GROWING ROOTS LLC Counseling,
Consulting and Evaluation
Stacey Redman, LMFT

Office is located:
85 Main Street, Suite 309
Plymouth, NH 03264
www.growingrootsllc.com

Growing Roots LLC was established in 2009. Our expertly trained staff provide compassionate evidence-based mental and behavioral health services to adults, adolescents and families in Southern and Central New Hampshire.

Our Services
Evaluation and treatment for:

- depression and mood disorders
- anxiety-related disorders
- obsessive compulsive disorder
- adult and adolescent eating disorders (anorexia, bulimia, ARFID & binge-eating)
- substance abuse and dependence
- anger and stress management
- life transitions (loss of loved one, divorce, change of career)
- sports psychology and performance improvement
- attention deficit and academic underachievement
- parent-child problems
- couple's issues

About Growing Roots Staff

Dr. Scott Schinaman,Psy.D. Licensed Psychologist is the founder of Growing Roots LLC. He completed his Master of Arts in Counseling Psychology with an emphasis in Marriage, Child and Family Therapy at the University of San Francisco and his Doctorate in Clinical Psychology with a concentration in Health Psychology at the California School of Professional Psychology, San Francisco. Dr. Schinaman completed his postdoctoral training in Integrated Behavioral Health at Wilford Hall Medical Center in Texas. He also has advanced post-graduate training in Cognitive Behavioral Therapy, Dialectical Behavior Therapy and Maudsley Family Based Treatment for Eating Disorders. Prior to dedicating himself to full time practice, Dr. Schinaman served as Senior Adolescent Specialist and a Director at Walden Behavioral Care's Adolescent Hospital Based Programs in Waltham, MA.

Stacey Redman, M.Ed., LMFT is a Licensed Marriage and Family Therapist and received her undergraduate degree from Worcester State College and her Masters of Education in Marriage and Family Therapy from Springfield College. She brings over 20 years of expertise in areas of Cognitive Behavioral Therapy, Dialectical Behavioral Therapy, Family Systems, as well as Maudsley Family Based Therapy for Eating Disorders. Prior to joining Growing Roots LLC, Ms. Redman worked in community mental health systems and as Director of Counseling for New Hampton School, in New Hampton, NH.

NOTICE OF PRIVACY PRACTICES

This notice describes how Growing Roots, LLC may use and disclose your healthcare information.

Growing Roots, LLC (Dr. Scott Schinaman, Psy.D. and Stacey Redman, LMFT) is required by law to maintain the privacy of your protected health information. This information consists of all records related to your health including demographic information, either created by or received by Growing Roots, LLC. From other health care providers. We are required to provide you with notice of our legal duties and privacy practices with respect to your protected health information. These legal duties and privacy practices are described in this notice. Growing Roots, LLC will abide by the terms of this Notice, or the Notice currently in effect at the time of the use or disclosure of you protected health information.
Growing Roots, LLC reserves the right to change the terms of this Notice and to make any new provisions effective for all protected health information that we maintain. Patients will be provided with a copy of any revised Notices upon request. An individual may obtain a copy of the current Notice at any time.

Client Rights and Responsibilities
Introduction to the Practice

Psychological Services: Psychotherapy (or "therapy") is a change-oriented process. Therapy occurs in the context of a trusting relationship between a mental health professional and one or more individuals known as clients or patients. Therapy is unlike many medical treatments as it requires the patient's active contribution. Thus, therapeutic change is most likely when the patient is actively engaged both in face-to-face meetings ("Sessions") with the service provider and practicing relevant skills between these meetings.

Psychotherapy can have benefits and risks. Since therapy often involves establishing healthy means of coping with distressing matters, as the clinical patient you may experience uncomfortable feelings like anger, sadness, guilt, frustration, loneliness, and helplessness. Learning how to better manage these experiences in the context of a psychotherapeutic relationship can improve relationships, change behaviors and reduce distress. Unfortunately, there are no guarantees how your psychotherapy will progress or its outcomes. It is your responsibility to alert your therapist at any time if you find the process to be misdirected or unmanageable.

