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Information and Consent to Treatment

Welcome

Thank you for your interest in obtaining your psychiatric/mental health treatment through my practice. All good treatment begins with a clear understanding of what each party's rights and responsibilities entail, as therapeutic relationships are built from trust. This document will outline what you need to know as you begin treatment. Please carefully read this document, initial the bottom of each page, and sign on the last page. This document will become part of your medical records. A second copy of this document may be provided to you for your personal records, upon request.

The Nature of Treatment

Unlike general medicine, psychiatry is not an exact science – what works for one person may not work for another. Therefore, your treatment will be specifically tailored to your individual needs, and I may suggest different therapeutic approaches as time goes on. I hope to engage in a conversation with you about these suggestions so that you have a full understanding of the choices being presented.

Whether you are seeking psychotherapy, medication management, or both, psychiatric/mental health treatment comes with the potential for psychological discomfort. Such discomfort often assists in one's overall mental health recovery and well-being. However, it is important that these issues are brought to the therapeutic setting – it is never my wish to intentionally cause you discomfort.

Appointments

I provide services by appointment only. If you feel you need to see me sooner than our next scheduled appointment, please contact me and I will schedule you as soon as possible.

To respect everyone's busy schedules, I will do my best to ensure all appointments begin and end on time. Thus, if you arrive late for your appointment, you will have an abbreviated session on that day.

Cancellations and Associated Fees

If you need to cancel a scheduled appointment, you must provide me with at least 24 hours notice in order to avoid a cancellation fee. Cancellations made less than 24 hours in advance, or simply not showing up to your appointment, will result in a \$75 late cancellation/No Show fee. Exceptions, though rare, will be considered on a case-by-case basis.

Initials: _____

Reimbursement

Payment in full is due at the time of service, including health plan deductibles or copayments. Currently I accept cash and checks only. Returned checks will be assessed a service fee of \$25.

It is your responsibility to inform me of any changes to your health plan. It is my responsibility to verify your insurance coverage and to inform you in a timely manner if my services are not covered by your plan.

Listed below are the fees which will be billed to your insurance company or, if paying directly, to you:

- Initial evaluation: \$250
- 45-minute session: \$200
- 20-minute session: \$175

Please note the following surcharges:

- A \$10 charge will be applied to balances not paid within 30 days of the invoice date
- A \$20 charge will be applied to balances not paid within 60 days of the invoice date

Balances not paid within 60 days may result in termination of services and unpaid balances may be referred to a collection agency.

Substantial work that takes place outside of our scheduled appointment, such as preparing written documents on your behalf or consultation with other providers about your treatment will be prorated at \$200/hour. These fees are typically not covered by insurance plans and will be your responsibility. You will be notified when such charges may apply. Telephone calls lasting 20 minutes or longer may be subject to these rates, as well.

Contacting Me Between Sessions

For routine, non-emergent issues, you may leave a message on my confidential voicemail line at any time (**978-443-6960 ext. 2**). I will return your call within 24 hours, Monday through Friday. If it is a weekend or state/national holiday, please allow me up to 48 hours to return your call.

My email address (**jeremy.santacroce@gmail.com**) is available to you for non-emergent issues, such as scheduling or general questions. While convenient, please note that email is NOT a securely protected means of communication, and that email accounts have the potential to be accessed by unauthorized users. If you choose to contact me through email, please allow me the same time frames identified above for me to respond.

Psychiatric Emergencies

Occasionally, people may experience intense urges to harm themselves or other people, or feel as if they cannot control their actions. These events are considered emergencies, as people often need assistance from a professional to feel better. Should you find yourself experiencing extremely disturbing emotions, urges, or behaviors, or you experience the sudden onset of troubling side effects of medications I am prescribing for you, please do the following:

Initials: _____

1. Call 978-443-6960. Press “0” and ask the answering service attendant to have me paged.
2. I will call you back within 5-10 minutes.
3. If I do not call you back within 10 minutes, call 911 or go the nearest Emergency Room.

Clinical Coverage

I will schedule extended absences (i.e., vacations) in advance so as to minimize the disruption in your clinical services. In these cases and in situations where I will be away unexpectedly or otherwise unavailable, I will arrange for a colleague to provide clinical coverage. Coverage may include returning phone calls, refilling prescriptions, or conducting a therapy session. This person will have access to your medical records. I will leave a detailed message on my voicemail line regarding how to reach this provider.

Confidentiality

Confidentiality is a central part of the therapeutic relationship. In addition, safeguarding your Protected Health Information is a requirement of the law and my profession. However, I am also required to provide information to and notify the appropriate officials if any of the following situations are made known to me:

- If it is suspected that a child (ages 17 and under) or elderly person (ages 60 and over) is being abused, neglected, or exploited;
- If it is suspected that you or someone else is in immediate physical danger due to actions you are planning to take or have already taken;
- If a legal proceeding requires certain clinical information.

You will be informed if I need to break confidentiality.

Agreement and Informed Consent for Treatment

I have read, understand, and agree to the contents and terms of this document. I have had the opportunity to clarify any questions regarding the content of this document. I consent to receive psychiatric/mental health therapeutic counseling and/or psychiatric/mental health medication treatment from Jeremy SantaCroce, RN/NP, LICSW.

Full name (print)

Date

Signature