Manhattan Multicultural Counseling, Inc. www.mmcnyc.com
346 East 65th Street, New York, NY 10065
Mahroo Moshari, LCSW, Private Practice **646-420-6633**
mahroomoshari@gmail.com

CONSENT TO TREATMENT, POLICIES AND PROCEDURES

Thank you for your interest in working with me, Mahroo Moshari, at Manhattan Multicultural Counseling, Inc. (MMC). I am a licensed clinical social worker (LCSW), licensed by the New York State Education Department Office of the Professions.

This document is intended to inform you of what you can expect and what is expected of you during the course of your treatment. The following material will provide basic information about my practice's policies and procedures and should be retained for future reference. Please read the following five pages and complete the form and signature page and send it back to me via e-mail to Mahroomoshari@gmail.com.

Please feel free to contact me with any questions and/or concerns at my e-mail or my phone. I look forward to working with you!

MY PERSONAL STATEMENT

I come to private practice with 20 years of experience in the mental health field. I believe in a universal and multicultural approach and provide culturally sensitive therapy in English, Italian, and Farsi.

We are ALL living in uncertainty during the COVID-19 pandemic. ALL of us face unprecedented personal and professional challenges, which bring up feelings of isolation, anxiety, and sadness. ALL of us, wherever we are in the world, are grieving because of loss. The upheaval caused by the pandemic leaves us ALL confused and fearful. I am concerned about the large proportion of children and families who need help but are not stepping up to receive care due to fear of stigma and cultural barriers.

We live in a diverse interconnected world. Culture and diversity influence many aspects of our mental health; symptoms communicate the need for care and can contribute to mental illness if not addressed. Mental disorders occur across all cultures and at all stages of life. If not treated, risk factors increase and may lead to other health problems.

Prioritizing our mental health is critical during the coronavirus crisis. We can ALL manage our wellbeing by overcoming the stigma and barriers that prevent us from seeking treatment for a wide variety of mental and emotional issues.

Mental health is of paramount importance not only for personal well-being, but to improve family relationships and an individual's ability to contribute to society. I am here to help you navigate your way through this difficult time.

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COMMUNICATION

Contacting the Office

You can reach out to me by phone, text, or email. If I am unavailable when you call, feel free to leave a message on my confidential voicemail. I will respond to messages within 24 hours.

This practice has no emergency coverage outside of regular office hours. The following resources can be helpful in the event that you feel a need for supportive contact when the therapist is unavailable.

EMERGENCY RESOURCES			
NYC WELL	888-692-9355	The Trevor Lifeline (LGBTQ)	866-488-7386
National Parent Helpline	855-427-2736	TeenLine	800-852-8336 (TLC-TEEN)
National Suicide Hotline	800-273-8255	SAMHSA (Substance Abuse)	800-662-4357

Clients must agree and be prepared to call 911 or go to the nearest emergency room when there is a risk of harm to themselves or others.

Initial Consultation

I offer a free initial 30-minute phone session for us to discuss your current problems and evaluate your needs. I will provide you with feedback and recommendations. During this time, you will have a chance to ask me questions so that by the end of the call we will decide if I am the best person for you to work with based on your treatment goals. If we choose to work together, we can schedule our first appointment.

Meeting Venue

Due to the recent circumstances of COVID-19, I am now **ONLY** providing services via *"telehealth"* by phone and video session.

Please read and sign the document entitled **Telemental Health Informed Consent** form indicating that you are aware of the risks associated with delivering services via technology-assisted media.

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Treatment Plan

The insurance provider requires a treatment plan which is reviewed quarterly. You will have an individually tailored treatment plan and we will regularly review our work toward meeting treatment goals. You will play an active role in the process.

Privacy and Use of Electronic Media

Although teletherapy falls under the laws, rules, and regulations governing licensed practice in the State of New York, there are still risks involved in communicating electronically. While I will do my best to make therapy accessible, be aware that some communications platforms such as Facetime, WhatsApp, Zoom and Skype are not secure, while others, including Doxy.me and multiple insurance platforms offer special safeguards for your security.

Access to the Internet

If you do not have access to a computer or the internet, or are not familiar with the use of technology, please let me know. I will provide the easiest and safest way to communicate. As an alternative, we can simply use the telephone.

CONTINUITY OF CARE

If I am inaccessible or unavailable for a short period of time (due to vacation, illness, or an emergency situation), I will notify you in writing and we will discuss your options.