Your first few sessions will involve an evaluation. Evaluation may include questionnaires, observations, third party documentation and/or interviews. By the end of the evaluation, we will offer initial impressions and a treatment plan. It is your responsibility as the clinical patient to participate in this process honestly and openly and to consider feedback and recommendations.

You may discontinue the service or ask for a referral to alternate services at any time. Because therapy may involve a significant commitment of time, emotion, money, and energy, you should be very careful to select a therapist whom you trust.

Contacting Growing Roots, LLC: Office number: 603-238-3149. We do not take calls when in session unless anticipating an emergent call. When unavailable, your call is answered by a confidential automated answering service that is monitored frequently. We will make every effort to return calls within 24 hours. You may email us at im.growingroots.org, we recommend limiting this type of communication to non-clinical matters, as we cannot guarantee confidentiality. It is our policy not to engage in social media communication with our clients. We do not search social media sites or search engines for information regarding our clients. Our email address is office@growingrootsllc.com

Unless specifically agreed in advance, Growing Roots, LLC does not provide 24/7/365 emergency coverage. In case of emergency, dial 9-1-1 or go to your local hospital emergency room. Once the emergency is stabilized and everyone is safe, call our office 603-238-3149 or email im.growingroots@gmail.com to inform us of the situation. Our work cell numbers may be used during business hours for scheduling and emergent issues not requiring 911. Please understand we will not answer our phones while in session. Dr. Schinaman 603-726-1108, Stacey Redman 603-726-1109.

Fees, Meeting and Billing:

Diagnostic Interview (initial assessment): $250.00
50-60 minute session $165.00
90 minute session: $225.00

Phone calls over ten minutes will be considered a partial session and are not reimbursable by insurance. They will be billed at a pro-rated rate of our hourly fee of $165.00
15-29 minutes: $60.00
30-44 minutes: $85.00
45-60 minutes: 165.00

Once an appointment hour is scheduled, you will be expected to pay for it unless you provide notice **one full business day** in advance except in instances of illness, injury or extreme weather conditions. **Please note, insurance does not pay for late cancellations (less than 24 hours) or missed appointments, you will be charged a flat rate of $100.00. We expect payment and/or co-payment fees at the time of service. We ask to have a credit card on file.**

We reserve the right to discontinue service if you have an outstanding bill or repeatedly fail to provide payment at the time of service. Outstanding balances of more than 90 days will be sent to collections at our discretion. Fees for collection will be your responsibility in addition to the amount due. Writing reports, attending meetings or providing other services on your behalf is billed at $165.00 per hour, also not covered by insurance.

In general, we will resist participating in concurrent legal processes in the belief that doing do so is likely to undermine the therapeutic relationship. However, if you require that Growing Roots, LLC participate in legal processes, you will be expected to pay for all professional time, including preparation and transportation costs, at an hourly fee. In this case, all anticipated costs will be due as an advance retainer, even if we are called to testify by another party. These services are not covered by your insurance.

We are In-Network providers for Anthem BCBS, Cigna, Tufts, and Wellsense. We will bill directly to these companies on your behalf. Co-payment or deductible will be required at the time of service. Please be clear about the limitations of your policy, it is your responsibility. If you are covered by another insurance company, if requested we will provide you with an invoice for you to submit for reimbursement. Regardless of your insurance status, you are responsible for the balance on your account for professional services rendered.

Diagnosis: Diagnosis is the formal identification of an illness corresponding to the clinical patient's constellation of social, emotional and intellectual strengths and weaknesses. All diagnoses relevant to psychological services are catalogued in the Diagnostic and Statistical Manual and the International Classification of Diseases. Growing Roots, LLC use formal diagnosis to support third party reimbursement.

