



# Attachment Institute of New England, Inc.

*Trauma Focused. Family Centered*

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## **Treatment and Fee Agreement and Informed Consent Regarding Confidentiality**

<b>Fees:</b>	Initial assessment session	\$300.00
	45-50 minute psychotherapy session	\$125.00
	100-110 intensive attachment session (2 clinicians/2hours)	\$500.00
	Copies may be applied per page	\$ .20

Additional charges: An hourly fee may be charged for other services including but not limited to: court appearances, letter and/or report writing, extensive telephone contact with attorneys, insurance companies, school consultations. *Whenever possible your therapist will inform you in advance of any additional charges.*

*Payment is due at the time services are provided. Documentation is available if requested for personal record keeping or in order to seek reimbursement from insurance companies. AT THIS TIME THE ATTACHMENT INSTITUTE OF NEW ENGLAND DOES NOT ACCEPT THIRD PARTY REIMBURSEMENT.*

**Cancellations and Missed Appointments:** I agree to provide at least 24 hour notice prior to canceling or rescheduling an appointment to avoid being charge a fee of 50% of the scheduled appointment fee.

**Treatment Agreement:** I am aware that in many instances, Attachment Therapy incorporates physical contact between parents, child and clinicians. I understand that physical contact is used to facilitate treatment and maintain safety. I understand that if physical contact is made, parents and/or guardians will be invited to be present at all times. I understand that Attachment Therapy may evoke strong positive and negative feelings in parents/guardians and the child. I understand that no guarantees may be made regarding the effectiveness of this or any other form of psychotherapy.

**I have received the following information regarding Attachment Therapy:**

- Attachment Institute of New England Notice of Privacy Policy
- Brief, general description of Eye Movement Desensitization and Reprocessing (EMDR)
- Treatment options other than Attachment Therapy

**Confidentiality:** I understand that records and information about me and my family will be held or released in accordance with the state and federal laws (HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996, a.k.a. HIPPA). I understand that this information is protected by law as confidential and privileged and cannot be released without my written permission EXCEPT IN THE FOLLOWING CIRCUMSTANCES:

**HARMFUL THREATS OR ACTS:** If the Attachment Institute therapist believes a child or an elderly or disabled person is being abused, the therapist is required by law to file a report with the appropriate state agency without permission. If the therapist believes that someone is in risk of serious harm, the therapist is legally required to take protective action that may include notifying the potential victim, the police, or seeing hospitalization for the individual posing the threat. If the threat is of self-harm, the therapist may seek hospitalization or may contact someone who may provide protection.

COURTS: A therapist may be ordered by the court to testify without permission in certain legal proceedings such as those relating to child custody and protection, adoption, personal injury, psychiatric hospitalization and court ordered evaluations.

CONSULTATION: Attachment Institute therapists at some point in treatment may feel it is necessary to seek consultation from peers or experts in specific areas of treatment. In such cases, information (as little as possible) may be shared without permission.

INSURANCE: If an insurance company has agreed to pay for treatment, it may be necessary at various times during treatment for a therapist to give information to representatives of the insurance company.

**CONFIDENTIALITY:**

Records and information about you and your family will be held or released in accordance with state and federal laws (HIPPA) regarding confidentiality of such records and information. All therapists at the Institute are licensed by the Commonwealth of Massachusetts. Information about you may not be released without your written permission. The exceptions are made if necessary to protect your safety or the safety of others, or if ordered to release your record by a court of law.

I have had an opportunity to discuss this document with the clinician and ask questions. I understand that the interventions described will be performed by specially trained professionals and I agree not to try any aspects of these techniques outside of the therapy sessions, unless directed to do so by the clinicians. I accept the fee and understand that I will be charged for sessions if I do not give 24-hour notice of cancellation.

I agree to become a client of The Attachment Institute of New England and to have my child \_\_\_\_\_ become a client of The Attachment Institute of New England

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Name (please print)

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date