**Keneisha Sinclair-McBride, PhD**

Licensed Clinical Psychologist

202 Washington Street
Suite #315
Brookline, MA, 02445

drkeneishasinclairmcbride@gmail.com

(617) 807-0375

**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:**

The purpose of meeting with a therapist is to get help with problems in your life that are bothering you or keeping you from being successful in important areas of your life. You may be here because you wanted to talk to a therapist about these difficulties, or you may be here because someone who cares about you had concerns about you.

My goal is to offer you a safe space where you feel understood and respected. I will ask questions and listen to you, and together, we will create a treatment plan to help you develop new coping skills, build insight, and work towards your personal goals. Part of successful treatment includes being open and honest in therapy, as well as trying out the things we talk about in therapy in your daily life. It is important that you feel comfortable talking to me about the issues that are bothering you, even when this includes things that you don’t want your parent(s)/guardian(s) to know about. Privacy, also called confidentiality, is an important and necessary part of good therapy.

**Confidentiality:**

As a general rule, I will keep the information you share with me in our sessions confidential, unless I have your written permission to share certain information with certain people.There are, however, some exceptions to this rule that are important for you to understand before you share personal information with me in a therapy session. In some situations, I am required by law or by the guidelines of my profession to disclose information whether or not I have your permission.

Confidentiality cannot be maintained if:

* I have good reason to believe that you plan to cause serious harm or death to yourself, and I believe you have the intent and ability to carry out this plan in the very near future. I must take steps to inform your parent(s)/guardian(s) and make a plan to make sure that you are protected from harming yourself.
* I have good reason to believe that you plan to cause serious harm or death to someone else who can be identified, and I believe you have the intent and ability to carry out this plan in the very near future. In this situation, I must inform your parent(s)/guardian(s). I am also required to inform the police and when possible, warn the person(s) who you intend to harm.
* You are doing things that could cause serious harm to you or someone else, even if you do not *intend*harm. In these situations, I will need to use my professional judgment to decide whether your parent(s)/guardian(s) should be informed.
* You tell me you are being abused – physically, sexually or emotionally – or that you have been abused in the past. In this situation, I am required by law to report the abuse to your local child protection agency. In most cases, I would also have to inform your parent(s)/guardian(s).
* You are involved in a court case and a request is made for information about your 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 your confidentiality, and if I am required to share information with the court, I will inform you that this is happening.
* You or your family 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.

**Communicating with your parents or guardians:**

Except for situations such as those mentioned above, I will not tell your parent(s)/guardian(s) specific things you share with me in our private therapy sessions. This includes activities that your parent(s)/guardian(s) would not approve of or might be upset by, as long as the behaviors do not put you at risk of serious and immediate harm. However, if your risk-taking behavior becomes more serious, then I will need to use my clinical judgment to decide whether you are in serious and immediate danger of being harmed. If I feel that you are in such danger, I will need to communicate this information to your parent(s)/guardian(s).

Please know: If you have questions about your sexual orientation or gender that we discuss in private therapy sessions, I will not, under any circumstances, share this information with anyone else without your consent.

Even if I have agreed to keep information confidential, I may believe that it is important for your parent(s)/guardian(s) to know what is going on in your life. In these situations, I will encourage you to tell your parent(s)/guardian(s) and I can help you find the best way to tell them. Also, when meeting with your parents, I may sometimes describe problems in general terms, without using specifics, in order to help them know how to be more helpful to you.

**Communicating with other adults:**

School: At times, I may request to speak to someone at your school to find out how things are going for you. In certain situations, it may be helpful for me to give suggestions to your teachers or counselor at school. If I want to contact your school, or if someone at your school wants to contact me, I will discuss it with you and ask for permission from you and your parent(s)/guardian(s). A very unlikely situation might come up in which I do not have your permission but your parent(s)/guardian(s) and I believe that it is very important for me to be able to share certain information with someone at your school. In this situation, I will use my professional judgment to decide whether to share any information.

Medical providers: It may be helpful for me to speak with your doctor(s), especially if you are taking psychiatric medication in addition to seeing me for therapy. I will need permission from you and your parent(s)/guardian(s) before sharing information with your doctor. The only time I will share information with your doctor without your permission is if you are doing something that puts you at risk for serious and immediate physical/medical harm.

**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. For these issues, private secure messaging through my electronic health record interface “Luminello” is most secure (you should have received an invite from me to logon to this platform).

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 you are 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:**

Your participation in therapy is voluntary and you have the right to end therapy whenever you want. 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 one final session to review what you have accomplished, offer feedback to each other, 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 needs.

**Child/Adolescent therapy patient:**

Signing below indicates that you have reviewed the policies described above and understand the limits to confidentiality. If you have any questions as we progress with therapy, you can ask me at any time.

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Printed name of patient

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Signature of patient

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

**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 will refrain from requesting detailed information about individual therapy sessions with my child. I understand that I will be provided with periodic updates about general progress, and/or may be asked to participate in therapy sessions as needed.

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