The Art in Therapy

413 Main Street Boonton, NJ 07005
Kim Traina-Nolan, LCAT, ATR-BC, ATCS
Registered and Board Certified Art Therapists
www.theArtintherapy.com
(862) 250-2303

Welcome to my Art Therapy practice. This document contains important information about my professional services and business policies. Please read it carefully and jot down any questions you might have so that we can discuss them at our next meeting. When you sign this document it will represent an agreement between us. You may revoke this agreement in writing at any time.

Art Therapy Services

What is Art Therapy?

Art Therapy is a mental health profession that uses the creative process of art making to improve and enhance the physical, mental and emotional wellbeing of individuals of all ages. It is based on the belief that the creative process involved in artistic self-expression helps people to resolve conflicts and problems, develop interpersonal skills, manage behavior, reduce stress, increase self-esteem and self-awareness, and achieve insight.

Art Therapy integrates the fields of human development, visual art (drawing, painting, sculpture, and other art forms), and the creative process with the modes of counseling and psychotherapy. Art therapists are mental health professionals who hold a master's degree in art therapy. They use art in treatment, assessment and research, and provide consultations to allied professionals. Art therapists work with people of all ages: individuals, couples, families, groups, and communities.

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Our first few sessions will involve an evaluation of your needs. By the end of the evaluation, I will be able to offer you some first impressions of what our work will include and a treatment plan to follow if you decide to partake in art therapy. You should evaluate this information along with your own opinions of whether you feel comfortable working with me. Therapy involves a large commitment of time, money, and energy, so you should be very careful about the therapist you select. If you have questions about my procedures, we should discuss them whenever they arise. If doubts persist, I will be happy to set up a meeting with another mental health professional for a second opinion.

Sessions

Each individual Art Therapy sessions is 50 minutes. Couples, specifically identified groups, and family therapy is 90 minutes. Sessions are scheduled weekly or biweekly, depending on your needs. Once an appointment hour is scheduled, you will be expected to pay unless you provide 24 hours advance notice of cancellation or unless we both agree that you were unable to attend due to circumstances beyond your control. If it is possible, I will try to find another time to reschedule your appointment.

Lateness/Missed-No Show/Canceled appointments

Your sessions will start and end at the scheduled time. If you are late, you are still responsible for payment and the session will end on time. This is due to the respect of other clients who have scheduled their appointments after you. If a session is missed without notice (no-show), the client will be billed for the session time scheduled. A 24 hour cancelation policy is required in order as to allow for adequate scheduling time to meet client needs. If you do not show up for two consecutive appointments, you will receive notice that your session time may be made available to other clients. ***All missed and canceled sessions, less than 24 hrs. Notice, will be charged a full session fee. A credit card is required to be kept on file***

Billing and Payments

My hourly rate for individual Art Therapy is $95.00-$115.00 (based on 50-60 minute session time). The fee for couple and family Art Therapy is $165 (based on 90 minute session). **All payments are due at the time of the appointment** unless prior arrangements have been made. Payments can be made in cash, check, or credit card (VISA, MasterCard and American Express).

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Additional fees may apply if you wish additional services. Other services include summary of client progress, telephone conversations lasting longer than 10 minutes, consulting with other professionals with your signed consent and the time spent performing any other services you may request of me directly related to the therapy. If you become involved in legal proceedings that require my participation, you will be expected to pay for all professional time. You will be informed of the cost of these services at the time they are requested.

Insurance Reimbursement

New Jersey does not allow Art Therapists to accept insurance at this time. It is the responsibility of the client to check with their individual insurance carrier to see if out of network provider reimbursement is applicable to Art Therapy service.

Contacting Me

I am often not immediately available by telephone, as I do not answer the phone when I am with a client. I will do my best to return your phone call as soon as possible on the day I receive it. If you leave a message on a weekend or holiday, I will return your phone call on the following business day. If you are unable to reach me and you feel you cannot wait for me to return you call, contact your family physician or the nearest emergency room and ask for the psychiatrist on call, or dial 911. If I am away or unavailable for an extended time, I will provide you with the name of a colleague to contact, if necessary.

