Laila Cooper, Ph.D.
Clinical Psychologist

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Fairfax, VA 22033

Informed Consent for Treatment

Welcome to my psychotherapy practice. Two fundamental components of a positive and productive therapy relationship are trust and understanding between therapist and client. For that reason, I request that we review my policies together and that you ask any questions you may have about them. I am always happy to answer your questions and respond to your concerns. We will both sign this form after we review it, and can return to it at any point in the future if you would like.

Qualifications

I have been providing psychotherapy to adolescent and adult individuals, couples, and groups since 2006. I have a PhD in Clinical Psychology from George Washington University, where I focused on service provision for cultural minority groups. I am licensed to practice Psychology in Virginia (0810004906), Maryland (04919) and Washington, DC (1001718). I am Certified as a Sex Therapist by the American Association of Sex Educators, Counselors, and Therapists.

Structure of Therapy

Timing

Unless we agree on an alternative format, therapy will take place once per week for 50 minutes.
There is no formula for how many sessions therapy should last, that is something that we will discuss and evaluate as we move toward meeting your goals. We will work together to decide when is an appropriate time to end therapy; this is a collaborative process.

Cancellation Policy

From time to time there may be a conflict that prevents you from attending therapy. Should this occasion arise, I request that you provide me **48** hours notice of the cancellation by sending me an email at drlailacooper@gmail.com. If you do not cancel a session 48 hours in advance and do not attend, you will be charged the full fee for a regular session ($225 or $250). There are some exceptions to this policy (e.g., severe illness, family death), that will be evaluated on a case-by-case basis. Your first missed session is free, and you will be charged thereafter.

Risks and Benefits

Therapy is a process that has distinct benefits as well as real risks. During therapy we may discuss topics that bring about painful and uncomfortable feelings (for example, anger, grief, or hopelessness). This is a normal process of working through the issues that pain you, and will likely not be permanent. I have confidence in therapy's ability to empower you to make the change you desire in your life. However, as a collaborative process that relies on hard work and a good match between us, we may decide that you would be better served by a different service or another therapist.

Email and Phone Policy

I use email to conduct most communication regarding scheduling between sessions. I try to reply to all emails within 48 hours. If you need to communicate about something else (not an emergency – see below), please let me know and we can either proceed via email (this is up to you based on your thoughts about confidentiality) or set up a time to talk by phone if it cannot wait for the next session.

I do not use text messaging; please do not text me, I will not receive it! I do receive emails realtime so that is the best way to communicate if you are arriving late, etc.

Emergencies

If you have an emergency between our sessions and need immediate help, I recommend that you call 911, 988, or go to your nearest emergency room. I do not check messages enough to be available for a crisis, and email is not a reliable way to communicate emergency needs. If we find that once weekly therapy is not an adequate level of care for your needs, I will make appropriate referrals and connect you with more comprehensive services.

Confidentiality

Your confidentiality is extremely important to me. Everything that we discuss in therapy is private and I do not share without your written permission to do so. If you choose to send me emails, it is important for you to know that I use gmail, and although I keep my personal account very secure, our communications are subject to ruptures in privacy known to affect all public internet and email information.

While your privacy is paramount, so is your safety and the safety of others who may be in danger. There are several situations in which I may be legally obligated to break confidentiality:

(i) If you express intent to seriously harm yourself or another person.
(ii) If there is suspicion or evidence of abuse/neglect of a child or elder.
(iii) If compelled by a court order to do so (this is extremely rare).

In any of the above situations, you and I will first discuss and attempt to come to an agreement on how to proceed. If we are unable to do so in a safe and legal way, I will do so independently.

In some cases I may seek consultation from another professional (psychologist, psychiatrist) in order to provide you the best possible care. In those cases, I will do everything possible to maintain your confidentiality, omitting from out consultation your name and any identifying information.

Fees

The fee for each 50-minute session is $225 for individuals and $250 for relationship therapy (two or more people). I will send you an invoice via Square at the end of the month for that month's sessions; this invoice can be paid by credit card, bank account, or often by HSA/FSA card.

I am not in-network with insurance panels, however each month I will provide you with a superbill with the necessary documentation to receive out of network reimbursement from your insurance company.

As above, fees incurred for missed sessions are due along with your regular invoice and do not qualify for out-of-network reimbursement.

(continued)

I, _____, have read and discussed the above policies with Laila Cooper, Ph.D. I was given the opportunity to ask questions, they were answered to my satisfaction, and I understand my rights and responsibilities as a client. I give consent to participate in therapy within the above guidelines. I have been given a copy of this form for my records.

_____ _____

Client Signature Date

_____ _____

Client Signature Date

_____ _____

Client Signature Date

_____ _____

Laila Cooper, Ph.D. Date

THE NO SURPRISES ACT
STANDARD NOTICE AND CONSENT DOCUMENTS

(OMB Control Number: 0938-1401)

SURPRISE BILLING PROTECTION FORM

The purpose of this document is to let you know about your protections from unexpected medical bills. It also asks whether you would like to give up those protections and pay more for out-of-network care.

IMPORTANT: You aren't required to sign this form and shouldn't sign it if you didn't have a choice of health care provider when you received care. You can choose to get care from a provider or facility in your health plan's network, which may cost you less.

If you'd like assistance with this document, ask your provider or a patient advocate. Take a picture and/or keep a copy of this form for your records.

