Peaceful Soul Counseling Policies:
Updated May 2014

Please read the following. Initial each section, and sign/date the last page, indicating you have read and agree to the terms of therapy.

New Client! Welcome!

Thank you for choosing Sivan Rose Elefson, LMHC, R-DMT with Peaceful Soul Counseling. I realize that starting counseling can be a major decision and you may have many questions. This document is intended to inform you of policies, State and Federal Laws, and your rights.

Credentials/Training:

Please allow me to share some information about my credentials and training. I earned a Bachelor of Arts degree from Roger Williams University and a Master's of Arts in Mental Health Counseling & Expressive Therapy from Lesley University. There I trained to become a licensed mental health counselor and dance/movement therapist. I am a licensed in the state of Massachusetts, and have worked for several agencies, and in different settings prior to opening a private practice, including outpatient clinics, inpatient hospitals, and residential facilities.

As a dance/movement therapist, I am equally comfortable using talk therapy as well as more active therapeutic methods that engage our thoughts and feelings differently, as well as engages the senses and the body. Some clients also find that using the Expressive Therapy approach is a spiritual experience that offers comfort, strength, and direction. My theoretical approach places emphasis on relationships and teaching coping skills to deal with emotions, communication, self-esteem, and identity.

Goals

The major goal of counseling is to help you identify and cope more effectively with problems in daily living and to deal with inner conflicts which may disrupt your ability to function effectively. This purpose is accomplished by:

- Increasing personal awareness.
- Increasing personal responsibility and acceptance to make changes necessary to attain your goals.
- Identifying personal treatment goals.
- Promoting wholeness through psychiatric treatment and/or psychological healing and growth

You are responsible for providing necessary information to facilitate effective treatment. You are expected to play an active role in your treatment, including working with me to outline your treatment goals and assess your progress. There may also be negative consequences if you do not follow through with recommended treatment. You may be asked to complete questionnaires or to do homework assignments.

Your progress in therapy often depends much more on what you do between sessions than on what happens in session.

Initials:_____

Appointments

Appointments are usually scheduled for 50 minutes. Clients are usually seen weekly or more/less frequently as appropriate. Ideally, I will see you at the same day and time each week. Counseling, coaching, and client consultation sessions are scheduled weekly, bi-weekly, or monthly depending on your needs. You and I will discuss this and make a determination together about session frequency. Sessions last 50 minutes, (unless we agree otherwise). I normally conduct an initial evaluation that lasts 2 – 4 sessions. During this time, we can both decide if I am the best person to provide the services you need and help you meet your treatment goals. You may discontinue treatment at any time, but please discuss this important decision with me.

Initials:_____

By Appointment Only:

Peaceful Soul Counseling is a "by appointment" outpatient therapy service. I do not take walk-ins, or crisis appointments. At times you may want to come in for an additional session due to needing support on a particular issue, or because of needing to change a previous appointment. If there is an opening in a given day or week, I will offer this to you and you may schedule an appointment in that time, however there are no walk-in slots available.

Initials:_____

24 Hour Cancellation Policy, No Shows, Frequent Cancellations:

You are financially responsible for all scheduled sessions. Payment is due at the start of each session. If you need to reschedule or cancel a session, I need 24 hours notice from your scheduled session time, otherwise you will be charged for the session in full. I will make reasonable efforts to reschedule your session when you cancel in a timely fashion.

Regardless of the reason for the cancellation, without proper notice, you will be charged for your session.

Telephone conversations lasting longer than 10 minutes, site visits, report writing and reading, longer sessions, travel time, etc. will be charged at the same rate, unless indicated and agreed upon otherwise. I will issue a monthly receipt upon request for insurance or tax purposes.

As an experienced psychotherapist and dance/movement therapist, I seek to provide the highest level of service to my clients. To best protect the integrity of your treatment, I do not participate directly with insurance panels or managed care. My clients value the independence this affords us in our work together. We maintain control over your treatment plan and confidentiality, not the insurance company. If you wish to explore it, you may find that your insurance will reimburse session costs. You may request a receipt for this purpose.

