Paula Shulman, LICSW – CASAC – LADC

Po Box 814 Arlington, Vermont 05250

Phone: (802) 379-5117 Fax: (802) 881-0168

Statement Of Understanding and Informed Consent - Basic

I have read and understand the HIPPA Privacy hand outs and the Patient bill of rights

I understand and have discussed with Paula Shuman the risks and benefits of psychotherapy

I understand I may take 2-4 sessions for my counselor to complete an assessment for me and then if this level of care is recommended we can develop a mutually agreed upon treatment plan.

I authorize payment to my insurance company directly to Paula Shulman.

I authorize the release of clinical information necessary to process insurance claims.

I give permission for Telehealth and email messages and text regarding my appointments.

I understand there is a no show fee of $95.00 due before or on the next session if I do not give 24 hours' notice for a cancelation, except for a true emergency.

I have been informed about Paula Shulman's current licenses and professional regulation reporting, the scope of her practice and ethical guidelines as well as her discrimination policy.

I understand all co-pays, coinsurance and/or deductibles are due at the date service.

I have been informed of a Good Faith Estimate if I am self-pay and/or additional non-clinical services for legal/court requests I might request from Paula Shulman.

I have been informed of Paula Shulman's after hours support and have been given resources for crisis support.

I understand if I miss an appointment/need a higher level of care/lose touch/or cannot be reached for rescheduling my case will be closed (unless previous arrangements have been made) to allow an opening for others who are waiting. Paula will be available for 30 days after the last appointment.

If I need a substance abuse assessment, I understand that Paula may ask for a collateral interview and random urine screens that are an additional fee of $50.00

Print Name _____

Signature _____

Date _____