Confidentiality: We realize confidentiality is one of the most important factors in the decision to pursue services from a mental health professional. For your protection, the following are limitations the law may impose:

- If you provide written permission to disclose information from your clinical record.
- We are required by law to disclose child abuse and/or neglect as well as the abuse of incapacitated adults.
- We are required by law to communicate the threat of violence to ourselves, other people, or property to the persons who might be harmed or law enforcement officials, or to seek commitment pursuant to New Hampshire law.
- If you are (or become) involved in a legal proceeding in which your psychological condition is an issue (e.g. personal injury, worker's compensation, disability, other insurance requests).
- If a court orders the release of clinical records.
- If the client is a minor child, we strive to respect the child's confidentiality, while also meeting the needs of the parent(s). If the client is an adolescent, we consider the session confidential unless the adolescent is a danger to her/himself or others.

Couples: Treatment records of couple's sessions contain information about each person. Both clients should be aware that either person has the right to obtain treatment records. If one requests records, it is our policy to notify the other person and to afford that individual an opportunity to receive a copy of the record as well.

Minors: Generally, the treatment of a minor child (under the age or 18) must be authorized by a parent or legal guardian. It is our policy to treat minors only with the consent of both parents, to the extent both are available. If one parent is unavailable and we determine it is appropriate to proceed with the consent of only one parents, the absent parent will have the right to the child's treatment records upon request. If both are available but cannot reach agreement about treatment and access to records, it is the responsibility of the parents to resolve their differences through a court hearing prior to instituting treatment. Parents have the authority to access and release the child's confidential treatment records. In New Hampshire, all information regarding your child's therapy file is considered privileged and therefore can only be released in limited circumstances. If there is a dispute about the release of your child's records, the court must determine what is in your child's best interest. Upon turning 18, the child gains control over treatment, information and records.

Group Therapy: Unlike individual treatment, confidentiality of group therapy is not privileged, and therefore not protected by law. Group members must sign and abide by a written confidentiality agreement prior to participating in the group. Clients with concerns about confidentiality should discuss them prior to beginning group treatment.

Conflicts of Interest: New Hampshire is a small state. From time to time, actual or potential conflicts of interest may arise. If we become aware of a conflict of interest we may be required to refer you to another therapist. Regardless of the existence of a conflict of interest, all information will remain confidential.

Professional Boundaries: Licensed psychotherapists are obligated to establish and maintain appropriate boundaries (relationships) with present and former clients. Therapists should not socialize or become friends with clients and should never become sexually involved with a client.

Consultation/Professional/Ethical Issues: We are professionally and ethically required to consult with other health and mental health professionals to maintain professional skills and perspective. During a consultation, we make every effort to avoid revealing the identity of the patient. The other professionals involved are also legally bound to keep the information confidential. We are professionally and ethically required to designate a colleague who will assist with record management/distribution upon our death or disability. The law encourages us to remind clients that they are legally protected against sexual contact and various other "boundary violations" by clinicians-behavior that, of course, would never be tolerated by any ethical practitioner, regardless of legal dictates.

Termination: Termination of psychotherapy can be an indication of the completion of the original treatment plan. If you wish to terminate prior to completion of the treatment plan, a final session will be scheduled to summarize progress, to discuss any unresolved issues, and/or to transfer to another clinician and to sign all release of information for the transfer of your file.

Note to Patients: In case I am suddenly unable to continue to provide professional services or to maintain client records due to incapacitation or death, I have designated a colleague who is a licensed psychologist as my professional executor. If I die or become incapacitated, my professional executor will be given access to my client records and may contact you directly to inform you of my death or incapacity; to provide access to your records; to provide psychological services if needed; and/or to facilitate continued care with another qualified professional if needed. If you have any questions or concerns about this professional executor arrangement, I will be glad to discuss them with you.

