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OUTPATIENT SERVICES CONTRACT

Welcome to my practice. This document contains important information about my professional services and business policies, including the following:

- Respectful treatment geared to your wants and needs
- 45 to 60-minute sessions
- Payment due at each session
- Fee for missed appointments or late cancellations (less than 24 hours notice)
- Importance of your active participation

Please read this document carefully and jot down any questions you might have so that we can discuss them when we meet. 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 psychologist and patient, and the particular problems the child brings forward. There are many different methods I may use to deal with the problems that you hope to have addressed. Psychotherapy is not like a medical doctor visit. Instead, it calls for a very active effort on your part and on your child's part. In order for the therapy to be most successful, you and/or your child will have to work on things we talk about both during our sessions and at home.

Psychotherapy can have benefits and risks. Since therapy often involves discussing unpleasant aspects of life, your child may experience uncomfortable feelings like sadness, guilt, anger, frustration, loneliness, and helplessness. On the other hand, psychotherapy has also been shown to have benefits for people who go through it. Therapy often leads to better relationships, solutions to specific problems, and significant reductions in feelings of distress. But there are no guarantees of what your child will experience.

Early on in the therapeutic process, you, your child, and I will create a treatment plan together. If you have questions about my procedures, we should discuss them whenever they arise.

MEETINGS

I usually schedule one or two 45 to 50-minute sessions per week at a time we agree on. Once an appointment hour is scheduled, you will be expected to attend it unless you provide 24 hours advance notice of cancellation. The first time there is a missed appointment or late cancellation, there will be no charge. After the first incident, however, there will be a $100 charge for each missed appointment or late cancellation (see Cancellation/Late fees below). If we both agree that the appointment was missed due to circumstances beyond your control, the fee may be waived.

PROFESSIONAL FEES

In general, your initial intake appointment is $200 and my 60-minute psychotherapy fee thereafter is $180, but these may vary depending on alternate types of services and insurance coverage. In addition to weekly appointments, I charge this amount for other professional services you or your child may need, though I will break down the hourly cost if I work for periods of less than one hour. Other services include report writing, telephone

conversations lasting longer than 20 minutes, attendance at meetings with other professionals you have authorized, preparation of records or treatment summaries, and the time spent performing any other service you may request of me. If you become involved in legal proceedings that require my participation, I charge $180 per hour for preparation and attendance at any legal proceeding.

BILLING AND PAYMENTS

You will be expected to pay for each session at the time it is held, unless we agree otherwise or unless you have insurance coverage which requires another arrangement. Payment schedules for other professional services will be agreed to when they are requested. In circumstances of financial hardship, I may be willing to negotiate a fee adjustment or payment installment plan.

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, its costs will be included in the claim. In most collection situations, the only information I release regarding a patient's treatment is his/her name, the nature of services provided, and the amount due.

INSURANCE REIMBURSEMENT

If you have a health insurance policy, it will usually provide some coverage for mental health treatment. I will fill out forms and provide you with whatever assistance I can in helping you receive the benefits to which you are entitled; however, you (not your insurance company) are responsible for full payment of my fees. It is very important that you find out exactly what mental health services your insurance policy covers.

You should carefully read the section in your insurance coverage booklet that describes mental health services. If you have questions about the coverage, call your plan administrator. Of course, I will provide you with whatever information I can based on my experience and will be happy to help you in understanding the information you receive from your insurance company. If it is necessary to clear confusion, I will be willing to call the company on your behalf.

Due to the rising costs of health care, insurance benefits have increasingly become more complex. It is sometimes difficult to determine exactly how much mental health coverage is available. "Managed Health Care" plans such as HMOs and PPOs often require authorization before they provide reimbursement for mental health services. These plans are often limited to short-term treatment approaches designed to work out specific problems that interfere with a person's usual level of functioning. It may be necessary to seek approval for more therapy after a certain number of sessions. While a lot can be accomplished in short-term therapy, some patients feel that they need more services after insurance benefits end.

You should also be aware that most insurance companies require you to authorize me to provide them with a clinical diagnosis. Sometimes I have to provide additional clinical information such as treatment plans or summaries, or copies of the entire record (in rare cases). This information will become part of the insurance company files and will probably be stored in a computer. Though all insurance companies claim to keep such information confidential, I have no control over what they do with it once it is in their hands. In some cases, they may share the information with a national medical information databank. I will provide you with a copy of any report I submit, if you request it.