You're getting this notice because this provider or facility isn't in your health plan's network. This means the provider or facility doesn't have an agreement with your plan.

Getting care from this provider or facility could cost you more.

If your plan covers the item or service you're getting, federal law protects you from higher bills:

- When you get emergency care from out-of-network providers and facilities, or
- When an out-of-network provider treats you at an in-network hospital or ambulatory surgical center without your knowledge or consent.

Ask your health care provider or patient advocate if you need help knowing if these protections apply to you.

If you sign this form, you may pay more because:

- You are giving up your protections under the law.
- You may owe the full costs billed for items and services received.
- Your health plan might not count any of the amount you pay towards your deductible and out-of-pocket limit. Contact your health plan for more information.

You **shouldn't** sign this form if you **didn't** have a choice of providers when receiving care. For example, if a doctor was assigned to you with no opportunity to make a change.

Before deciding whether to sign this form, you can contact your health plan to find an in-network provider or facility. If there isn't one, your health plan might work out an agreement with this provider or facility, or another one.

See the next page for your cost estimate.

Estimate of what you could pay

Patient name: _____

Out-of-network provider(s) or facility name: Laila Cooper, Ph.D.

Total cost estimate of what you may be asked to pay: It is your ethical right to determine your goals for treatment and how long you would like to remain in therapy unless you are pursuing mandatory treatment. Please see the breakdown of possible fees on page four.

► **Review your detailed estimate.** See the last page of this form for a cost estimate for each item or service.

► **Call your health plan.** Your plan may have better information about how much of these services are reimbursable.

► **Questions about this notice and estimate?** Please ask Laila Cooper directly (drlailacooper@gmail.com).

► **Questions about your rights?** Contact

DC Board of Psychology (https://dchealth.dc.gov/service/psychology-licensing)

MD Board of Psychology (https://health.maryland.gov/psych/Pages/contactus.aspx)

VA Board of Psychology (https://www.dhp.virginia.gov/psychology/)

Prior authorization or other care management limitations

Except in an emergency, your health plan may require prior authorization (or other limitations) for certain items and services. This means you may need your plan's approval that it will cover an item or service before you get them. If prior authorization is required, ask your health plan about what information is necessary to get coverage.

More information about your rights and protections

Visit https://www.cms.gov/files/document/model-disclosure-notice-patient-protections-against-surprise-billing-providers-facilities-health.pdf for more information about your rights under federal law.

By signing, I give up my federal consumer protections and agree I might pay more for out-of-network care.

With my signature, I am saying that I agree to get the items or services from (select all that apply):

☐ Laila Cooper, Ph.D.

With my signature, I acknowledge that I am consenting of my own free will and am not being coerced or pressured. I also understand that:

- I'm giving up some consumer billing protections under Federal law.
- I may get a bill for the full charges for these items and services or have to pay out-of-network cost-sharing under my health plan.
- I was given a written notice on _____ (today's date) explaining that my provider or facility isn't in my health plan's network, the estimated cost of services, and what I may owe if I agree to be treated by this provider or facility.
- I got the notice either on paper or electronically, consistent with my choice.
- I fully and completely understand that some or all amounts I pay might not count toward my health plan's deductible or out-of-pocket limit.
- I can end this agreement by notifying the provider or facility in writing before getting services.

IMPORTANT: You **don't** have to sign this form. But if you don't sign, this provider or facility might not treat you.

_____ or _____

Patient's signature | Guardian/authorized representative's signature

_____ _____

Print name of patient | Print name of guardian/authorized representative

_____ _____

Date and time of signature | Date and time of signature

Take a picture and/or keep a copy of this form.

It contains important information about your rights and protections.

FEDERAL TAX ID: 464807133
PROVIDER NPI#: 1437392388

More details about your estimate

Patient name: _____

Date of Birth: _____

Out-of-network provider(s) or facility name: Laila Cooper, Ph.D.

The amount below is only an estimate; it isn't an offer or contract for services. This estimate shows the full estimated costs of the items or services listed. It doesn't include any information about what your health plan may cover. This means that **the final cost of services may be different than this estimate**.

Contact your health plan to find out how much, if any, your plan will pay and how much you may have to pay.

GOOD FAITH ESTIMATE
TABLE OF SERVICES AND FEES

Date of Service (If Known)	Service code (CPT Code)	Description	Fee for Service (Number of Sessions Will Be Determined as We Progress &)
	90791	Initial Diagnostic Evaluation	$225 individual $250 relationship
	90832	Psychotherapy, 16-37 minutes	$115
	90834	Psychotherapy, 38-52 minutes	$225
	90837	Psychotherapy ≥ 53 minutes	$225
	90847	Family Psychotherapy with Patient Present, 50 minutes (Couples Therapy)	$250
	Cancelation Fee	Your Therapist Requires a 48-Hour Cancelation Fee	You are Responsible for the Fee of the Appointment Missed
	Production of Records/Letter Writing		Cost of appointment(s), if no appointment necessary no fee
Total Estimate: This Good Faith Estimate explains your therapist's rate for each service provided. Your therapist will collaborate with you throughout your treatment to determine how many sessions and/or services you may need to receive the greatest benefit based on your diagnosis(es)/presenting clinical concerns.			

Please note that Place of Service (in office vs. telemental health) is not delineated above since the charges are identical.