, serious threats to public safety, essential government functions, military, and when complying with worker's compensation laws.

## **Abuse**

If a client states or suggests that he or she is abusing a child or vulnerable adult, or has recently abused a child or vulnerable adult, or a child (or vulnerable adult) is in danger of abuse, the health care professional is required to report this information to the appropriate social service and/or legal authorities. If a client is the victim of abuse, neglect, violence, or a crime victim, and their safety appears to be at risk, we may share this information with law enforcement officials to help prevent future occurrences and capture the perpetrator.

## **Prenatal Exposure to Controlled Substances**

Health care professionals are required to report admitted prenatal exposure to controlled substances that are potentially harmful.

## **In the Event of a Client's Death**

In the event of a client's death, the spouse or parents of a deceased client have a right to access their child's or spouse's records.

## **Professional Misconduct**

Professional misconduct by a health care professional must be reported by other health care professionals. In cases in which a professional or legal disciplinary meeting is being held regarding the health care professional's actions, related records may be released in order to substantiate disciplinary concerns.

## **Judicial or Administrative Proceedings**

Health care professionals are required to release records of clients when a court order has been placed.

## Minors/Guardianship

Parents or legal guardians of non-emancipated minor clients have the right to access the client's records.

## Other Provisions

When payment for services are the responsibility of the client, or a person who has agreed to providing payment, and payment has not been made in a timely manner, collection agencies may be utilized in collecting unpaid debts. The specific content of the services (e.g., diagnosis, treatment plan, progress notes, testing) is not disclosed. If a debt remains unpaid it may be reported to credit agencies, and the client's credit report may state the amount owed, the time-frame, and the name of the clinic or collection source.

Insurance companies, managed care, and other third-party payers are given information that they request regarding services to the client. Information which may be requested includes type of services, dates/times of services, diagnosis, treatment plan, description of impairment, progress of therapy, and summaries.

Information about clients may be disclosed in consultations with other professionals in order to provide the best possible treatment. In such cases the name of the client, or any identifying information, is not disclosed. Clinical information about the client is discussed. Some progress notes and reports are dictated/typed within the clinic or by outside sources specializing in (and held accountable for) such procedures.

In the event in which the clinic or mental health professional must telephone the client for purposes such as appointment cancellations or reminders, or to give/receive other information, efforts are made to preserve confidentiality. Please notify us in writing where we may reach you by phone and how you would like us to identify ourselves. For example, you might request that when we phone you at home or work, we do not say the name of the clinic or the nature of the call, but rather the mental health professional's first name only. If this information is not provided to us (below), we will adhere to the following procedure when making phone calls: First we will ask to speak to the client (or guardian) without identifying the name of the clinic. If the person answering the phone asks for more identifying information we will say that it is a personal call. We will not identify the clinic (to protect confidentiality). If we reach an answering machine or voice mail we will follow the same guidelines.

## Your Rights

You have the right to request to review or receive your medical files. The procedure for obtaining a copy of your medical information is as follows. You may request a copy of your records in writing with an original (not photocopied) signature. If your request is denied, you will receive a written explanation of the denial. Records for non-emancipated minors must be requested by their custodial parents or legal guardians. **The charge for this service is \$ 1.00 per page, plus postage.**

You have the right to cancel a release of information by providing us a written notice. If you desire to have your information sent to a location different than our address on file, you must provide this information in writing.

You have the right to restrict which information might be disclosed to others. However, if we do not agree with these restrictions, we are not bound to abide by them.

You have the right to request that information about you be communicated by other means or to another location. This request must be made to us in writing.

You have the right to disagree with the medical records in our files. You may request that this information be changed. Although we might deny changing the record, you have the right to make a statement of disagreement, which will be placed in your file.

You have the right to know what information in your record has been provided to whom. Request this in writing.

If you desire a written copy of this notice you may obtain it by requesting it from the Clinic Director at this location.

## Complaints

If you have any complaints or questions regarding these procedures, please contact the clinic. We will get back to you in a timely manner. You may also submit a complaint to the U.S. Dept. of Health and Human Services and/or the Maryland Board of Professional Counselors. If you file a complaint we will not retaliate in any way.

Direct all correspondence to: Mona Rubenfeld, LCPC

**I understand the limits of confidentiality, privacy policies, my rights, and their meanings and ramifications.**

Client's name (please print): \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Signed by: \_\_\_\_ client \_\_\_\_ parent/legal guardian

**Clinical Counselors, PA**  
**Mona Rubinfeld, M. A., LCPC**  
11447 Cronhill Drive – Suite L, Owings Mills, MD 21117  
Phone: (410) 960-3954 Fax: (410) 581-3504 Email: [MRubinfeld@ClinicalCounselors.com](mailto:MRubinfeld@ClinicalCounselors.com)

**Release of Information Consent**

Client's Name: \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Phone: \_\_\_\_\_ DOB: \_\_\_\_\_

I, \_\_\_\_\_, authorize \_\_\_\_\_ to:  
\_\_\_\_\_ (send) \_\_\_\_\_ (receive) the following \_\_\_\_\_ (to) \_\_\_\_\_ (from)

Name: \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

*A SEPARATE AUTHORIZATION, AS DEFINED BY HIPAA, IS REQUIRED FOR \*PSYCHOTHERAPY NOTES.*

- |   |   |
|---|---|
| <input type="checkbox"/> Academic testing results     | <input type="checkbox"/> Psychological testing results        |
| <input type="checkbox"/> Behavior programs            | <input type="checkbox"/> Service plans                        |
| <input type="checkbox"/> Progress reports             | <input type="checkbox"/> Summary reports                      |
| <input type="checkbox"/> Intelligence testing results | <input type="checkbox"/> Vocational testing results           |
| <input type="checkbox"/> Medical reports              | <input type="checkbox"/> Entire record, except progress notes |
| <input type="checkbox"/> Personality profiles         | <input type="checkbox"/> *Psychotherapy Notes                 |
| <input type="checkbox"/> Psychological reports        | <input type="checkbox"/> Other, specify _____                 |

The above information will be used for the following purposes:

- Planning appropriate treatment or program  
 Continuing appropriate treatment or program  
 Determining eligibility for benefits or program  
 Case review                       Updating files  
 Other (specify) \_\_\_\_\_

I understand that this information may be protected by Title 42 (Code of Federal Rules of Privacy of Individually Identifiable Health Information, Parts 160 and 164) and Title 45 (Federal Rules of Confidentiality of Alcohol and Drug Abuse Patient Records, Chapter 1, Part 2), plus applicable state laws. I further understand the information disclosed to the recipient may not be protected under these guidelines if they are not a health care provider covered by state or federal rules.

I understand that this authorization is voluntary, and I may revoke this consent at any time by providing written notice, and after 1 year this consent automatically expires. I have been informed what information will be given, its purpose, and who will receive the information. I understand that I have a right to receive a copy of this authorization. I understand that I have a right to refuse to sign this authorization.

Your relationship to client:  Self     Parent/legal guardian     Other (describe) \_\_\_\_\_

If you are the legal guardian or representative appointed by the court for the client, please attach a copy of this authorization to receive this protected health information.

Client's Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Parent/guardian/personal representative (if applicable)  
Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Witness (if client is unable to sign)  
Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_