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OUTPATIENT SERVICES CONTRACT

Welcome to my private practice. This document contains important information about my professional services and business policies. Please read it carefully and make note of any questions that you might have so that we can discuss them during our session. **Please sign your initials on the line provided following each section, indicating that you have read and agreed to my policies. When you sign this document, it will represent an agreement between us.**

PSYCHOLOGICAL SERVICES: Psychotherapy is not easily described in general statements. It varies depending on the personalities of the psychotherapist and the patient, and the particular difficulties with which you are struggling. There are many different methods that I may use to deal with the problems that you address. Psychotherapy is different from a medical doctor visit in that it calls for a very active effort on your part. In order for the therapy to be most successful, you will have to work on these things we talk about both during and in between our sessions.

Psychotherapy can have benefits and risks. Since therapy often involves discussing unpleasant aspects of your life, you may experience uncomfortable feelings such as sadness, guilt, anger, frustration, loneliness, and helplessness. Psychotherapy has also been shown to have many benefits. Therapy often leads to stronger, more communicative relationships, solutions to specific problems, and significant reductions in feelings of distress. There are no guarantees as to what you will experience.

Our first few sessions will involve an evaluation of your needs. I will be gathering information regarding your background, presenting difficulties, and current mental health symptoms in order to formulate a clinical diagnosis. 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. Subsequent sessions may include on-going assessment, treatment, scheduling, discussion of insurance benefits/past due fees, and other administrative details. If you have any questions about your treatment, we should discuss them as they arise.

_____ (please initial)

APPOINTMENTS AND CANCELLATIONS: I will usually schedule one 45 to 55 minute session per week at a mutually convenient time. Appointment scheduling will occur at the conclusion of each session. The scheduling of an appointment involves the reservation of time set specifically for us. In the event that you need to cancel an appointment, **please inform me of your cancellation at least 24 hours in advance**.

Please be advised that insurance companies usually do not cover missed or cancelled appointments. Therefore, you are responsible for the **full session fee** for all missed appointments and appointments cancelled less than 24 hours in advance. Illness is not an exception unless accompanied by medical documentation.

_____ (please initial)

PROFESSIONAL FEES: My fee for service is $250 per 45 to 55 minute session. In addition to weekly appointments, I charge this amount for other professional services you may need. For services lasting a duration of less than one hour, the fee will be assessed on a pro rata basis. Additional services may include but are not limited to telephone conversations lasting longer than 10 minutes, report writing, attendance at meetings with other professionals you have authorized, preparation of records/treatment summaries, and time spent performing other services you may request of me. Please be advised that I have 15 days to provide letters and treatment summaries, and 30 days to provide treatment records from the time of request. If you become involved in legal proceedings that require my participation, you will be expected to pay for my professional time even if I am called to testify by another party.

_____ (please initial)

BILLING AND PAYMENTS: You will be expected to pay at the beginning of each session (via cash, check, or card), whether you are utilizing private pay or health insurance benefits. Health insurance companies will often cover a portion of the cost of psychotherapy. If you are planning on utilizing your health insurance benefits, please be advised that you may be expected to pay the contracted amount upfront, depending on your plan, deductible, and whether or not I am in-network. On occasion, mental health insurance rates (i.e. contracted rates, co-payments/co-insurance rates, deductibles) may change during the course of our work together. Please be advised that should your rates change, you will be expected to pay the difference for these services.

Payment schedules for other professional services will be agreed to when they are requested. I may be willing to negotiate a payment installment plan in times of financial hardship.

You are responsible for ensuring that your account balance is paid in full. If your account has not been paid for more than 60 days and arrangements for payment have not been agreed upon, I have the option of using legal means to secure the payment. This may involve hiring a collection agency or going through small claims court. If such legal action is necessary, such costs will be included in the claim. In most collections situations, the only information I will release regarding a patient's treatment is his/her contact information, the nature of services provided, and the amount due.

_____ (please initial)

INSURANCE BENEFITS: It is important to evaluate what resources you have available to pay for your treatment. If you have a health insurance policy, it is your responsibility to determine whether or not you have coverage and what kind of coverage you have prior to

each appointment. Please be advised that you will be responsible for any and all claims denied or unpaid by insurance. If you have questions about the coverage, call your health plan administrator. In order for you to receive your insurance benefits, you will be required to authorize me to provide a mental health diagnosis and dates of service. I may have to provide additional clinical information such as treatment plans, summaries, or copies of the entire record (in rare cases). This information will become part of the insurance company records and I have no control over what they do with it once it is in their possession. It is important to remember that you always have the right to pay for my services via private pay to avoid the problems described above.

