THE SANTOSHA INSTITUTE, LLC

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Welcome! I am pleased to have the opportunity to work with you. This document contains important information about my professional services and business practices. Please read it carefully. It explains many of your rights and responsibilities and will represent an agreement between us, unless it is amended or terminated in writing. If you have any questions or concerns about these policies or any other aspect of my practice, please feel free to discuss them with me.

PROFESSIONAL SERVICES

Treatment may include discussion of issues that are uncomfortable for you. While I am using my best professional judgment for your well being, I cannot guarantee that you will obtain the results you seek. You have the right to challenge any aspect of the treatment I recommend. If you believe I have mismanaged your treatment or your privacy, please discuss this with me and I will do my best to resolve the concerns you have.

CONFIDENTIALITY

In general, state law protects the confidentiality of all communications between a client and a therapist and I can only release information about your treatment to others with your written permission. However, there are some situations in which I am legally entitled or even legally required to release patients' protected health information without their authorization. If I believe that a child, an elderly person, or disabled person is being abused, I must file a report with the appropriate agency. If I believe that a client is threatening serious bodily harm to him or herself or to another, I am required by law to take protective actions which may include contacting authorities, family members or others who can help provide protection. I will inform you of these reports.

The standards of my profession require that I record and maintain appropriate treatment records. You are entitled to request a copy of any protected health information or any communication from me in a variety of means and locations. You have the right to request that your information be amended or restricted from certain uses and disclosures. While I will seek to honor your requests, I may decide that it is not prudent for me to agree to your requests (Please read the HIPPA Disclosure form provided to you for more details).

APPOINTMENTS
To schedule, cancel or change your appointment, please call OR TEXT (973) 704-9222. You may leave a confidential voicemail message for me 24 hours a day. Your call will typically be returned as soon as possible and within 24 hours unless otherwise discussed with you (e.g. when I have informed you that I am on vacation or out-of-town). If I am unavailable for longer than 2 weeks to meet with you, I will provide you with the name and number of the professional that will be covering for me during such time.

CANCELLATION POLICY
Twenty-four hour advance notice is required to avoid being charged a full session fee with very few exceptions. You will be charged a full session fee of 185.00 and payment for your missed session is expected immediately either by mail, walk-in, or upon your next visit.

EMERGENCIES
In case you need urgent care in between sessions and you are unable to reach me, please dial 911 or proceed to your nearest emergency room.

FEES
My basic fee is $185.00 per 50-minute individual session. The fee for an initial evaluation (60-90 minutes) and consultation is $265.00. By engaging in treatment, you are agreeing to pay my fee and to pay me upon each session unless otherwise arranged by you and me. I accept Aetna insurance. All other clients are responsible for all fees even if you are planning to bill an insurance company for reimbursement.

MISSED APPOINTMENTS
If an appointment is missed or cancelled with less than 24 hours notice, you will be charged for the full fee with few exceptions.

In order for us to set realistic treatment goals and priorities, it is important to evaluate what resources you have available to pay for therapy. I will offer a sliding scale fee (reduced fee) from my regular fees to those who can demonstrate a legitimate need for this. If a sliding scale fee is agreed upon for an amount that is fair for you and for me, you are expected to inform me whenever your financial circumstances improve, and your fee will be adjusted accordingly.

Cash, checks, or Venmo are accepted for payment. Please make all checks payable to: The Santosha Institute, LLC. I will provide you with a receipt for your records after each payment only upon your request.

Your signature indicates that you have received a copy, read, understood, and are willing to abide by the above agreement.

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Signature Date

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Signature of Minor's Guardian and/or Interpreter Date