Daniel T. Merlis, MSW, LICSW
3931 Jenifer Street, NW
Washington, DC 20015
Phone 202-364-3637 x2
Fax 202-600-2836

To New Clients:

I look forward to meeting with you very soon. I have asked you to complete this paperwork prior to our meeting so that we will not have to take time in our session to address these administrative details. Please complete the following forms and mail or fax to me with payment for the initial consultation.

The ***Client Data Form*** provides me with basic identifying and contact information for yourself. Please make sure to enter contact information including fax number for any psychotherapist or psychiatrist you are currently seeing. Also, please complete the ***Release of Information Form*** included in your packet entering the name of the clinician (s) in the spaces provided. We will discuss the possibility of my having contact with that clinician as part of an initial evaluation. If you are a parent of a child who I will be seeing, please use your child's name as the client and complete the form accordingly.

The ***Client Clinician Agreement Form:*** This outlines my practice policies regarding financial matters, confidentiality of information, and other administrative issues. Please review this form completely. If you are not currently in psychiatric or psychotherapy treatment, please sign the form at the top of the second page. If you are currently in treatment and are seeing me for adjunctive treatment, please sign the form at the top and at the bottom of the second page.

The ***Consent for Brief Teletherapy Form***: This describes the policies and practices related to the use of Teletherapy. Please complete this form if you are seeking teletherapy and not in-person therapy.

A ***Medicare Opt-Out Agreement Form:*** To be completed if you are age 62 or older as I am not a Medicare panel participant.

The ***Payment Preference Form:*** Please designate your payment preference. You may elect to pay by check each session or to be billed monthly via PayPal. The latter option allows you to pay by credit card, e-check, or PayPal account.

Thank you again for taking care of these administrative tasks prior to our initial meeting. We will be able now to focus all of our time on the personal concerns you wish to consult me about.

My best,

Daniel T. Merlis, LICSW

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3931 Jenifer Street, NW; Washington, DC 20015; Tel. 202.364.3637 x2; Fax 202.600.2836

Date: _____

Client Name: _____

Address: _____

_____

Telephone: (home)_____(work)_____(cell)_____

Fax number: _____e-mail: _____

Age: _____ Date of Birth: _____Sex: _____

By whom you were referred: _____

Occupation: _____Employer/ School: _____

Current Spouse/Partner's Name, Age & Occupation: _____

_____

Children's Name(s), Age(s): _____

_____

Name, address phone of person(s) to be contacted in an emergency: _____

_____

FOR MINORS: Parents' Names, Work, Home, and Cell Phone Nos.: _____

_____

_____

Name, address, phone of treating psychiatrist/psychotherapist: _____

_____

_____

What days of the week and blocks of time would you be available?

_____

_____

CLIENT-CLINICIAN AGREEMENT

This document reflects the policies of the Clinician, Daniel T. Merlis, LICSW, regarding fees, privacy of records and confidentiality of information, and other administrative issues related to the provision of professional services to the Client.

FEE STRUCTURE AND TREATMENT DURATION: The fee is $220.00 for 55 minutes. Longer sessions are billed as follows: 75 min- $300; 90 min- $360. The initial appointment is 55 minutes for individuals unless other arrangements are made in advance. Treatment is limited to 10 sessions but might be extended if client is making significant progress. The Clinician will provide referral assistance for clients who wish to continue treatment beyond our contracted treatment period.

MISSED APPOINTMENTS: The Client agrees that if s/he is unable to keep an appointment, s/he will provide a minimum of 48 hours prior notice to the Clinician by leaving a message on the Clinician's voice mail or by speaking to the Clinician directly. Email is not adequate notice. **If an appointment is canceled or missed without 48 hours' notice, the Client understands that s/he will be billed for the session.** In this event, the bill will reflect a late cancellation and not a clinical session. If the Clinician fails to provide 48 hours notice of cancellation, the next appointment shall be at no charge.

PAYMENT METHOD: A**ppointments are to be paid for via a PayPal monthly bill.** If, for whatever reason, the Client's account remains unpaid after 10 days following the monthly billing, the Clinician reserves the right to suspend or discontinue treatment until the charges are paid in full or a suitable payment arrangement is agreed to in writing by both the Client and the Clinician. If payment is not made in accordance with this arrangement, there will be a brief time period devoted to terminating treatment during which the Clinician will offer referral assistance to the Client.