TERMINATION AND SCOPE OF SERVICE

I reserve the right to terminate our treatment relationship for the following reason:

- Non-payment. If this case should arise, I will notify you in writing and provide the names of other providers that may be more convenient for you.

- In the course of my practice, I may be faced with a patient whose condition or complaint is beyond my professional competence and training. In that case, I may consult with a colleague or clinic/hospital who is better qualified to provide treatment. This communication can only happen after we discuss that option and after you sign a consent form. I will provide you with a treatment summary, upon request.

- The client also has the right to terminate therapy at any time. If you wish to do so, the request must be made in writing.

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FEES AND PAYMENT INFORMATION

Individual therapy is billed at the rate of $150 per 60-minute session.

Couple therapy is billed at the rate of $170 per 60-minute session.

Family therapy is billed at the rate of $200 per 60-minute session.

Group therapy is billed at the rate of $25 per person per 60-minute session.

I also offer a sliding scale option only for individuals who do not have insurance. You are responsible for full payment of fees via cash, check, or Paypal, at the time of service.

INSURANCE

I accept United Healthcare, Oxford, CIGNA, Oscar and AETNA. You are responsible for your copay. Please contact your insurance company to find out if I am in their network and the amount of your copay.

Some health insurance companies may reimburse a portion of your therapy fees if you have out-of-network coverage for behavioral or mental health. In this case, I am able to provide you with receipts to submit when filing a claim. Please note that I cannot guarantee you will be reimbursed or qualify for a reimbursable diagnosis. It is your responsibility to contact your insurance company to find out if you have out-of-network coverage.

CANCELLATION POLICY

Cancellations must be made by phone, text, or email at least 24 hours in advance. A fee of $55 will be charged for each missed treatment session or late cancellation. **There are no exceptions to this fee.** You will be responsible for paying out of pocket.

CONFIDENTIALITY OF PERSONAL INFORMATION

It is my professional responsibility to maintain the confidentiality of your records. You are entitled to receive a copy of your records upon your request.

For information regarding the protection of and/or potential disclosure of your confidential health information, please see the separate document entitled **Notice of Confidentiality and Privacy Practices**.

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PATIENTS 'RIGHTS

- You have a right to participate in developing an individual plan of treatment, including an explanation of services and how much they cost.
- You have a right to verify the credentials of the licensed professionals who provide services.
- You have a right to participate voluntarily in and to consent to treatment.
- You have a right to object to, or terminate, treatment.
- You have a right to have access to your records.
- You have a right to receive clinically appropriate care and treatment that is suited to your needs and competently administered with respect for your dignity and personal integrity.
- You have a right to be treated in a manner which is ethical, culturally sensitive, and free from abuse, discrimination, mistreatment, and/or exploitation.
- You have a right to privacy.
- You have a right to be free to report grievances regarding services to the New York State Education Department.
- You have a right to request a change of therapist.
- You have a right to request that another clinician review the individual treatment plan for a second opinion.
- You have a right to have records protected by confidentiality and not be revealed to anyone without your written authorization (with a few specific exceptions mentioned above).

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PATIENT INFORMATION

Name	D.O.B.	Age
(Optional) Gender	Ethnicity	Religion
Marital Status	# of children	
Social Security #		
Home Address	City and State	Zip Code
Email	Cellphone	Home Phone
EMPLOYMENT INFORMATION		
Employer	Work Phone	
Occupation	Income	
INSURANCE INFORMATION		
Policy #	Member ID #	Group #
Primary Care Physician		
Psychiatrist and Medication		
EMERGENCY CONTACTS		
Name	Relationship	
Address	City and State	Zip Code
Home phone	Cell phone	

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I acknowledge that I have read and understood the preceding 6 pages:

_____ _____
Patient /Legal Guardian Signature Date

_____ _____
Clinician Signature Date

CONSENT TO TREATMENT

By signing below, you or your legal guardian agree to the following:

I consent to treatment by Mahroo Moshari, LCSW, for myself, or my child. I understand *that I am obligated to pay in full at the time of service. Any outstanding balance will result in termination of service.*

I have read all 6 pages of this document thoroughly and understand the information it contains. I agree to the conditions of my treatment as described in the document. I understand that I will receive a copy of this signed document and another copy will remain in my file.

X_____
Patient's/Legal Guardian's Name Date

X_____
Signature Date

X_____
Patient's/Legal Guardian's Signature Date

X_____
Therapist's Signature Date