Doug DiMartile, LMHC - Thrive Catalyst, LLC
50 Congress Street, STE 636, Boston, MA 02109
p. 617-429-6838 f. 855-532-9720

PRACTICE DOCUMENTS

The following documents are intended to provide you with important information related to your treatment. Please read each document carefully and be sure to ask me any questions you might have related to the content. You will be prompted to verify that you have read and agree to the terms of each document prior to moving on to the next document.

The documents include:

1. Practice Policies and Procedures
    a. Practice Information
    b. Rights, Responsibilities, and Limitations
    c. Counseling Process
    d. Benefits and Risks of Counseling
    e. Overview of Counseling Process
    f. Ending of Therapy
    g. Confidentiality
        i. Limits to Confidentiality
        ii. Record Keeping
        iii. Professional Consultation
        iv. Contact in Public
    h. Scheduling of Appointments
    i. Professional Fees and Health Insurance
    j. Cancelation Policy
    k. Counselor Availability Outside of Sessions
    l. Electronic Communications
    m. Social Media Policy
2. Notice of Privacy Practices
    a. Your rights and my responsibilities regarding how your personal information is to be protected during and after treatment.
3. Informed Consent for Treatment
4. Client Portal Instructions

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1. PRACTICE POLICIES & PROCEDURES

INTODUCTION

Welcome! This document is intended to help you understand what to expect from the counseling process and to clarify the terms of the therapeutic relationship between counselor and client. I am also required to provide you with important information about the professional services I offer, such that you can make a well-informed decision related to your mental health care. Legally, this is called "Informed Consent." **When you sign this document, it will represent an agreement between us.** We can discuss any questions or concerns you may have before you sign this document, or at any time in the future once counseling has begun. **Please read this document in its entirety and indicate that you have reviewed this information and agree to it by filling in the checkbox at the end of this document.**

Practice Information I, Doug DiMartile, LMHC, own and operate an individual private practice incorporated in the State of Massachusetts under the name "Thrive Catalyst, LLC." I operate my practice out of two different offices within the same office suite located at 50 Congress Street, STE 636, Boston, MA 02109. While there are other private practitioners that share the same office suite, they assume no responsibility or liability for the clients with whom I have a signed "Informed Consent for Treatment," and nor do I accept responsibility or liability for clients under their care. Each provider operates as an independent individual private practice.

Rights, Responsibilities and Limitations: The therapeutic relationship is unique in that each participant, both client and counselor, has clearly defined rights and responsibilities, along with some legal limitations. The following sections outline these rights, responsibilities, and limitations, as well as provide a clear framework for our work together. Feel free to discuss any of this information with me at any time.

Counseling Process: You have taken a very positive step by deciding to seek mental health counseling; a psychotherapeutic process by which the counselor and client, and sometimes other related individuals, explore the client's life experiences, challenges, events, feelings, and memories to create lasting positive change. The intended outcome is for the client to experience a more balanced and satisfying life, while providing the opportunity to deeply understand oneself and one's problems. Psychotherapy is a collaborative process between counselor and client which requires active participation from both parties.

Benefits and Risks of Counseling: Risks may include experiencing uncomfortable feelings, such as sadness, guilt, anxiety, anger, frustration, loneliness, and helplessness, as you remember unpleasant aspects of your life and become aware of the feelings associated with them. However, counseling has also been shown to have great benefits. Treatment often leads to a significant reduction in feelings of distress, increased satisfaction in interpersonal relationships, greater personal awareness and insight, increased skills for managing stress and resolutions to specific problems. While there are no miracle cures and I cannot promise that your behavior or

circumstance will change, I can promise to support you and do my very best to understand you and repeating patterns, as well as to help you clarify what it is that you want for yourself. I'll need your full participation during and outside of our meetings for you to gain maximum benefit.

During the therapeutic process, many clients find that they feel worse before they feel better. This is generally a normal course of events. Personal growth and change may at times be easy and swift but may also be slow and frustrating. I ask you to trust the process, and more importantly please inform me of any concerns you have regarding your progress in therapy.