Mental Health Bill of Rights: New Hampshire State Law requires Patients be notified they may obtain the following information from their provider:

The licensed professional code of ethics.
The licensed degree, license and areas of expertise.
Confidentiality and its limits.
The licensed psychologist's responsibilities to communicate the threat of violence to self, person or property to the victim or victims or to notify the police department of such threat or obtain civil commitment.
Reporting requirements regarding child abuse and the abuse of incapacitated adults
Illegality of sexual contact and other boundary violations between a current client or former client and therapist.
An individual mental health diagnosis as part of evaluation as designated in RSA 330-A: 2 VI.
Cost of services.
Nature of assessment and access to assessment results.
Recommended treatment with rationale and if no treatment recommended an explanation.
Provision for emergency coverage.
Provision for record management following death or disability of the licensed psychologist; and
Information as to what to do if dissatisfied with treatment.
Provision for emergency coverage.
Provision for record management following death or disability of the licensed psychologist; and
Information as to what to do if dissatisfied with treatment.

Complaints and Concerns: Your concerns will most effectively and efficiently be addressed by bringing them directly to our attention. You have the right to bring any such concerns to the attention of the following agencies:

New Hampshire Board of Mental Health Practice 117 Pleasant Street Concord, NH 03301 603-271-6762
New Hampshire Board of Psychologists 121 South Fruit Street Concord, NH 03301 email: jabarnes@dhhs.state.nh.us

Informed Consent Agreement

I have read and agree to each of the previous sections of the agreement. I have had an opportunity to discussed any questions or concerns. By signing below, I indicate that I understand and agree to the terms of this agreement. ***Please note if the parents of an underage child (the client) are divorced, both parents need to be aware of and consent to treatment.**

Client Name_____Date_____

Signature Client_____Date_____

Signature (Parent)_____ Date_____

Signature (Parent) _____Date_____

CLIENT INFORMATION / INTAKE FORM

PLEASE PRINT – complete all items that apply

CLIENT NAME: _____ BIRTHDATE: _____

IF THE CLIENT IS UNDER 18 YEARS OLD, WHO IS CUSTODIAL PARENT:
Name _____ Relationship _____

Name _____ Relationship: _____

Address _____

City _____ State _____ Zip code _____

Home phone_____ _____Cell phone _____

E-mail address_____

Client's occupation_____

Employer (or school) _____

Work phone: _____

Years of education completed: _____

Client's marital status: _____

Spouse/partner's name: _____

May we contact him/her in an emergency Yes /No Phone number: _____

In Case of emergency contact: _____

Relationship: _____Phone number: _____

FAMILY MEMBERS or others who currently live in your household:

Name	**DOB**	**Relationship**	**Occupation**
~~	~~~~~	~~~~~	~~~~~
~~	~~~~~	~~~~~	~~~~~
~~	~~~~~	~~~~~	~~~~~
~~	~~~~~	~~~~~	~~~~~
~~	~~~~~	~~~~~	~~~~~

LIST ANY ACTIVE OR PAST HEALTH CONCERNS:

CURRENT MEDICATIONS (Prescription, Over the Counter, Vitamins, Herbs, and/or Pain Medications)

Drug Name	**Dose**	**Frequency**
~~	~~~~~	~~~~~
~~	~~~~~	~~~~~
~~	~~~~~	~~~~~

Have you previously taken any psychiatric medications not listed above? Yes/No:

Name of medication: Effect:

SURGICAL HISTORY

Please list date of the operation or your age: Procedure/Operation:

Hospitalizations other than for surgery:

Please list date/age: Reason:

Have you ever received any previous treatment mental health treatment? Yes No

IF YES, Please list providers, dates of service, reason for service, and perceived effect of treatment:

Describe any concerns or problematic experiences with mental health services in the past?

