ISLAND COUNSELING GROUP

Alexia Ioannides, M.S., LMHC
Leah A. Carmo, M.Ed., M.S., LMHC
www.islandcounselinggroup.com

Thank you for deciding to seek counseling with Island Counseling Group. The following information will help you understand many of the details about your therapy. We are committed to providing evidence-based, time-effective treatment to individuals, couples and families regardless of age, race, sex, or religious affiliation.

You may call (561) 469-8846 or email islandcounselinggroup@gmail.com regarding any questions you may have (i.e. billing, appointments, etc.) After hours, leave a voice mail message with your contact information and you will be contacted the next business day. In the meantime, you can view pertinent information on our website www.islandcounselinggroup.com.

SESSIONS

Individual, couples, and family sessions are typically scheduled for 50 minutes at a frequency to be determined by Island Counseling Group and client. Intake sessions are sometimes a little longer, between 60-80 minutes. Group sessions are typically 90 minutes.

COST OF TREATMENT AND PAYMENT POLICY

At Island Counseling Group we see clients on a fee-for-service basis only. Sliding scale fees are available for extenuating circumstances. The regular fee schedule is as follows:

Alexia Ioannides, M.S. Licensed Psychotherapist $175 an hour, $225 for 1.5 hour intake

Leah Carmo, M.Ed., M.S. Licensed Psychotherapist $175 an hour, $225 for 1.5 intake

INSURANCE

Many insurance plans reimburse for some portion of psychotherapy. Please direct questions about reimbursement amounts and timeliness to your insurance company. We are not contracted (in network, preferred provider) with any insurer. We will provide you with a receipt for the counseling service at your appointment that may be used to submit for reimbursements if you choose. Please note that we do not complete any insurance paperwork.

CANCELLATIONS

We understand that it may, at times, be necessary to cancel an appointment. To help us be most efficient and responsible in the use of our time, we require that any changes or cancellations be made at least 24 hours in advance. A full session fee is charged for missed, cancelled, or changed appointments with less than a 24-hour notice unless it is due to illness or an emergency. A bill will be mailed directly to all clients who do not show up for or cancel an appointment. Thank you for your consideration regarding this important matter.

CONFIDENTIALITY

Contents of all therapy sessions are considered to be confidential. Both verbal information and written records about a client cannot be shared with another party without the written consent of the client or the client's legal guardian. Noted exceptions are as follows:

Duty to Warn and Protect

When a client discloses intentions or a plan to harm another person, the mental health professional is required to warn the intended victim and report this information to legal authorities. In cases in which the client discloses or implies a plan for suicide, the mental health professional is required to notify legal authorities and make reasonable attempts to notify the family of the client.

Abuse of Children and Vulnerable Adults

If a client states or suggests that he or she is abusing a child (or vulnerable adult) or has recently abused a child (or vulnerable adult), or a child (or vulnerable adult) is in danger of abuse, the mental health professional is required to report this information to the appropriate social service and/or legal authorities.

Prenatal Exposure to Controlled Substances

Mental Health care professionals are required to report admitted prenatal exposure to controlled substances that are potentially harmful.

Minors/Guardianship

Parents or legal guardians of non-emancipated minor clients have the right to access the clients' records.

Insurance Providers (when applicable)

Insurance companies and other third-party payers are given information that they request regarding services to clients. Information that may be requested includes, but is not limited to types of services, dates/times of service, diagnosis, treatment plan, description of impairment, progress of therapy, case notes, and summaries.

FINANCIAL AGREEMENT AND AUTHORIZATION FOR TREATMENT

I have been informed of and read the preceding information and agree to it. I authorize treatment of the person named below and agree to pay all fees as stated above.

_____ _____

Signature of Client or Legal Guardian Date

_____ _____

Signature of Therapist Date