Overview of Counseling Process: The first 2-4 sessions will involve a comprehensive evaluation of your needs and current situation. By the end of the evaluation, I will be able to offer you some initial impressions of what our work might include, including a clinical diagnosis of the problem(s) that you are electing to work on. At that point, we will discuss your treatment goals and create an initial treatment plan. You should evaluate this information and make your own assessment about whether you feel comfortable working with me. If you have questions about my procedures or this process, I invite you to discuss them whenever they arise. If your doubts persist, or I am not able to help you reach your goals, I will be happy to help you set up a meeting with another mental health professional for a second opinion. Keep in mind that you have freedom of choice when it comes to choosing a therapist.

Ending of Therapy (aka "Termination of Counseling"): Ending relationships can be difficult. Therefore, it is important to have an intentionally thoughtful process in place to achieve some closure. The appropriate length of the closure process depends on the length and intensity of the treatment. I may terminate treatment after appropriate discussion with you and I determine that the psychotherapy is not being effectively used, or if you are in default on payment. I will not terminate the therapeutic relationship without first discussing and exploring the reasons and purpose of terminating. If therapy is terminated for any reason or you request another therapist, I will provide you with a list of qualified psychotherapists to treat you. You may also choose someone on your own or from another referral source.

Should you fail to schedule an appointment for three consecutive weeks, unless other arrangements have been made in advance, for legal and ethical reasons, I must consider the professional relationship discontinued.

Confidentiality The session content and all materials relevant to the client's treatment will be held confidential unless the client requests in writing to have all or portions of such content released to a specifically named person/persons. **Limitations of such client held privilege of confidentiality exist and are itemized below:**

1. If a client threatens or attempts to commit suicide or otherwise conducts themselves in a manner in which there is a substantial risk of incurring serious bodily harm.
2. If a client threatens grave bodily harm or death to another person.
3. If I have a reasonable suspicion that a client or other named victim is the perpetrator, observer of, or actual victim of physical, emotional, or sexual abuse of children under the age of 18 years.

4. Suspicions as stated above in the case of an elderly person who may be subjected to these abuses.
5. Suspected neglect of the parties named in items #3 and # 4.
6. If a court of law issues a legitimate subpoena for information stated on the subpoena.
7. If a client is in therapy or being treated by order of a court of law, or if information is obtained for the purpose of rendering an expert's report to an attorney.

Professional Consultation Occasionally I may need to consult with other professionals in their areas of expertise to provide the best treatment for you. Information about you may be shared in this context without using your name.

Records and Record Keeping I often take notes during our sessions, either on paper or electronically. And, following each session I write a summary of topics explored along with therapeutic interventions employed. These notes, along with intake paperwork, emails, text communications, secure messages, and billing related business records become part of your medical record and I am required by law to maintain it for seven years following our last contact. *(Please see "Notice of Privacy Practices" for further details on your rights regarding how your private information is managed.)*

Contact in Public If we see each other outside of the therapy office, I will not acknowledge you first. Your right to privacy and confidentiality is of the utmost importance to me. However, if you choose to acknowledge me first, I will be more than happy to say hello and chat briefly about non-personal related subjects. While you may feel comfortable having a longer conversation in public, I will limit public conversations outside of the therapy office to be respectful of your confidentiality and maintain my professional boundaries.

SCHEDULING APPOINTMENTS

- Counseling sessions are generally 55 minutes long and occur on a weekly basis at an agreed upon, regularly scheduled time. If you are interested in a shorter/longer session or increased frequency, please let me know and we can schedule accordingly. Please arrive on time to ensure that you receive your full session, and plan to end our session on time to accommodate other clients who have appointments after you.

- Once a session is scheduled, you will be expected to pay for it unless you provide at least 24 hours notice of cancellation or reschedule the appointment for another time during the same week. Please note that I must confirm or verify the cancellation to be sure that I received notice and to ensure that we both agree that you are unable to attend. If you don't hear back from me, please call, and/or send an email, as an absence of reply from me means that I did not receive your initial communications. Please note that appointments may also be canceled through the *Client Portal* up to 24 hours prior.