INSURANCE AND THIRD PARTY PAYMENTS: The Clinician does not accept direct insurance assignments. At the client's request, a monthly statement will be provided to the Client that can be submitted to the insurance company for reimbursement. The Client should be aware that most insurance companies require a clinical diagnosis and a procedure code. The Clinician assumes no responsibility for confidentiality of the information once it is released to the insurance company.

MEDICARE: The Clinician has opted-out of the Medicare Program and is not a Medicare provider. The client agrees not to submit a claim nor will the provider submit a claim to Medicare or to any Medi-Gap program and agrees that neither Medicare's fee limitations nor any other Medicare or Medi-Gap reimbursement regulations apply to charges for services provided to Client. **Clients 62 years old and older must review and sign a Medicare opt-out form available on the website.**

BILLING FOR TELEPHONE CONTACTS: Brief phone contacts with the Client of less than five minutes duration and calls relating to scheduling issues will not be billed; however, the standard fee will be charged on a prorated basis for telephone contacts with the Client of more than five minutes' duration. Except in situations where the Clinician assesses the Client to be at risk of self-harm or harm to others, phone contacts with family or friends will not be made by the Clinician unless approved by the Client in advance with a signed release of information.

INTAKE PROCESS; CLINICAL CONSULTATION: During the intake process, the Clinician will explore with the Client the nature of the Client's concerns and will determine whether the Clinician can treat the problem as presented, or whether a referral to another Clinician would be more appropriate. The fee will be charged for the consultative services provided by the Clinician during the intake process. The Client understands that until a plan of treatment has been developed and agreed upon by both Clinician and Client, all services provided are consultative in nature and the Clinician shall assume no obligation to provide continuing services to the Client. In the event the Clinician recommends services elsewhere, the Client will be offered referral assistance. The initial clinical consultation will be billed as an *Assessment (CPT Code 90791)* while subsequent consultation sessions will be billed as *Individual Psychotherapy (CPT Codes 90834 or 90837)*. A provisional diagnosis will be given on the bill for purposes of Client reimbursement from the insurance carrier. This diagnosis is subject to change based on further assessment.

CONFIDENTIALITY AND RECORDKEEPING: All communications between Client and Clinician are confidential. Information will only be released to a third party under the following conditions: a) the Client authorizes the Clinician to release information with the Client's written permission; b) the Client is threatening serious bodily harm to self or another; c) the Clinician learns that a child, an elderly person or a disabled person has been or is being abused; d) pursuant to a court order in a judicial proceeding; e) or as requested in a professional board investigation. The Client understands and agrees that the Clinician's working notes are not considered part of the clinical record and will not be released to the Client or to any other persons, agencies or organizations under any circumstances. The Client understands and agrees that any records obtained from other clinicians, agencies, or institutions also will not be released by the Clinician under any circumstances. The clinical record shall include dates of contact, diagnosis, any evaluation forms completed by the Client and any treatment plan forms prepared for review by the Client's health insurance carrier. In clinical situations where more than one person is the 'Client', such as in couples or family consultation, evaluation, therapy or counseling, no information will be released without the written consent of **all** adults who participate. The Clinician will respond to any court order for records by providing only the dates of contacts and a general summary of psychotherapy/counseling activity. The Clinician will have broad discretion to release any information he deems relevant in situations (b) and (c) above where he believes the Client or others to be at risk of physical harm, physical or sexual abuse, molestation, or severe neglect. The Clinician may contact the parent or guardian of a minor-age Client if deemed clinically necessary. Clinical records of inactive cases will be destroyed after seven years.

TERMINATION OF TREATMENT: It is understood that the course of treatment is limited to 10 sessions at which time treatment will be terminated. The Client may terminate treatment at any time without moral, legal or financial obligation beyond payment for services already rendered. It is expected that the Clinician and the Client will discuss the prospect of termination so that both parties will be clear about any details that might need attention as part of the termination process. If the Client fails to schedule a future appointment, cancels a scheduled appointment, or fails to keep a scheduled appointment, and does not contact the Clinician within 30 days of the date of last recorded contact, it will be understood that the Client has terminated treatment. The Clinician shall have no further obligation to the Client once treatment has been terminated. Should the Client make contact with the Clinician at a later date requesting additional services, the Clinician may choose to see the Client on a consultative basis, or may recommend that the Client seek services elsewhere. The Clinician also may terminate the treatment if he determines the therapy process to be unproductive and/or if he determines that the Client would be better served by other health or mental health practitioners. The Clinician will provide 15 days notice of intent to terminate to allow the Client to make other treatment arrangements.

