Caines Center
For Psychotherapy
Claire Caines, MSW, LCSW, LCADC, CSAT

Information and Agreement

I am pleased you have chosen me as your therapist. This document is designed to inform you about my background and insure that you understand our professional relationship.

I earned a Master of Social Work from New York University and received additional training at the American Hypnosis Training Academy. I am a fellow of the National Board of Certified Clinical Hypnotherapists. I am a Licensed Clinical Alcohol and Drug Counselor and Certified Sex Addiction Therapist.

An important ingredient to therapeutic change is the development of trust between the client and therapist. I will keep confidential anything you say to me with the following exceptions: you direct me to tell someone else, I determine you are a danger to yourself or others, I become aware of child or elder abuse, or I am ordered by a court to disclose information. I do not participate in litigation of any kind that you may be involved with.

I agree to provide psychotherapy and/or hypnotherapy services to you for $150 per 50-minute session or your insurance co-pay. Sessions longer that 50 minutes are available when therapeutically appropriate.

The fee or co-pay for each session will be due and must be paid at the conclusion of each session. Please be aware that some services are not covered by insurance. Cash, personal checks, credit and debit cards are acceptable payment. I will provide you with a monthly receipt for all fees paid if requested.

Video Conferencing and Telephone sessions are also available under certain circumstances. Although I offer these services, video conferencing, telephone, email and text are not secure methods of communication. By engaging in electronic communications, you acknowledge that there is a possibility your Protected Health Information may be seen or heard by others.

In the event you will not be able to keep an appointment, you must notify me 24 hours in advance. If I do not receive such advance notice, you will be responsible for paying the full contracted rate for the missed session.

Health insurance companies require a diagnosis in order to cover your treatment.

If you have any questions, feel free to ask. Your signature below indicates consent to release information to insurance companies as well as allowing payment to me by insurance companies.

_____ (*Please Initial*) In the event insurance or Medicare do not cover my services, you will assume full responsibility to pay for the services provided to you.

_____ _____
Claire Caines, MSW, LCSW, LCADC Signature of Client Date

_____ _____
Signature of Parent or Guardian Date Print Client Name

Please Print and Bring This Document to Your First Visit

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