- ***Client Portal:*** For your convenience, you may view your upcoming appointment schedule in your *Client Portal*. I make a limited number of appointments available to clients who may, on occasion, have an unchangeable conflict with our regularly

scheduled meeting time and wish to find an alternative time to meet that same week. *(Please see "Online Scheduling" for further information.)*

PROFESSIONAL FEES AND HEALTH INSURANCE

- ***Fees***: Your payment is due in full at the beginning of each session, unless you have enrolled in auto-billing (see *Billing Procedures* below), or we have discussed other arrangements. I accept payment by cash, check, credit card, healthcare spending account card, and flexible spending account card.

  My fee schedule is as follows:

  - 15 Initial Phone Consultation – No Charge
  - 55 Minute Session - $220
  - 15 Minute Telehealth Check-In *or* in addition to 55 min. session - $60

  I reevaluate my fees once per year in June, based on changes in the cost of running business, and implement the change in September. You will be notified at least one month in advance of any changes that will impact you directly.

- ***Billing Procedures***: Following each session, you will be electronically invoiced and the credit/debit card on file will be charged for the appropriate amount. You can access a copy of your paid invoices in the *Client Portal* at your convenience. Automatic billing allows us to remain focused on your treatment during your session time. Should you desire another form of payment and/or billing process, please let me know and we can make alternative arrangements. *(Please see "Billing Process Explained" for further information. This document is available in the documents section of your Client Portal.)*

- ***Health Insurance***: As a Licensed Mental Health Counselor, many health insurance plans will help you pay for therapy and other services I offer. However, due to huge variability in health insurance plan coverage between companies, I cannot tell you accurately what your plan covers. *Please call the customer service number located on your insurance card and ask about coverage for "Outpatient Psychotherapy" or "Behavioral Health" services to determine what your out-of-pocket costs will be per session.*

  ***Blue Cross and Blue Shield (BCBS)*:** The only health insurance plan that I currently accept is BCBS. This means that I accept a discounted contract rate with BCBS who will pay me directly for all, or a portion, of my fee according to the benefits of your health insurance policy. You will be responsible for paying the deductible (if applicable) and copay amount (if applicable) for each session. If you have BCBS, reference the benefits listed under "Mental Health – Outpatient – In-Network" to find out what your costs would be for treatment.

  Other Health Insurance (aka *Out-of-Network Benefits*): If you do NOT have BCBS, it is likely that you can still use your health insurance benefits to cover part of my fee. I

can assist you with getting reimbursed from your insurance company and will prepare the paperwork necessary for you to seek reimbursement from them. However, please keep the following in mind:

- If you subscribe to a Health Maintenance Organization (**HMO**), or Preferred Provider Organization (**PPO**), or have another kind of health insurance with a Managed Care Organization (**MCO**), decisions about what kind of care you need, from whom, and how much of it you can receive will be reviewed by the health insurance plan. The plan has rules, limits, and procedures that we should discuss. **Please bring your health insurance plan's wallet card to our first meeting so that we can talk about it and decide what to do.**

- Your health insurance policy is a contract between you and your insurance company and does not guarantee payment for my services. I have no role in determining what your insurance policy covers. For example, if you receive health insurance through your employer, it is your employer who decided which services will be covered, which will not be covered, and how much you must pay. You are responsible for checking your insurance coverage, deductibles, payment rates, copayments, and so forth. I will make every effort to support you in getting the information you need to make informed decisions about your care. We can discuss any questions you may have when we meet.

- Please note: **You are responsible for paying the fees we agree upon** – not your insurance company or any other person or company**.** If you ask me to bill a separated spouse, a relative, or an insurance company, and I do not receive payment on time, I will charge your credit card on file within 30 days from the date of service.