Minors

If you under 18 years of age, it is my policy to request to an agreement from your parents/guardians that they agree to give you confidentiality rights with me as your therapist. If this is agreed upon, I will provide them only with general information about our work together, unless I feel there is a high risk that you will seriously harm yourself or someone else. In this case, I am mandated to notify them of my concern as well as DCPP. Before giving them any information, I will discuss that matter with you, if possible, and do my best to handle any objections you may have with what I am prepared to discuss.

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Confidentiality

In general, the law protects the privacy of all communication between a client and a therapist, and I can only release information about our work to others with your written permission. There are few exceptions:

In most legal proceedings, you have the right to prevent me from providing any information about your treatment. In some proceedings involving *child custody and those in which your emotional conditions an important issue, a judge may order my testimony if he/she determines that the issues demand it. (*On occasion parents will request that I become involved in a custody situation, without the courts request. I do not like to get involved because it seems to end the therapeutic relationship between the child and therapist by breaking confidentiality. Therapy should be a safe place for a child to express himself/herself).

There are some situations in which I am legally obligated to take action to protect others from harm, even if I have to reveal some information about a client's treatment. For example: if I believe a child elderly person, or disabled person is being abused, I must file a report with the appropriate state agency.

If I believe that a client is threatening serious bodily harm to another, I am required to take protective actions. These actions may include notifying the potential victim, contacting the police, or seeking hospitalization for the client. If the client threatens to harm himself/herself, I may be obligated to seek hospitalization for him/her or to contact family members or others who can help provide protection.

These situations have rarely occurred in my practice. If a similar situation occurs, I will make every effort to fully discuss it with you before taking action.

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_____ _____

Signature of Client Kim Traina-Nolan, LCAT, ATR-BC,

(parent/guardian if under 18 years of age)

Date: Date:

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Credit Card kept on file: A 24 hour cancelation policy is required in order as to allow for adequate scheduling time to meet client needs. If you do not show up for two consecutive appointments, you will receive notice that your session time may be made available to other clients. ***All missed and canceled sessions less than 24 hrs. notice will be charged a full session fee. A credit card is required to be kept on file***

Credit Card (circle: Visa, MasterCard, American Express)

Card Number : _____

Exp. Date: (MM/YY) _____

CVV number: _____

Zip code of billing address: _____

Client/Parent Signature: _____

Client/Parent Print Name: _____

Kim Traina-Nolan, ATR-BC, LCAT ATCS

Authorization Consent to Release: Art Work

Name of Client/Student:

Client/Student Date of Birth:

I understand that my Art work contains information about my art therapy session(s). I understand that my art work is a visual record, therefore, protected by state and federal laws which require they are kept confidential and require my written consent to disclose through electronic image for the purpose of educational workshops, seminars, professional articles and/or research in the field of Art Therapy and/or The Art in Therapy website and/or forms. The client/student name/identity will be concealed and follow the guidelines of HIPAA .

I, _____hereby authorize

Kim Traina-Nolan, ATR-BC, LCAT, ATCS

To document/share art images for the sole purpose of the following: educational workshops, seminars, professional articles and/or research in the field of Art Therapy and/or The Art in Therapy website and/or forms.

_____

I understand that I have the right to revoke at any time.

I have been informed and understand this authorization to release art work image, the nature of listed content that I am willing to release, and the implications of their release.

Signature of client: **Printed Name/Relationship:**

(parent/guardian if under 18 years of age)

Date: **Date:**

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Authorization to Release Confidential Information to Professionals

Name of Client:

Client Date of Birth:

I understand that my records contain information about my therapy sessions and my mental health. I understand that all of my records are protected by state and federal laws that require they are kept confidential and require my written consent to disclose.

I, _____ hereby authorize _____ to

Disclose to _____ for the sole purpose of the following:

_____

I understand that I have the right to revoke at any time. This release will expire on _____

Or 6 months from the date form was signed.

I have been informed and understand this authorization to release records and information, the nature of listed content that I am willing to release, and the implications of their release.

This request is voluntary.

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Signature of client: **Printed Name/Relationship:**

(parent/guardian if under 18 years of age)

Date: **Date:**

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American Art Therapy Association.

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Name Client: DOB: Age: School/Grade:

Family members:

1.

2.

3.

4.

Referral Narrative: (Clients reason for seeking therapy service)

Address: **Telephone:**

Email:

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