NEW ENGLAND PASTORAL INSTITUTE, INC.

5 Summer Street
Lynnfield, MA 01940
603-890-6767

15 Ermer Road, Suite 215
Salem, NH 03079
603-890-6767
FAX 603-893-6767

20 West Park Street, Suite 214
Lebanon, NH 03766
603-448-2414

Clinical Practices

The New England Pastoral Institute, Inc. (NEPI) is committed to offering quality psychotherapy services which will aid clients in reaching their stated goals. This Informed Consent statement sets forth NEPI's policies and procedures regarding competent and ethical psychotherapeutic services for your review.

EMERGENCY PROCEDURES Should you need to reach your psychotherapist in an emergency, call 603-890-6767 and enter his/her extension. If your therapist is not available to the telephone you will be instructed to leave a voice mail message. Indicate in the message that it is an emergency. If you do not receive a response in a reasonable time or if you are unable to wait for your call to be returned, go to the emergency room of yourlocal hospital and ask to speak to the on-call psychotherapist or psychiatrist.

HOLIDAYS AND VACATIONS You will know your psychotherapist's vacation and holiday schedule well in advance and be informed who is providing backup while your psychotherapist is away. Your fee for any backup consultation will be your responsibility and will be at that professional's regular fee.

CANCELLATION POLICY When you schedule an appointment, that time is reserved for you and, therefore, not available for others who are waiting for services. Failed appointments will be charged to you according to your regular fee. If you must cancel an appointment notify your psychotherapist as soon as possible. You will not be charged for the cancelled session if you are able to reschedule another appointment within that same week, or if your psychotherapist is able to fill the time with another appointment. If your services are coved by insurance, your policy will not reimburse for non-delivered services such as a missed session and you will be charged directly the full fee for a failed or cancelled appointment. Providing your psychotherapist with sufficient advanced notice of cancellation is very helpful as it enables him or her to attempt to fill the time.

FEE POLICY Your psychotherapist has a standard fee schedule for services which will be discussed with you during your intake appointment. In some cases, if you are unable to afford the standard fee, you may be able to negotiate your fee according to a sliding fee. The setting of your fee is individually negotiated and payable by you at each session. Allo charges for returned checks are your responsibility. If you have insurance or other third party payment resources, the fee for your psychotherapy is your responsibility. Your psychotherapist will assist you in completing and filing claims forms so that you can be reimbursed directly by your insurance plan.

Your psychotherapist may find it helpful to offer telephone contact for therapeutic purposes. Fees for telephone conversations regarding therapeutic issues will be based on the rate per session. Any telephonic conversations that include clinical material must be made on a land line to assure confidentiality. Under no circumstances will clinical material be discussed utilizing cell/mobile connections. Insurance policies do not cover therapy by telephone. Consequently all telephonic clinical services shall be paid for at the next office visit. Fees are prorated as follows based on the full fee for a regular session: 5 – 15 minutes at ¼ the session rate; 16 – 30 minutes at t ½ the session rate. Time exceeding 30 minutes will be charged at the full session rate. Telephone contact regarding administrative issues (i.e., appointment scheduling or insurance questions) is not billed. Time your psychotherapist spends outside of your regular sessions reading and responding to email, journal entries, and clinical homework is also prorated based on the schedule described above.

CONFIDENTIALITY Legal and ethical aspects of clinical confidentiality are described in the "Notice of Privacy Practices" that accompanies this document.

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Consent to Evaluate/Treat for Child/Adolescent

1. **Consent to Evaluate/Treat:** I voluntarily consent that my child will participate in a mental health evaluation and/or treatment by staff from the New England Pastoral Institute, Inc. I understand that following the evaluation and/or treatment, complete and accurate information will be provided concerning each of the following areas:
   a. The benefits of the proposed treatment
   b. Alternative treatment modes and services
   c. The manner in which treatment will be administered
   d. Expected side effects from the treatment and/or the risks of side effects from medications (when applicable).
   e. Probable consequences of not receiving treatment
   f. The evaluation or treatment will be conducted by a licensed pastoral psychotherapist, psychotherapist, social worker, mental health counselor, licensed therapist or an individual supervised by any of the licensed professionals listed. Treatment will be conducted within the boundaries of New Hampshire Law for mental health practices. We have an office in Massachusetts to serve our Massachusetts residents. This office is in compliance with MA state applicable law and regulation.

2. **Benefits to Evaluation/Treatment:** Evaluation and treatment may be administered with psychological interviews, psychological assessment or testing, psychotherapy, as well as expectations regarding the length and frequency of treatment. It may be beneficial to my child, as well as the referring professional, to understand the nature and cause of any difficulties affecting my child's daily functioning, so that appropriate recommendations and treatments may be offered. Evaluation and treatment may be administered with psychological interviews, psychological assessment or testing, psychotherapy, as well as expectations regarding the length and frequency of treatment. It may be beneficial to my child, as well as the referring professional, to understand the nature and cause of any difficulties affecting my child's daily functioning, so that appropriate recommendations and treatments may be offered. In some clinical approaches it may be helpful or necessary to refer my child to a collateral professional and/or agency for evaluation, testing, medication evaluation and/or monitoring, and/or treatment. I will be informed of the necessity of any such referral and will be given the opportunity to provide informed consent. Uses of my child's evaluation include diagnosis, evaluation of recovery or treatment, estimating prognosis, and education and rehabilitation planning. Possible benefits to treatment include improved cognitive or academic performance, health status, quality of life, and awareness of strengths and limitations.

3. **Charges:** Fees are based on the length or type of the evaluation or treatment, which are determined by the nature of the service. I will be responsible for any charges not covered by insurance, including co-payments and deductibles. Fees are available to me upon request.

4. **Confidentiality, Harm, and Inquiry:** Information from my child's evaluation and/or treatment is contained in a confidential medical record at the New England Pastoral Institute and I consent to disclosure for use by [Your Organization's Name] staff for the purpose of continuity of my child's care. Per New Hampshire and Massachusetts mental health laws, information provided will be kept confidential with the following exceptions: 1) if my child is deemed to present a danger to himself/herself or others; 2) if concerns about possible abuse or neglect arise; or 3) if a court order is issued to obtain records.

5. **Right to Withdraw Consent:** I have the right to withdraw my consent for evaluation and/or treatment of my child at any time by providing a written request to the treating clinician.

6. **Expiration of Consent:** This consent to treat will expire 12 months from the date of signature, unless otherwise specified.

I have read and understand the above, have had an opportunity to ask questions about this information, and I consent to the evaluation and treatment of my child. I also attest that I am the legal guardian and have the right to consent for the treatment of this child. I understand that I have the right to ask questions of my child's service provider about the above information at any time.

_______________________________ _______________ _______________
Signature of legal guardian for minor under age 18 **Date of birth of Child** **Date of Signature**

_______________________________ _______________
Signature of witness **Date**