The Client(s), by signing below, indicates that s/he fully understands and agrees to the policies stated on page 1 and page 2 above. Copies of this form are available on the Clinician's website.

_____ _____

Client Signature Date

_____

Client Printed Name

AGREEMENT FOR ADJUNCTIVE TREATMENT ONLY

ADJUNCTIVE TREATMENT: There are occasions where the Clinician might agree to provide adjunctive services to a Client who is in primary treatment with another provider. In these cases, it is understood that the adjunctive treatment will be focused and time-limited, usually limited to 10 sessions, in support of the primary treatment provided elsewhere. Because of potential problems in effectively coordinating treatment, it is understood that the Clinician, as an adjunctive therapist, may at any time make a clinical decision to terminate adjunctive treatment and will notify the Client and primary therapist of this decision. It is understood that upon termination of adjunctive treatment by either Client or Clinician, the Clinician will have no further clinical obligation to the Client.

_____ _____

Client Signature Date

_____

Client Printed Name

CONSENT FOR BRIEF TELETHERAPY
Therapist: Daniel T. Merlis, LICSW

Introduction

Teletherapy is the delivery of mental and developmental health services using interactive audio and visual electronic systems where the provider and the client are not in the same physical location. The interactive electronic systems used in teletherapy incorporates network and software security protocols (encryption) to protect the confidentiality of client information and audio and visual data.

Potential Benefits of Teletherapy

- Increased accessibility to care
- Client convenience

Potential Risks with Teletherapy

As with any healthcare service, there may be potential risks associated with the use of teletherapy. These risks include, but may not be limited to:

- Information transmitted may not be sufficient (e.g., poor resolution of video) to allow for appropriate therapeutic decision making by provider.
- Providers may not be able to provide or arrange for emergency care that I may require.
- Delays in treatment may occur due to deficiencies or failures of the equipment.
- Security protocol can fail (although extremely unlikely) causing a breach of privacy or my confidential information.
- A lack of access to all the information that might be available in a face-to-face session but not in a teletherapy session may result in errors in therapeutic judgement.

Alternatives to the Use of Teletherapy

Traditional face to face sessions with a provider when

- Available or possible
- Phone session with a provider

Confidentiality Standard Required for Teletherapy

- During a teletherapy session, both locations shall be considered a client/provider office regardless of room's intended use.
- Both sites shall be appropriately chosen to provide audio and visual privacy.
    - Rooms shall be designated private for the duration of the session with the provider and unauthorized access shall not be permitted.
    - Both sites shall take every precaution to ensure the privacy of the session and the confidentiality of the client. All persons in the room at both sites shall be identified to all participants prior to the consultation and the client's permission shall be obtained for any visitors or clinicians to be present during the session.
    - HIPAA confidentiality requirements apply the same for teletherapy as for face-to-face consultations.

My Rights

1. I understand that the laws that protect the privacy and confidentiality of therapeutic information also apply to teletherapy.
2. I understand that the video conferencing technology used is encrypted to prevent unauthorized access to my private information.
3. I have the right to withhold or withdraw my consent to the use of teletherapy during the course of my care or treatment.
4. I understand that the provider has a right to withhold or withdraw his/her consent for the use of teletherapy during the course of my care at any time.
5. I understand that the provider may record any of our teletherapy sessions with prior written consent.

My Responsibilities

1. I will not record any teletherapy sessions without prior written consent from the provider.
2. I will inform the provider if any other person can hear or see any part of our session before the session begins. The provider will inform me if any other person can hear or see any part of our session before the session begins.
3. I understand that I, not the provider, am responsible for the configuration of equipment on my computer which is used for teletherapy. I understand that it is my responsibility to ensure the proper functioning of all electronic equipment before my session begins. I understand that I may need to contact a designated third party (secure telehealth) or technical support to determine my computer's readiness for teletherapy prior to beginning teletherapy sessions with my provider.
4. I understand that if I need emergency mental health services, I should contact my local emergency provider at 911.