Have you received any inpatient mental health services? YES/NO Describe:

Please share any relevant information regarding developmental milestones (for your child/the patient):

Please share any relevant information regarding pregnancy (regarding your child/the patient):

FAMILY HISTORY Has any member of your family (including parents, siblings and children) ever had problems with the following:

Condition	**Specify who in the family**
Anxiety	
Depression	
Substance abuse or dependence	
Schizophrenia	
Suicide	
ADHD	

Who Referred you to this office:

HOBBIES / RECREATION:

SCHOOL HISTORY
What kind of grades do / did you earn in school_____
Have you ever been retained/suspended/expelled from school? Yes No
(If yes please indicate reasons for retention/suspension/expulsion)

Are there any special circumstances in your educational history: (such as an Individual Education Plan (IEP), tutoring, special education courses like Chapter 1, talented and gifted/honors programs, accommodations like extended test times or special seating) Yes/No Describe:

Please describe any extracurricular activities that you participate in:

Please describe your involvement with religious and spiritual beliefs:

Describe life events or changes that have occurred in the past year (e.g., job changes, death in the family, Divorce, child entering/leaving school, serious illness financial problems:

What do you expect to get out of this treatment or evaluation:

What is the most stressful thing in your life right now?

Please circle any of the following that you feel are *currently problematic*:

Nervousness/Anxiety	Depression	Marriage	Fears
Shyness	Sexual Problems	Suicidal Thoughts	Nightmares
Drug Use	Inferiority Feelings	Unhappiness	Sexual Abuse
Anger	Alcohol Use	Money Problems	Temper
Irritability	Emotional Abuse	Self-Control	Appetite
Stress	Making Decisions	Relaxation	Sleep
Money	Concentration	Legal Matters	Children
Headaches	Health Problems	Energy	Tiredness
Physical Abuse	Memory	Stomach Problems	Loneliness
Parents Insomnia	My thoughts	Education Other:	

HEALTH RISKS

Do you wear seats belts? YES/NO
Do you use tobacco? YES/ NO
Do you drink alcoholic beverages? YES/NO
Do you drink caffeinated beverages? YES/NO How many?
Do you use drugs? YES/NO Explain:
Is there a gun in your home? YES/NO Is it locked/secured?
Have you been in a relationship where you have been physically hurt by someone? YES/NO Explain:
Do you feel afraid of your Partner? YES/NO

INSURANCE FORM

**Outpatient mental health coverage should be verified by the patient or guardian prior to the first appointment. Benefits can be verified by calling the phone number on the back of the health insurance card. The insured is held responsible for any expenses not paid by insurance provider.*

Patient Legal Name: _____Date_____
Date of Birth_____
Insured's Name (if different than patient) _____
Date of Birth: _____Relationship to the patient: _____

Daytime Phone Number: _____ (circle)Work/Home/Cell
Evening Phone Number: _____ (circle) Work/Home/Cell
Cell: _____

Name of Insurance Company: _____
Telephone Number of Company: _____
ID or Policy #: _____
Group # (if applicable): _____
Employer's Name: _____

Max # of Visits per year: _____Co-pay: _____Insurance effective dates: _____

Payment Authorization

I authorize my insurance plan to pay benefits on my behalf to Growing Roots, LLC:
Responsible party: _____Date: _____

I authorize Growing Roots, LLC to release information about my claims to my insurance company.
Name of Adult Patient or Subscriber: _____Date_____

Authorization to Exchange Confidential Information

Patient_____ Date of Birth: _____

State and Federal law limits the exchange of healthcare information in the absence of written acknowledgement and authorization from the client and/or the client's legal custodian.

By signing below, you authorize Growing Roots, LLC to release to and/or to receive information regarding you from the party identified below. This release and authorization is inclusive of all matters, even in those jurisdictions which information pertaining to the use of drugs and/or alcohol and/or tobacco and in which information pertaining to sexual activity, reproductive health, HIV and AIDS status may be subject to specific conditions of confidentiality.

This release will remain in effect for one (1) full year from the date of signature unless and until you or your legal custodian rescind it in writing or the court nullifies it.

