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**Welcome to my Practice:Your Rights and My Policies**

This document contains important information about my practice and policies, as well as patient rights. It is important that you read it thoroughly; when you sign this document, it will represent an agreement between us. We can discuss any questions you have when you sign this agreement at your first appointment, and we can revisit your questions or this agreement at any time in the future.

**Virtual Visits**

I use virtual platforms for sessions. Doxy.me is my preferred platform and my waiting room for this service is <https://doxy.me/drsinclairmcbride>. In the event we have a connection issue, I will 1) send you a Zoom link and/or 2) finish the session by phone if video methods are not working.

**What to expect:**

You have likely found a psychologist for your child because you are concerned about the way they may be acting or feeling. My goal is to offer you and your child a safe space where you all feel understood and respected. I will engage your child in therapeutic activities to assess their mood and worries, learn more about their functioning, and teach them new coping skills. These activities will be tailored to your child’s interests and based on best evidence-based practices. I will also be working with you as parents/guardians to identify treatment goals for your child and to establish a parenting plan that includes consistent rules and structure with a focus on reinforcing positive behaviors in your child.

**Confidentiality:**

As a general rule, I will keep the information that your child shares with me in our sessions confidential. I will share general themes and progress with you as parents/guardians, but I will keep the details of our sessions private unless your child gives me permission to share them with you. In some situations, I am required by law or by the guidelines of my profession to disclose information to you, whether or not I have your child’s permission.

Confidentiality cannot be maintained if:

* I have good reason to believe that your child plans to cause serious harm or death to themselves. I will inform you of my concerns and we will make a plan to make sure that your child is protected from harming themselves.
* I have good reason to believe that your child plans to cause serious harm or death to someone else who can be identified. I will inform you of my concerns and I am also required to inform the police and when possible, warn the person(s) who your child intends to harm.
* Your child tells me they are being abused – physically, sexually or emotionally – or that they have been abused in the past. In this situation, I am required by law to report the abuse to your local child protection agency.
* Your child is involved in a court case and a request is made for information about their therapy. If this happens, I will not disclose information without your written agreement *unless* the court requires me to. I will do all I can within the law to protect their confidentiality, and if I am required to share information with the court, I will inform you and your child that this is happening.
* You choose to submit for insurance reimbursement. Your insurance company will have access to the information included on the itemized receipt I provide to you. Your insurance company will not have access to information not included on the receipt, unless you give permission for additional information to be shared.

**Collateral with outside agencies and institutions:**

School: At times, I may request to speak to someone at your child’s school to gather information about their functioning and/or provide suggestions to their teachers or counselor at school. If I want to contact the school, I will discuss it with you and ask for permission from you and your child.

Medical providers: It may be helpful for me to speak with your child’s doctor(s), especially if they have a chronic medical condition, experience distressing physical symptoms, or are taking psychiatric medication in addition to seeing me for therapy. If I want to contact your child’s doctor(s), I will discuss it with you and ask for permission from you and your child.

**Professional records:**

I am required to keep brief notes about each session; I include the date of the session, a brief description of the topics we discussed, progress reports from your perspective, interventions and impressions from my perspective, and our next steps in treatment. My records are kept secure in accordance with HIPAA requirements.

**Fees:**

Venmo is the preferred method of payment with no additional fees charged. Venmo is not HIPPA compliant but can be set to “private” mode. When in-person visits resume, fees should be paid by check or cash at the beginning of each session, unless I have made other arrangements with you. Returned checks will be charged a $30 fee. For those uncomfortable with Venmo, payments can also be made Zelle through your bank account or via the HIPAA compliant app “Ivy Pay” (2.75% will be added to cover fees charged for Ivy Pay).

Initial phone consultation (15 minutes): free

Intake Appts: $300 (approximately 60 mins)\*

Therapy Sessions: $250 (approximately 45 minutes)

\*Intakes may need additional time depending on nature of the concerns: $150 per each additional half hour needed

Phone consultation and collaterals: $300/hr

* I am not in-network with any insurance providers, but I am happy to provide you with an itemized receipt for you to collect reimbursement. Please note that not all insurance plans reimburse for out-of-network providers.
* If you anticipate becoming involved in a court case, I recommend that we discuss this before you waive your right to confidentiality. If your case requires my participation, you will be expected to pay for the professional time required even if another party compels me to testify.

**Cancellation policy:**

Please give me at least 48-hours notice if you need to cancel or reschedule an appointment. Appointments cancelled without 48 hrs notice are charged a cancellation fee of $100. No shows are charged the full rate of the session. Any missed sessions will need to be paid for at or before your next session. Please note that missed sessions are not eligible for reimbursement from insurance. In addition, it is important for you to arrive on time; if you are late, your appointment will still need to end on time.

**Communication:**

Phone calls: (617-807-0375): I am often not immediately available by telephone and I do not answer my phone when I am with patients or otherwise unavailable. You may leave a message on my confidential voicemail and I will return your call as soon as possible. Generally, issues that require more than brief management or recommendations (i.e., more than 15 minutes) will require an office visit. If required by the situation, I may be able to provide more extended services over the phone based on my hourly rate of $300.

Text: Texting is appropriate when you are running late for a session, for example, but generally texting should not be used for communication between sessions (phone calls or emails are preferable). Please know that regular texting is not secure so please be mindful of any identifying information or personal disclosures.

Email: (drkeneishasinclairmcbride@gmail.com): Patients and parent(s)/guardian(s) are welcome to communicate briefly with me via email. I will do my best to return your email within 24 hours. Email is not appropriate for urgent matters, and please keep in mind that despite my best efforts to maintain your security, email is not truly private. Remember to think about whether you would be comfortable if the information you share with me over email became public. Do not use email for urgent messages, and please do not provide me with clinical information, highly sensitive topics, or requests for clinical advice via email.

Emergencies: I do not have 24-hour emergency or “on call” coverage, but I can provide you with a crisis number for your area. If your child is experiencing a psychiatric emergency, you should call 911 or go to your nearest hospital emergency room rather than sending me a voicemail, text, or email.

**Ending therapy:**

You have the right to end your child’s therapy whenever you wish. If you do decide to end therapy for whatever reason, I encourage you to talk with me about the reason for your decision and I ask that you allow for at least one final session so that I can review with your child what they have accomplished, make final recommendations, and say goodbye. I reserve the right to end our therapy work together and provide you with appropriate referrals, for reasons including, but not limited to, failure to participate in therapy, conflicts of interest, late fees, or my belief that I may not be the best person for your child’s needs.

**Parent(s)/Guardian(s):**

Your signature below indicates that you have read this agreement regarding my policies and your rights, and you agree to the terms.

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Printed name(s) of parent/guardian

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Signature(s) of parent/guardian

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
Date

Additionally, please initial below indicating your agreement to respect your child’s privacy:

**\_\_\_\_\_** I understand that at least one parent/guardian will be asked to join for the end portion of each of my child’s individual sessions. I also understand that I will be asked to meet with my child’s therapist separately for regular parent/guardian-only sessions.

**\_\_\_\_\_** Although I know I have the legal right to request written records since my child is a minor, I agree NOT to request these records in order to respect the confidentiality of my child’s treatment.

**\_\_\_\_\_** I understand that I will be informed about situations that could endanger my child. I know this decision to breach confidentiality in these circumstances is up to the therapist’s professional judgment and may sometimes include confidential and de-identified consultation with a colleague.

 Therapist Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_