

**PRACTICE INFORMATION & TREATMENT CONTRACT**

This document contains important information about my professional services and business policies.

**Psychological Treatment** Psychotherapy is not easily described in general statements, as it varies depending upon the personalities of the psychotherapist and client, the particular concerns brought into treatment, and the therapist's style of working. There are many different treatment methods that I use to assist you in addressing your concerns. Psychotherapy calls for a very active effort on your part. In order for therapy to be successful, you will have to work on the matters we discuss during our sessions and at home.

**Risks and Benefits** Therapy is both an art and a science. Therapeutic outcome depends upon many factors. In agreeing to work with you, I bring a commitment to work ethically within my area of training and expertise. I will present de-identified cases to my peer supervision group when necessary, for us to maintain clarity in the treatment that I am providing. Since therapy often involves discussing difficult aspects of your life, you may experience uncomfortable feelings like sadness, guilt, anger, frustration, loneliness, and helplessness. Making changes in your beliefs or behaviors can provoke anxiety and may be disruptive to the relationships you already have. It is important that you consider carefully whether these risks are worth the benefits to you of changing. Psychotherapy has shown to have benefits for those who go through it, often leading to better relationships; solutions to specific problems; and significant reduction in feelings of distress. There are no guarantees to what you specifically will experience.

**Evaluation and Treatment** Initial sessions will involve an evaluation of your needs, and allow me to offer you some initial impressions of what our work together will include should you decide to continue in therapy. You should evaluate this information along with your own opinions about whether you feel comfortable working with me. Therapy involves a commitment of time, energy and money, so it is important that you feel comfortable with the therapist you are working with. If you have questions or concerns about your treatment, we should discuss them as they arise and if you are unsure about the therapeutic match, I will be happy to provide referral information for other therapists.

**Appointments** Appointments are generally scheduled weekly. Frequency may increase or decrease dependent upon clinical or practical reasons. I will inform you of my planned absences in advance. An appointment is a commitment to our work together and a contract between us. If you are late for an appointment, we will use the rest of the time but we will not be able to go past your scheduled time.

**Cancellations** A commitment to attend all agreed upon sessions is important, as missed appointments or lateness impedes the therapeutic process. If you are unable to attend a scheduled session, a 24 hour notice is required. Without this advance notice, you will be responsible for payment of the session as insurance companies will not pay for missed appointments.

**Telephone Calls** I have a confidential voice mail system to take messages, when I am not readily available. When I am on vacations, I will provide the name of a therapist with whom clients can talk, should they have a need. In the event of an emergency, I suggest that you either go to your nearest emergency room, or call the **24 hour crisis hotline at (888) 568-112 or (207) 774-HELP (4357)**.

**Confidentiality** With the exception of certain specific exceptions described in detail in the privacy policy I have provided, you have the right to confidentiality in therapy. However, there are situations in which a therapist is legally bound to release confidential information. These include:

**STEPHANIE MCLEOD-ESTEVEZ, LCPC**  
**222 Saint John Street, Suite 219, Portland, ME 04102 (207) 370-5520**

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**Confidentiality cont.**

- A) When a client's condition indicates there is a clear and imminent danger to self or others;
- B) When information revealed suggests psychological, sexual, or physical mistreatment and/or neglect of minors or incapacitated adults;
- C) If the therapist is required by a court of law to release confidential information pertaining to a particular case;
- D) When you have signed a release of information permitting the release of information.

**Payment** Payment for the session is expected at the time of each session. The cost of the initial Assessment/Evaluation sessions is \$135.00. The cost of each follow-up 55-minute session is \$150.00. You are responsible for paying any co-payments at the time of service and any annual deductibles that apply. If you do not have insurance with a company for which I am a provider, you will be expected to pay in full for each session. The ultimate responsibility for payment of treatment is yours.

**Termination** Termination of treatment is appropriate upon completion of your goals, or if either of us thinks that another provider would better serve you. Discussion of a plan to terminate should be done in person, during a session. A final session is expected in which to bring closure to our work together. Your records will be maintained for 7 years after termination and then destroyed.

**I have read and agree to the terms and conditions of this contract. My signature is free from pressure or influence from any person or entity.**

**Client's Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_  
**Therapist's Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_  
**Guardian's Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Notice of Privacy Practices- Receipt and Acknowledgement of Notice**

**Name:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_

I hereby acknowledge that I have received and have been given an opportunity to read a copy of Stephanie McLeod-Estevez's Notice of Privacy Practices. I understand that if I have any questions regarding the Notice or my privacy rights, I can contact Stephanie McLeod-Estevez.

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**Signature of Client** \_\_\_\_\_ **Date** \_\_\_\_\_  
**Signature of Parent/Guardian/Personal Representative\*** \_\_\_\_\_ **Date** \_\_\_\_\_

\*If you are signing as a personal representative, please describe your legal authority to act for this individual (power of attorney, healthcare surrogate, etc.).

Client refuses to acknowledge receipt.  
**Signature of Therapist** \_\_\_\_\_ **Date** \_\_\_\_\_