- If your health insurance plan is a preferred provider organization (**PPO**) plan, I am considered an "Out-of-Network" provider. Should you choose to utilize your health insurance to pay a portion of my services I will charge you the full amount of each session (see *Billing Procedures* above), and then provide you with a billing statement that you can submit to your insurance company for reimbursement according to your plan's benefits. This statement will be available for download in your *Client Portal*.

CANCELLATION POLICY

- **If you are unable to keep an appointment, you must notify me at least 24 hours in advance of the scheduled appointment to avoid being charged for the session.** Consistency is an essential part of the counseling process. When you make an appointment, this time is reserved specifically for you and is not available to other clients.

- Please note: **Insurance companies do not provide reimbursement for canceled sessions and you will be responsible for paying a cancellation fee of $110.00** (50% of the full fee of $220). This fee will be automatically charged to the credit card on file at the end of the business day, unless we have communicated otherwise (as mentioned above). This is necessary because a time commitment is made to you and is held exclusively for you. I also understand that life can sometimes be unpredictable and ask that you communicate a cancelation as soon as you know you are unable to attend. There are some extenuating circumstances where I choose to waive the cancellation fee.

- I reserve the right to collect a $10.00 service charge for any checks returned for any reason.

COUNSELOR AVAILABILITY OUTSIDE OF SESSIONS

Office Schedule: I am physically present in the office on Tuesdays (8am-7pm), Thursdays (8am-7pm), and Fridays (8am-2pm). On Mondays and Wednesdays, I am available by phone and for telehealth sessions. Please do not expect me to return phone calls on the weekends, holidays, or while I am away on vacation. I try my best to ensure that my voicemail and email autoreply is set accordingly.

Phone: If you need to contact me between sessions, please leave a message on my voice mail or send me a secure message through the Client Portal. **I am often not immediately available due to the nature of counseling work.** I will attempt to return your call or message within 24 hours on weekdays, and by the following business day during weekends and holidays.

Vacations: During the calendar year (January – December) I take up to 8 weeks away from the office for seminars, trainings, and personal vacations. I try my best to provide at least 2 weeks of notice.

Sick Leave: If I become sick, or if my child becomes sick and is unable to go to school, I will call you to cancel our appointment as soon as I am able. If I do not speak to you directly, I will leave a voice message and notify you of the cancelation via both the Secure Portal and Text Message.

ELECTRONIC COMMUNICATION

Text Messaging: Text messaging should only be used to notify me that you are running late or need to reschedule a session. Texting personal information is strongly discouraged. **Please be advised that text messaging is not a secure form of communication and if you choose to send a text message you do so at your own risk.** Text messages are considered part of your treatment record and are stored securely in your electronic medical record.

Secure Messaging via Client Portal: If you wish to share personal information with me or ask a specific question related to your treatment, I encourage you to send me a private and secure

message using your Client Portal. (*Please see "Client Portal – Secure Messaging Guide" in the documents section of your Client Portal for more information.*)

- You can communicate securely through the *Secure Messaging* feature located in your *Client Portal*. I receive these messages during my normal business hours (M-F) and do my best to respond same day.
- **In the event of an emergency, please call your local emergency services department, or go to your nearest Hospital's Emergency Department.**

SOCIAL MEDIA POLICY

Due to the importance of your confidentiality and the importance of minimizing dual relationships, I do not accept friend or contact requests from current or former clients on any social networking site (Facebook, LinkedIn, Twitter, Instagram, etc.). I believe that adding clients as friends or contacts on these sites can compromise your confidentiality and our respective privacy. It may also blur the boundaries of our therapeutic relationship. If you have questions about this, please bring them up when we meet, and we can talk more about it.

About Doug:

I strongly believe that you should feel comfortable with the therapist you choose and hopeful about the therapy. When you feel this way, therapy is more likely to be most helpful to you. I consider myself fortunate and privileged to join with individuals on their journey to find healing, happiness, success, order, peace and understanding. With a passion for working with individuals, I offer support through a trained holistic lens, where we collaboratively examine life through the biological, social, psychological and spiritual lens'. The methods and techniques I use most are pulled from Cognitive Behavioral, Person-Centered, Psychodynamic, Gestalt, Internal Family Systems, Body-Oriented, Interpersonal, and Mindfulness-Based Therapies. I aim to be fully present with you in your self-exploration, while helping to guiding your process. I look forward to our work together.