_____ (please initial)

CONTACTING ME: I often am not immediately available by telephone, because I do not answer the telephone when I am with a patient or during meetings. When I am unavailable, you may leave a confidential message that I monitor frequently. I will make every effort to return your call within one business day, with the exception of weekends and holidays. Email and text are not secure ways of communicating personal and confidential information.

If an emergency situation arises, you may call me and leave a message stating the nature of the emergency and a telephone number at which you can be reached. I will make every effort to return your call immediately. You may also dial 911 for immediate assistance or dial 988, which is the National Suicide Prevention Lifeline. If I will be unavailable for an extended period of time, a qualified professional will be available for you to contact during my absence.

_____ (please initial)

PROFESSIONAL RECORDS: The laws and standards of my profession require that I keep treatment records. You are entitled to receive a copy or summary of your records. These professional records can be misinterpreted by untrained readers. Therefore, if you wish to view your records, I recommend that you review them in my presence so that we can discuss the contents.

_____ (please initial)

MINORS: If you are under eighteen years of age, please be aware that the law may provide your parents the right to examine your treatment records. It is my policy to request a verbal agreement from parents that they agree to give up access to your records. If they agree, I will provide them only with a treatment summary or general information about our work together, unless I feel there is a risk that you will be seriously harmed, seriously harm yourself, or someone else. Before giving them any information, I will discuss the matter with you, if possible, and do my best to handle any objections you may have with what I am prepared to discuss.

_____ (please initial)

CONFIDENTIALITY: In general, the privacy of all communications between a patient and a psychologist, including that of minors, is protected by law. Therefore, I am not at liberty to release information to another professional or interested party without written permission except where disclosure is permitted or required by law. 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 patient's treatment. Disclosure may be required in the following circumstances:

(1) When there is a reasonable suspicion of child abuse, elder abuse, or abuse of a dependent adult (i.e., an adult who relies on the care of others). In this case, I am required by law to file a report with the appropriate state agency.
(2) If I believe that a patient 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 patient.
(3) If the patient threatens serious bodily harm to himself/herself, I may be obligated to seek hospitalization for him/her or to contact a family member or others who can help provide protection.
(4) When disclosure is required pursuant to a legal proceeding (i.e., court order).
(5) In the event that the services occurred in my practice. If a similar situation occurs, I will make every effort to fully discuss it with you before taking any action.

I may occasionally find it helpful to consult other professionals about a case. During a consultation, neither your name nor identifying information about you will be revealed. The consultant also is legally bound to keep the information confidential.

_____ (please initial)

TERMINATION: I reserve the right to terminate therapy at my discretion due to nonpayment, noncompliance with treatment recommendations, conflicts of interest, nonparticipation in therapy, lack of progress in therapy, or if your needs are outside the scope of my competence or practice. You also have the right to terminate therapy at any time. Unless special arrangements have been made, a duration of 30 days or longer with no clinical activity is subject to having your chart closed with my office.

_____ (please initial)

CONSENT FOR TREATMENT

I, _____, authorize and request that _____, provide psychological assessments, examinations, treatment, and/or diagnostic procedures which are advisable during the course of my care as a patient. The frequency and type of treatment provided will be decided between me and my therapist.

I understand that there is an expectation that I will benefit from psychotherapy but there is no guarantee that this will occur.

I understand that maximum benefit will occur with consistent attendance and that, at times, I may feel conflicted about my therapy as the process can sometimes be uncomfortable.

I understand that my participation in psychotherapy is completely voluntary and that I may terminate psychotherapy at anytime.

I have received a copy of the *Outpatient Services Contract*. I understand that the purpose of these guidelines is to clarify the nature of our professional relationship.

My signature below indicates that I have read and fully understand the information in the *Outpatient Services Contract* and I agree to abide by its terms during our professional relationship.

_____ _____
Patient's Signature Date

_____ _____
Parent/Guardian/Financial Guarantor's Signature Date

_____ _____
Therapist's Signature Date