Once we have all of the information about your insurance coverage, we will discuss what we can expect to accomplish with the benefits that are available and what will happen if they run out before you feel ready to end our sessions. It is important to remember that you always have the right to pay for my services yourself to avoid the problems described above.

CANCELLATION / LATE TO APPOINTMENT / OUTSTANDING BALANCE FEES

- **CANCEL / NO SHOW:**

A missed appointment delays the success of therapy. When you must cancel, I require at least 24 hours notice as I am rarely able to fill a cancelled session unless I know at least 24 hours in advance. If you are unable to provide at least 24 hours notice when you cancel, or if you do not show up for a scheduled appointment, you will be charged $100 cancellation fee unless I am able to fill it with another client. The only time I may waive this fee is in the event of serious or contagious illness or emergency. Note that insurance companies do not reimburse fees charged for missed or late appointments. Clients who are unsure if they can commit to therapy appointments scheduled for them should seek services elsewhere.

- **LATE TO APPOINTMENT:**

If you're late to your scheduled appointment, the length of your appointment time will be shortened to fit into the time that was originally reserved for your services.

  - If you are more than 15 minutes late, a **Late to Appointment Fee of $25** will be charged to your account.
  - If you are more than 25 minutes late, a **Late to Appointment Fee of $50** will be charged to your account.
  - If you are more than 35 minutes late, the appointment will be considered a No Show and the $100 cancellation fee will be charged to your account.

- **OUTSTANDING BALANCE FEE:**

Account balances that are your responsibility are due by the end of the month in which the balance is billed. Outstanding balances more than 30 days past due will result in a $10 fee being charged to the account for each month there is a balance not paid.

CONTACTING ME

- **PHONE**: I am often not immediately available by telephone. I will not answer the phone when I am with a patient. When I am unavailable, my telephone is answered by an answering machine that I monitor frequently. I will make every effort to return your call within 24 hours, with the exception of weekends and holidays. Please be aware I am not in my office on Thursdays and Fridays. If you are difficult to reach, please inform me of sometimes when you will be available.
- **TEXTING/EMAIL**: Texting and Email is NOT to be used as a method of therapy. Texting and Email is not an effective means for treatment and is not private or secure. You can text and/or email with me ONLY to communicate about appointment scheduling.
- **EMERGENCIES**: If you are unable to reach me and feel that you can't wait for me to return your call, contact your family physician or the nearest emergency room and ask for the psychologist or psychiatrist on call. If I will be unavailable for an extended time, I will provide you with the name of a colleague to contact, if necessary.

MINORS

For patients under eighteen years of age confidentiality may be limited in that their parents may require information about their treatment. It is important that the lines of communication remain open between therapist, child, and parents. Most of the time, children have no objection to this. It is my policy, however, to request an agreement from parents that they respect the confidentiality of the child's treatment. If you agree, I will not share with you information that your child would like kept confidential, unless I feel there is a high risk that your child will

seriously harm himself or herself or someone else. In this case, I will notify you of my concern. Before giving you any information, I will discuss the matter with your child, if possible, and do my best to handle any objections your child may have with what I am prepared to discuss.

Please check below to indicate which option you prefer:

___ I agree to respect my child's confidentiality to the extent deemed appropriate by the therapist.

___ I want to have full access to all information regarding my child's treatment.

CONFIDENTIALITY

In general, the privacy of all communications between a patient and a psychologist is protected by law, and I can only release information about my work with your child to others with your written permission. But there are a 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 condition is an important issue, a judge may order my testimony if he/she determines that the issues demand it.

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. For example, if I believe that a child is being abused, I must file a report with the appropriate state agency.

If I believe that a patient is threatening serious bodily harm to another, I may be required to take protective actions. These actions may include notifying the potential victim, contacting the police, or seeking hospitalization for the patient. If the patient 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 any action.

Your signature below indicates that you have read the information in this document and agree to abide by its terms during our professional relationship.

_____	_____
Patient Name	Date of Birth
_____	_____
Parent/Guardian Signature	Date
_____	_____
Therapist Signature	Date