This notice is effective September 1, 2018.

BY CLICKING ON THE CHECKBOX BELOW I AM AGREEING THAT I HAVE READ, UNDERSTOOD AND AGREE TO THE ITEMS CONTAINED IN THIS DOCUMENT.

2. NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW PSYCHOLOGICAL AND MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW THIS NOTICE CAREFULLY.

Your health record contains personal information about you and your health. This information about you that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services is referred to as Protected Health Information ("PHI"). This Notice of Privacy Practices describes how I may use and disclose your PHI in accordance with applicable law, including the Health Insurance Portability and Accountability Act ("HIPAA"), regulations promulgated under HIPAA including the HIPAA Privacy and Security Rules, the American Mental Health Counselors Association ("AMHCA") and American Counseling Association ("ACA") Code of Ethics and Massachusetts statutes and regulations. It also describes your rights regarding how you may gain access to and control your PHI.

I am required by law to maintain the privacy of PHI and to provide you with notice of my legal duties and privacy practices with respect to PHI. I am required to abide by the terms of this Notice of Privacy Practices. I reserve the right to change the terms of my Notice of Privacy Practices at any time. Any new Notice of Privacy Practices will be effective for all PHI that I maintain at that time. I will provide you with a copy of the revised Notice of Privacy Practices by posting a copy inside of your Client Portal or providing one to you at your next appointment.

I. USES AND DISCLOSURES FOR TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS, REQUIRING CONSENT

I may use or disclose your PHI for treatment, payment and health care operations purposes with your consent as discussed below:

For Treatment: Your PHI may be used and disclosed by those who are involved in your care for the purpose of providing, coordinating, or managing your health care treatment and related services. This includes consultation with clinical supervisors or other treatment team members. An example of treatment would be when I consult with another health care provider, such as a family physician or another mental health provider. I may disclose PHI to any other consultant only with your authorization.

For Payment: I may use and disclose PHI so that I can receive payment for the treatment services provided to you. This will only be done with your consent. Examples of payment-related activities are: making a determination of eligibility or coverage for insurance benefits, processing

claims with your insurance company, reviewing services provided to you to determine medical necessity, or undertaking utilization review activities. If it becomes necessary to use collection processes due to lack of payment for services, I will only disclose the minimum amount of PHI necessary for purposes of collection.

For Health Care Operations: I may use or disclose, as needed, your PHI in order to support my business activities including, but not limited to, quality assessment activities, employee review activities, licensing, and conducting or arranging for other business activities. For example, I may share your PHI with third parties that perform various business activities (e.g., billing or typing services) provided I have a written contract with the business that requires it to safeguard the privacy of your PHI. For training or teaching purposes PHI will be disclosed only with your authorization.

II. USES AND DISCLOSURES REQUIRING AUTHORIZATION

Uses and disclosures not specifically permitted by applicable law will be made only with your written authorization, which may be revoked at any time, except to the extent that I have already made a use or disclosure based upon your authorization. The following uses and disclosures will be made only with your written authorization:

- Most uses and disclosures of psychotherapy notes which are separated from the rest of your medical record;
- Most uses and disclosures of PHI for marketing purposes, including subsidized treatment communications;
- Disclosures that constitute a sale of PHI; and
- Other uses and disclosures not described in this Notice of Privacy Practices.

III. USES AND DISCLOSURES WITH NEITHER CONSENT NOR AUTHORIZATION

I may use or disclose PHI without your consent or authorization in the following circumstances:

- **Child Abuse**: If I, in my professional capacity, have reasonable cause to believe that a minor child is suffering physical or emotional injury resulting from abuse inflicted upon him or her which causes harm or substantial risk of harm to the child's health or welfare (including sexual abuse), or from neglect, including malnutrition, I must immediately report such condition to the Massachusetts Department of Children and Families.
- **Elder Abuse**: If I have reasonable cause to believe that an elderly person (age 60 or older) is suffering from or has died as a result of abuse, I must immediately make a report to the Massachusetts Department of Elder Affairs.
- **Abused of a Disabled Person**: If I have reasonable cause to suspect abuse of an adult (ages 18-59) with mental or physical disabilities, I must immediately make a report to the Massachusetts Disabled Persons Protection Commission.
- **Health Oversight**: The Board of Registration of Allied Mental Health and Human Service Professions has the power, when necessary, to subpoena relevant records should I be the focus of an inquiry.

- **Judicial or Administrative Proceedings**: If you are involved in a court proceeding and a request is made for information about your diagnosis and treatment and the records thereof, such information is privileged under state law and I will not release information without written authorization from you or your legally-appointed representative, or a court order. The privilege does not apply when you are being evaluated for a third party or where the evaluation is court-ordered. You will be informed in advance if this is the case.
- **Serious Threat to Health or Safety**: If you communicate to me an explicit threat to kill or inflict serious bodily injury upon an identified person and you have the apparent intent and ability to carry out the threat, I must take reasonable precautions. Reasonable precautions may include warning the potential victim, notifying law enforcement, or arranging for your hospitalization. I must also do so if I know you have a history of physical violence and I believe there is a clear and present danger that you will attempt to kill or inflict bodily injury upon an identified person. Furthermore, if you present a clear and present danger to yourself and refuse to accept further appropriate treatment, and I have a reasonable basis to believe that you can be committed to a hospital, I must seek said commitment and may contact members of your family or other individuals if it would assist in protecting you.
- **Worker's Compensation**: If you file a workers' compensation claim, your records relevant to that claim will not be confidential to entities such as your employer, the insurer and the Division of Worker's Compensation.

- **Specialized Government Functions**: I may review requests from U.S. military command authorities if you have served as a member of the armed forces, authorized officials for national security and intelligence reasons and to the Department of State for medical suitability determinations, and disclose your PHI based on your written consent, mandatory disclosure laws and the need to prevent serious harm.
- **Public Health**: If required, I may use or disclose your PHI for mandatory public health activities to a public health authority authorized by law to collect or receive such information for the purpose of preventing or controlling disease, injury, or disability, or if directed by a public health authority, to a government agency that is collaborating with that public health authority.

IV. YOUR RIGHTS AND MY OBLIGATIONS

Patient's Rights:

You have the following rights regarding PHI I maintain about you:

- **Right of Access to Inspect and Copy**: You have the right to inspect or obtain a copy (or both) of PHI and psychotherapy notes in my mental health and billing records used to make decisions about you for as long as the PHI is maintained in the record. Your access may be denied in certain circumstances, but in some cases, you may be able to have this decision reviewed. On your request, I will discuss with you the details of the request and denial process. I may charge a reasonable, cost-based fee for copies. If your records are

maintained electronically, you may also request an electronic copy of your PHI. You may also request that a copy of your PHI be provided to another person.

- **Right to Amend:** If you feel that the PHI we have about you is incorrect or incomplete, you may ask me to amend the information although I am not required to agree to the amendment. If I deny your request for amendment, you have the right to file a statement of disagreement with me. I may prepare a rebuttal to your statement and will provide you with a copy. On your request, I will provide you with details of the amendment process.
- **Right to an Accounting of Disclosures**: You have the right to request an accounting of PHI for which you have neither provided authorization nor consent. On request, I will discuss with you the details of the accounting process. I may charge you a reasonable fee if you request more than one accounting in any 12-month period.
- **Right to Request Restrictions**: You have the right to request a restriction or limitation on the use or disclosure of your PHI for treatment, payment, or health care operations. I am not required to agree to your request unless the request is to restrict disclosure of PHI to a health plan for purposes of carrying out payment or health care operations, and the PHI pertains to a health care item or service that you paid for out of pocket. In that case, I am required to honor your request for a restriction.
- **Right to Receive Confidential Communications by Alternative Means and at Alternative Locations**: You have the right to request that I communicate with you about health matters in a certain way or at a certain location. I will accommodate reasonable requests. (For instance, you may not want a family member to know you are seeing me. Upon your request, I will send your bills to another address.) I may require information regarding how payment will be handled or specification of an alternative address or other method of contact as a condition for accommodating your request. I will not ask you for an explanation of why you are making the request.
- **Breach Notification**: If there is a breach of unsecured PHI concerning you, I may be required to notify you of this breach, including what happened and what you can do to protect yourself.
- **Right to a Paper Copy of this Notice**: You have the right to a paper copy of this notice upon request, even if you have agreed to receive the notice electronically.