**Two "Unexcused" no shows (consecutive or total) will result in discontinuing therapy. Active participation and respect for each other's time is important. Frequent cancellations (even if not late) will require a conversation about scheduling, frequency, and potentially ending therapy if it is getting in the way of being therapeutically helpful to the client.

Initials:_____

Running late:

We are human so if you are running late by a minute or two, don't sweat it. Your 50 minutes in that case it would be your 48 minutes*. We will not be able to extend past your time slot. However if you are going to be 5 minutes late or more, please call 508.404.0441 to let me know so that I knows you are coming.

*Arrival 25+ minutes late will result in not being able to hold the session, and charged a no show/late cancel fee, as stated above.

Initials:_____

Emergency and Clinical Crisis Policy:

In between sessions, In the event of an emergency please choose one of the following:

- Call 911, or visit your local emergency room.
- Call the Statewide Emergency Services Program (ESP) Toll Free 877.382.1609 and enter your zip code to get the toll free phone number for your local ESP provider
- Contact your psychiatrist or general practitioner.

While there are times when we feel overwhelmed or need more support, a clinical crisis is when we are concerned that ourselves, or someone else is a risk to themselves or others. This includes, but is not limited to, suicidal thinking/plans, homicidal thinking/plans, or loss of grounding in reality such as full mania or active hallucinations impacting decision making, or inappropriate use of substances resulting in harm to self or others.

While it may feel like you want to speak to me if you are experiencing a clinical crisis, it is not clinically helpful or appropriate at that time to call Peaceful Soul Counseling or Sivan Elefson. Please instead call 911 or bring the concerning person (or yourself) to the closest Emergency Room for immediate help and support. Their job is to act in the moment to help make sure each individual is safe and getting the support they need.

Once discharged from the hospital/ER, please contact me to let me know what has happened, as I would be happy to follow up continue to work on ongoing outpatient therapy (if and when appropriate) or support you in making a healthy decision on your next steps.

There may be times that clinically I feel you need more intensive, or higher level of support, and I will have to make clinical referrals, suggestions, at times decisions, that will help give you the support you need.

Please identify an **emergency contact** in case of an emergency while in session. This will not be about appointments, or ongoing clinical care (unless the client is a minor) however will be in case of an actual emergency for the safety and wellbeing of the client.

EMERGENCY CONTACT: _____

Relationship:_____ Phone number: _____

Additional forms will be provided for release of information for coordination of care purposes.

Initials:_____

Contact:

I check my voicemail during business hours Monday through Friday 9 am – 6pm. If you call me during these hours, I will return your call by the next business day. You also agree that I can contact you via phone or mail up to a year after our work has ended for the purposes of coordinating care or marketing.

Initials:_____

Email

Email privacy is not guaranteed. Please be advised that email transmissions are capable of being intercepted, so any confidential information that is sent or received cannot have its privacy guaranteed. By requesting an emailed response to your medical inquiry, you are acknowledging that you are aware of the risks to your (or your patient's) privacy and indicating that you will take responsibility for any related consequences.

Initials:_____

Confidentiality:

Protecting the confidentiality of my therapy, consultation, and supervision clients is of utmost importance. Your written permission is required in order for me to release information to anyone else about you or our work, except when disclosure is required by law.

Initials:_____

When Disclosure Is Required by Law:

Some of the circumstances under which disclosure is required by law are: where there is a reasonable suspicion of child, dependent, or elder abuse or neglect, where a client presents a danger to self, to others, to property, or is gravely disabled.

Initials:_____

When Disclosure May Be Required:

Disclosure may be required pursuant to a legal proceeding. If you place your mental status at issue in litigation initiated by you, the defendant may have the right to obtain the psychotherapy records and/or testimony by this provider.

Initials:_____

Record Keeping:

A clinical chart (paper and/or electronic) is maintained describing your condition, treatment, progress, dates and fees for sessions, and notes about each therapy session. Your records will not be released without your written consent, except as outlined in the Confidentiality section above. Medical records are locked/password protected, and kept in a secure location.

Initials:_____

Consultation:

I consult regularly with other professionals regarding my clients. However, client names or other identifying information are never mentioned. The client's identity remains completely anonymous, and confidentiality is fully maintained. The professionals with whom I consult are bound by the same strict rules of client confidentiality.

Initials:_____

Payment:

Payments are expected at the time of receiving the service, unless other payment plans have been discussed. (Some services are paid upfront prior). Peaceful Soul Counseling accepts cash payments, or personal check payments, made out to Sivan Rose Elefson, LMHC, R-DMT
If you do not have payment at the beginning of session, you will not be able to be seen for that session. This will also count as a late cancellation. Please see the late cancellation policy.

There is a $30 dollar fee for all return checks.

Initials:_____

Legal Matters:

In the event you are involved in divorce, child custody, or other legal matters you agree that you will not subpoena me to provide testimony or to provide any written documentation. The purpose of therapy is as a support to you. Use of this information in a legal matter is ultimately not therapeutic for you.

Alcohol and Substance Use In Session:

If you are suspected of being under the influence of a substance at the time of a session, Sivan will ask you to leave and you will be charged the no show/late cancellation fee. It is not conducive to proper psychotherapy to be under the influence when in session. This puts the client and clinician at risk.

Social Networking Websites & Dual Relationships:

It is my policy not to socialize or communicate with clients aside from in the clinical setting via social networking websites or otherwise (i.e. Facebook, etc.). Any attempts by clients to make contact with me in this manner, kindly will be not responded to.

Informed Consent:

Sivan Elefson is a Massachusetts Licensed Mental Health Counselor and is bound by the American Counseling Association Code of Ethics, Massachusetts State Laws, and United States Federal Laws. She is also a Registered Dance/Movement therapist and is bound by the American Dance Therapy Associations standards of ethical and legal practices as well.

Sivan Elefson's goal in therapy is to be positive and supportive where possible, and if there is someone or a service better suited to help, she will provide that information, referral or transfer as needed.

Therapy is hard work, and requires patience, attendance, motivation, and engagement in the process.
Sometimes therapy can uncover or trigger old feelings, memories, and experiences that may be challenging. The goal is to work through these with your therapist, in order for you to manage emotions, thoughts, and reactions to these experiences in a healthier way. At times outpatient psychotherapy may not be the best, or only, treatment one needs, and it is Sivan's job to discuss with you as the client what those other options may be (psychopharmacology, medication management, more intensive treatment, seeing a specialist, hospitalization, crisis evaluations, etc).

By entering into this therapeutic relationship, you are agreeing to the above terms, and if recommended for additional support or different support is clinically necessary, a lack of following through would be a breach of this and non compliance with treatment. This may result in ending the therapeutic relationship.

NOTICE OF PRIVACY PRACTICES AND CLIENT RIGHTS:

I have read and received a copy of the Notice of Privacy Practices and Client Rights document.
Initials:_____

Consent for Treatment

By signing below, you are stating that you have read and understood this policy statement and have had your questions answered to your satisfaction. I accept, understand, and agree to abide by the contents and terms of this agreement and further, consent to participate in evaluation and/or treatment. I understand that while the course of my treatment is designed to be helpful, my practitioner can make no guarantees about the outcome of my treatment. Further, the psychotherapeutic process can bring up uncomfortable feelings and reactions such as anxiety, sadness, and anger. I understand that this is a normal response to working through unresolved life experiences and that these reactions will be worked on between my practitioner and me. I understand that I may withdraw from treatment at any time.

_____ _____

Client/Legal Guardian Signature date

_____

Client printed name

_____

Legal guardian printed name (if client is minor)

_____

Relationship to client

_____

Witness signature

_____

Date