Lynette Ingram Cassel, ATR, LMHC
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617-855-5749

INFORMATION AND CONSENT TO TREATMENT

My Credentials and Experience:
I am a Licensed Mental Health Counselor (MA # 6326) and a Registered Art Therapist with over ten years of experience. I am trained to provide individual, family, and group therapy as well as assessment and consultation for peopled aged three to adult. I have a master's degree in Art Therapy and Counseling from Eastern Virginia Medical School. I am glad to talk with you more about my background, training, and approaches upon request or you may read more at my website: www.lynetteingramcassel.com.

What to expect in Counseling/Therapy:
Success in therapy is dependent upon many factors, some that reside within the client (i.e. motivation for change), and some that reside within the therapist (i.e. particular skills and techniques) and some that result from the interaction and match between the therapist and client. A strong therapeutic relationship is indicated by such things as: feeling understood and respected by your therapist, agreeing on the goals and tasks of treatment, and seeing your therapist's approach as a "good fit" for you. I hope that you will let me know if any of these factors need to be addressed.

Confidentiality:
All professional contacts with me are safeguarded by confidentiality regulations. However, there are exceptions to confidentiality which include, but are not limited to, the following:

1. Instances involving the abuse to a child, elderly or disabled person.
2. Situations in which a client is judged to be threatening serious harm to him or herself or another person.
3. Parents or legal guardians of non-emancipated minor clients have the right to access the clients' records. If I am working with a teenager, I use my professional judgement to determine what information will remain confidential between the adolescent and myself, however parents or guardians to have the right to general information such as dates of service and generally how therapy is going.
4. Judicial proceedings involving a court order to testify.
5. When collection agencies or other processes are required to collect unpaid fees.

In these circumstances, I am required to inform appropriate authorities to insure the safety of the client or others, or to comply with a court order. If one of the above circumstances takes place, and I must break confidentiality, I will inform you.

Fees & Payment:
You are responsible for payment of all session fees. Payment is due at time of service. Cash or check accepted. Please write checks out to: "Lynette Ingram Cassel". Cancelled check fee $35.

- One 50-minute (Individual) psychotherapy session: $125
- One 60-minute (Couples) psychotherapy session: $150
- Reports and correspondence with other professionals: $125/hr
- Clinical Supervision: $75/hr

I also am an "in network" provider for the following insurance companies. They may cover some portion of the fee, while you pay a "co-payment".
Blue Cross Blue Shield
Harvard Pilgrim/United Behavioral Health
Tufts Health Plan

If you use your health insurance to pay for part of the fee, they require some basic information about your reason for treatment, and in some case your symptoms and goals. Additionally, I use the company Streamline Health Care Solutions to process the billing and health insurance claims. They also require some basic information about you.

If your bill remains unpaid, I reserve the right to suspend therapy services until the bill is paid. There is a $35 fee for returned checks.

Cancellations & Missed Appointments:
If you must cancel an appointment, please give me 24 hours notice by email or phone.
If you do not give 24 hours notice, you will be charged $75. If you are running more than 10 minutes late, please call. I have limited appointment times available, and it is very hard to offer the time to another client without 24 hours notice. If you forget your appointment, you will be required to pay for the missed visit.

Client Initials & Date:______________________________________

In case of emergency:
I do not provide crisis counseling and cannot promise that I will be available at all times. If you have a crisis or emergency, I encourage you to leave this message on my voicemail, however if you are in need of immediate assistance please call 911 or go to the emergency room.

Your rights as a client:
Massachusetts requires that all Licensed Mental Health Counselors (LMHC) make the following written information available to all clients. If you have any questions or concerns after reading the following, you may discuss them with me at any time.

The Massachusetts Board of Allied Mental Health regulates the practice of Licensed Mental Health Counselors. Any questions, concerns, or complaints regarding the practice of mental health may be directed to the State Board.

Board of Allied Mental Health
239 Causeway Street, 5th Floor
Boston, MA 02114
617-727-3080

As a consumer of mental health services, you have the right to:
1. Have full and complete knowledge of your therapist's qualifications, training, and licenses.
2. Be fully informed regarding proposed evaluation, treatment, methods of therapy, the techniques used, the duration of therapy, if known, and the fee structures.
3. Discuss your therapy with anyone you choose, including another therapist or mental health provider.
4. Refuse treatment entirely, or any component of any proposed treatment arrangement.
5. You may terminate therapy at any time.
6. Request that information from your treatment be shared with another therapist or organization, provided that appropriate consent forms have been signed.
7. Question your therapist's competence. Should you become displeased with services, you are encouraged to talk to me to see if the matter can be resolved. If you feel unable to address these concerns with me, you may address these concerns with another therapist or pertinent professional or legal bodies.
8. Request copies of ethical principles or other guidelines that govern my practice.

Acceptance of Information and Consent to Treatment

By completing the following you agree to the policies and procedures detailed above.

Client (please print): ____ Date: _______________

Signature ____

Printed Name and Signature of Parent/Guardian if Client is under 18 years of age: ___________________

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