Obligations of Doug DiMartile, LMHC:

- I am required by law to maintain the privacy of PHI and to provide you with a notice of my legal duties and privacy practices with respect to PHI.
- I reserve the right to change the privacy practices described in this Notice. Unless I notify you of such changes, however, I are required to comply with the terms currently in effect.

If I revise my privacy practices, I will provide you with a copy of the revised Notice of Privacy Practices by posting a copy inside of your Client Portal or providing one to you at your next appointment.

V. COMPLAINTS

If you believe I have violated your privacy rights or you disagree with a decision I made about access to your records, you may contact me directly: Doug DiMartile, LMHC - Thrive Catalyst, LLC, 50 Congress Street, STE 636, Boston, MA 02109, p. 617-429-6838, f. 855-532-9720, e. Doug@ThriveCatalyst.com.

You may also send a written complaint to the Secretary of Health and Human Services at 200 Independence Avenue, S.W. Washington, D.C. 20201 or by calling (202) 619-0257. I will not retaliate against you for filing a complaint.

VI. EFFECTIVE DATE OF PRIVACY PRACTICES

This notice is effective April 11, 2017.

3. INFORMED CONSENT TO TREATMENT

I have read the preceding documents, titled "Practice Policies & Procedures" and "Notice of Privacy Practices", and agree to the terms contained therein.

I acknowledge that I have had all my questions about treatment answered fully and to my satisfaction.

I seek and consent to take part in treatment with Doug DiMartile, LMHC. I understand that developing a treatment plan and regularly reviewing our work toward meeting the treatment goals are in my best interest. I understand and agree to play an active role in the therapy process.

I understand that no promises have been made to me about the results of treatment or of any procedures by Doug DiMartile, LMHC.

I am aware that I may stop my treatment with Doug DiMartile, LMHC at any time. If I do, I will have to pay for the services I have already received. I understand that I may lose other benefits or may have to deal with other problems if I stop treatment. (For example, if my treatment has been court ordered, I will have to answer to the court.)

I know that I must call to cancel an appointment at least 24 hours (1 business day) before the time of the appointment. If I do not cancel and do not show up, I will be charged for that appointment.

I am aware that my health insurance company or other third-party payer may be given information about my diagnosis(es) and life functioning, as well as the type(s), cost(s), and providers of any services or treatments I receive. I understand that if payment for the services I receive here is not made, the therapist may stop my treatment.

My signature below shows that I understand and agree with all these statements.

_____	_____	_____
Signature of client or legal representative	Printed name of client	Date
_____	_____	_____
Printed name of legal representative	Relationship to client	Date

I, Doug DiMartile, LMHC, have discussed the issues above with the client (and/or their parent, guardian, or other representative). My observations of this person's behavior and responses give me no reason to believe that this person is not fully competent to give informed and willing consent.

_____ _____

PRACTICE DOCUMENTS

Signature of Doug DiMartile, LMHC Date

___ Copy accepted by client ___ Copy kept by Doug DiMartile, LMHC

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I, Doug DiMartile, LMHC, have discussed the issues above with the client (and/or their parent, guardian, or other representative). My observations of this person's behavior and responses give me no reason to believe that this person is not fully competent to give informed and willing consent.

_____	_____
Signature of Doug DiMartile, LMHC	Date

___ Copy accepted by client ___ Copy kept by Doug DiMartile, LMHC