Growing Roots, LLC reserves the right to withhold any information she believes, in her sole discretion, might cause harm.

Authorization to Exchange Confidential Information with:

Name of intended party: _____

Party's Mailing address: _____

Phone/fax/email contact: _____

Purpose of communication: _____

Signature of Client or Client's Legal Custodian

Print your name: _____
Signature of client if 18 or older: _____
Signature of legal Custodian: _____

If you are working with Knower Academics, may we speak with them regarding treatment planning as related to academics.
Signature:_____

Agreement of Between-Session Communication

As you or your child / adolescent participate in treatment, it may be helpful at times to receive additional support by communicating outside of a scheduled treatment session by phone, text and/or email. Though not all patients may require or request this service, the following offers an outline of expectations and limitations for those who do choose to communicate outside of scheduled treatment sessions. By reviewing and signing this document, you confirm that you understand and agree with its stated conditions, and that you've discussed the details of this agreement with your treating clinician.

Clinicians within the Growing Roots office may offer to communicate by phone, text and/or email with patients and patient's parents / guardian outside of program hours. This communication will be focused on problem-solving strategies, skills generalization, and the sharing of information relevant to treatment-related goals and interventions.

Clinicians and patients / families who choose to communicate outside of program hours do so voluntarily and following a discussion of treatment goals and need areas. Please understand online communication may not be secure. This communication can be discontinued by the clinician or family at any time.

Clinicians who communicate with patients and/or families between sessions must document the duration and general content of phone and email contact in progress notes within the next business day. These communications will incur a charge if longer than 10 minutes (please see treatment cost sheet)

Clinicians communicating with patients and/or families outside of program do so according to HIPAA guidelines of privacy and confidentiality. Individuals and families who have agreed to communicate with Growing Roots clinicians by phone or email have reviewed these guidelines and have signed all related consents and authorizations at intake.

Patients or parents who are unable to reach their Growing Roots clinician during times of crises, agree to contact emergency services as needed.

Clinicians concerned for the safety and well-being of an adolescent patient during between session contact, will notify the adolescent's parents immediately. In the event the clinician is unable to reach a parent; the clinician will contact emergency services as needed.

Patient/Adolescent Signature: _____
Signature of Parent/Guardian _____

CREDIT CARD FORM

Payments can be made by check or credit card. *Please note if paying with AMEX we will add a $5.00 service fee to offset higher processing fees.

Credit card information:

Type of Card:

Name on Card:

Card number:

Expiration date:

CV2 code on back of card:

Card billing address:

Signature authorizing credit card payment: _____

Date: _____

Boarding School Agreement

I have contracted to provide counseling and consultation services to area private schools. In order to minimize time away from school activities and to eliminate the need for transportation to my office, I will travel to the school to meet with your child. Referrals for services will be coordinated by the school counselor. In all cases I will speak directly with you, the parent and will ask you to complete all necessary paperwork prior to my first session with your son/daughter.

Services offered to private school clients are different than a typical office visit. I make every attempt to work around your child's academic and athletic schedule, I am available to your child by phone/text between sessions**.** This communication will be focused on problem-solving strategies, skills generalization, and the sharing of information relevant to treatment-related goals and interventions.

My current private pay rates are $250.00 for the initial diagnostic interview, $165.00 for a clinical hour and $200.00 for a 90-minute session. Providing services outside of my office setting increases liability, travel time, scheduling time and availability to you and your child.

If you wish to use your insurance (Blue Cross Blue Shield, Cigna, Tufts) we will need to bill you directly an additional $50.00 for these increased services, as described above. For those paying the full private pay rate there will be no added fee.

Payments can be made by check or credit card. *Please note if paying with AMEX we will add a $5.00 service fee to offset higher processing fees.

Credit card information:

Type of Card:

Name on Card:

Card number:

Expiration date:

CV2 code on back of card:

Card billing address:

Signature authorizing credit card payment: _____

Date: _____