Client Consent to the Use of Teletherapy

I have read and understand the information provided above regarding teletherapy, have discussed it with my provider and all of my questions have been answered to my satisfaction. I hereby give my informed consent for the use of teletherapy in my psychotherapeutic care and authorize my therapist, to use teletherapy in the course of my assessment and treatment.

Print Client Name: _____

Signature of Client:_____ **Date:** _____

MEDICARE OPT-OUT AGREEMENT

To Be Completed by Clients 62 years old and older

This agreement is between Daniel T. Merlis, LICSW ["Clinician"], whose principal place of business is 3931 Jenifer St. NW, Washington, DC 20015, and _____ ["Patient"], who resides at _____ and is a Medicare Part B beneficiary seeking services covered under Medicare Part B pursuant to Section 4507 of the Balanced Budget Act of 1997. The Clinician has informed Patient that Clinician has opted out of the Medicare program effective on 7/30/09 and expects to remain always on “opt out” status in the future, and is not excluded from participating in Medicare Part B under Sections 1128, 1156, or 1892 or any other section of the Social Security Act.

Clinician agrees to provide the following medical services to Patient (the "Services"):

Psychotherapy Consultation and Evaluation
Individual Psychotherapy

In exchange for the Services, the Patient agrees to make payments to Practitioner pursuant to the Fee Schedule detailed in the Client-Clinician Agreement Form provided to the Patient by the Clinician. Patient also agrees, understands and expressly acknowledges the following:

- **Patient agrees not to submit a claim (or to request that Clinician submit a claim) to the Medicare program with respect to the Services, even if covered by Medicare Part B.**
- Patient is not currently in an emergency or urgent health care situation.
- Patient acknowledges that neither Medicare's fee limitations nor any other Medicare reimbursement regulations apply to charges for the Services.
- Patient acknowledges that Medi-Gap plans will not provide payment or reimbursement for the Services because payment is not made under the Medicare program, and other supplemental insurance plans may likewise deny reimbursement.
- Patient acknowledges that he has a right, as a Medicare beneficiary, to obtain Medicare-covered items and services from Clinicians and practitioners who have not opted-out of Medicare, and that the patient is not compelled to enter into private contracts that apply to other Medicare-covered services furnished by other Clinicians or practitioners who have not opted-out.
- Patient agrees to be responsible, whether through insurance or otherwise, to make payment in full for the Services, and acknowledges that Clinician will not submit a Medicare claim for the Services and that no Medicare reimbursement will be provided.
- Patient understands that Medicare payment will not be made for any items or services furnished by the Clinician that would have otherwise been covered by Medicare if there were no private contract and a proper Medicare claim were submitted.
- Patient acknowledges that a copy of this contract has been made available to him.
- Patient agrees to reimburse Clinician for any costs and reasonable attorneys' fees that result from violation of this Agreement by Patient or his beneficiaries.]

Executed on _____[date] by _____[Patient] and

Daniel T. Merlis, LCSW-C, LICSW [Clinician]

_____[Patient signature]

_____[Clinician signature]

Daniel T. Merlis, LICSW
3931 Jenifer St. NW
Washington, DC 20015

PAYMENT PREFERENCE FORM

Client Name: _____

I understand that I will be billed via a PayPal payment request email from ***dmerlisbilling@gmail.com***. I will pay by credit card, e-check, or from my PayPal account. I agree to make payment within 10 days of receipt of the monthly bill and understand that services might be suspended if payment is not received within this time frame.

_____ _____

Signature Date

RELEASE OF INFORMATION

I authorize Mr. Daniel Merlis, to make contact, by phone, in writing, or in person with

(Name of Clinician) _____

and to release any and all information concerning me as may be necessary and/or helpful

in my clinical evaluation, treatment planning, and treatment activity.

I authorize the above named clinician to release any and all information requested by

Mr. Merlis. It is my intention that the professionals with whom I have been in treatment

and who I am currently seeing for consultation and/or treatment be able to freely exchange information in

order to coordinate their clinical efforts on my behalf.

_____

Client's Name (Print)

_____ _____

Client's Signature Date

Name of Clinician:

Address:

Phone:

Fax:

Email: