Take Back Control
Mental Health Counseling

Welcome to

Take Back Control Mental Health Counseling!

PSYCHOTHERAPY PROFESSIONAL DISCLOSURE STATEMENT AND INFORMED CONSENT

Disclosure Statement

This is a statement of your rights and responsibilities for our therapeutic relationship. The Disclosure Statement is designed to inform you of my professional credentials, types of service offered, fee schedule, and therapeutic orientation and style. You will receive this copy for you records and I will keep the signature pages for my records. Please read this carefully and if you have questions that are not covered here or want further clarification please ask me when we discuss this statement during the session.

Education and Credentials

My name is Gabriella Mastronardi and I received a Masters of Mental Health Counseling in 2016 from The City College of New York in New York, NY. I have been providing psychotherapy since that time. I am licensed by the state of New York 009315. I received additional training in the field of eating disorders at the Institute for Contemporary Psychotherapy in their Center for the Study of Anorexia and Bulimia in New York, NY. I work with clients struggling with anxiety, eating disorders, life transitions, mood disorders, relationship issues, self-esteem, stress and adjustment disorders.

Services Offered & Length of Session

I provide individual psychotherapy. Services will be rendered in a professional manner consistent with ethical standards. It is impossible to guarantee any specific results regarding your counseling goals because the outcome is dependent on your work as well as mine. Sessions are **45 minutes** in duration. We will schedule our sessions by mutual agreement.

- ◊ On our initial visit, an evaluation will take place and can usually range from 1-2 sessions (duration varies). The therapist will then provide feedback and let the client know whether she/he thinks it is appropriate that we decide to a) continue the evaluation and schedule a second evaluative visit or b) schedule a permanent weekly meeting time.
- ◊ If we both decide that I am the best person to provide the services you need, I will schedule a one **45-minute** (can range from 45-55 minutes) per week that fits both of our schedules. Please think of a time that will be convenient and do-able for you on a weekly basis. My cancelation and reschedule policy is 48-hours notice. In

some cases, if I am able to do so, I will try to find another time to reschedule the appointment during the same week. See cancelation policy below.

Counseling Process and Approach

In my work as a psychotherapist, I utilize an integrated approach that consists of Psychodynamic Therapy, Cognitive Behavioral Therapy (CBT), and Dialectical Behavioral Therapy (DBT) skills. These theoretical orientations and their accompanying techniques are empirically-based and may sometimes cause some discomfort before relief.

Insurance Reimbursement & Diagnosis

If you found me through Headway Mental Health**, please contact them at** (646) 506-3905 **with any questions regarding your insurance coverage, including deductible amounts, copayments, charges, and reimbursements.**

Otherwise, should you wish to use an insurance policy for counseling services, it is your responsibility to contact your insurance company to inquire about specific coverage for **out-of-network** benefits for mental health services. Please note that most insurance companies require a psychiatric diagnosis in order to reimburse for mental health counseling. I work as an out-of-network provider with any other insurance plans that provide out-of-network coverage. I can provide a superbill for you to mail to your insurance company for possible reimbursement. Any diagnosis made will become part of your permanent insurance records.

Counseling Fee

Payment or co-payment is due at each session. Regardless of insurance, you agree that you are responsible for payment of all fees for services rendered. Cash, personal checks, Visa, Mastercard, American Express, and Discover are acceptable methods of payment and I will provide a receipt for all fees paid.

- ◊ **Self-Pay Rate:** Ranges from **$125.00 - $175.00** per session based on individual's affordability
- ◊ On January 1st of every year, the rate will increase by **$5.00**; any clients accepted by October 1st of the previous year will be affected by the increase.
- ◊ **Sliding Scale:** I offer a **limited** number of sliding scale rates depending on the client's individual financial situation, in which I will ask for some financial information, such as income and expenses.

Referral Requests:

- ◊ Any requests I make for medical evaluations, psychiatric consultations, or other referrals must be completed within **30 days** of the original request. Otherwise, we may need to take a break from our work together, meaning temporarily closing your case, until the request is followed through. This is to ensure your safety and quality of care.

Cancelation & Reschedule Policy

- ◊ Please be mindful that there is a **48-hour** cancelation policy. There is a flat fee of **$75.00** if you do not cancel within the 48-hour time period. I understand that things happen and you may need to cancel our scheduled session, but I kindly ask that you let me know within **48-hours or two *business days*** before our scheduled session. Thus, if you need to cancel a session on Tuesday at 10:00am, I would ask that you let me know by Friday at 10:00am. This gives me enough time to schedule any intake or rescheduled sessions with my other clients. This also ensures that we set a good boundary within our therapeutic relationship.

- ◊ Please understand that your insurance will not reimburse you for any portion of a missed appointment and you are responsible for the full fee.

Emergencies

I do not provide 24-hour on-call emergency services. You are free to call me after hours and leave a message on my voice mail. Should you have a mental health emergency and are unable to reach me, please go to your nearest hospital emergency room, call 911, call 1-800-LIFENET, or NYCWell at 1-888-692-9355, call the Mobile Response Team at 1-800-573-1006, call 1-800-SUICIDE, call your psychiatrist/physician, or a family member/friend.

Confidentiality

All information shared in session is confidential, with these few exceptions: (1) For case consultation purposes, I may consult with other therapists, who are required to keep client information confidential. (2) The State Law of New York requires that suspected abuse or neglect of a child, elder, dependent adult, or developmentally disabled person be reported. (3) The State Law of New York also requires that others be informed if a client threatens suicide or harm to herself/himself, or others. If that threat is clear and imminent danger, the proper individuals and law enforcement must be contacted. The person against whom the threat has been made may also be contacted to prevent harm. (4) Should I be presented with a court order, I may be required to disclose information in the presence of a judge; however, I will first assert legal privilege in an effort to protect your confidentiality. (5) Information, which may jeopardize my safety, will not be kept confidential. (6) In the event of a medical emergency on your part, emergency personnel may have to be provided with some of your information. (7) If you bring a complaint against me with the New York State Board of Regents, information will be released. (8) Children and adolescents must have permission from a parent or legal guardian before receiving services. Confidential information will be shared with a parent or legal guardian only if the child or adolescent is in imminent physical or emotional danger. (9) If I am made aware that you have a communicable and fatal disease and that you have willfully exposed an identified third party to it.

Consent and Acknowledgment of Receipt of Professional Disclosure Statement

I _____ (print name) hereby acknowledge that during the initial contact with Gabriella Mastronardi, LMHC, we discussed confidentiality and privacy issues. I was provided a written Notice of Privacy Practices dated April 14, 2003, which outlines how protected health information will be treated in her practice. By my signature, I acknowledge that I have read and understand this Professional Disclosure Statement. I consent to therapy with Gabriella Mastronardi, LMHC, according to the terms described here. I have read the preceding information and understand my rights as a client.

Please initial where applicable:

- _____ I have been informed about how my privacy and confidentiality will be maintained by Gabriella Mastronardi, LMHC.
- _____ I have reviewed and received a copy of the Notice of Privacy Practices.
- _____ I have read the Professional Disclosure Statement of Gabriella Mastronardi and I have been provided a copy.
- _____ I consent to treatment and voluntarily agree to participate in all treatment and may stop such treatment at anytime.

_____ _____

Signature of Client Date

_____ _____

Gabriella Mastronardi, LMHC Date