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PRACTICE INFORMATION AND CONSENT FOR TREATMENT

Welcome to my practice. This consent contains important information about my professional services and business policies. Please feel free to ask any questions about my services or policies at any time during your treatment.

PSYCHOLOGICAL SERVICES. Therapy can be of great benefit to individuals, couples and families. It can reduce distress, improve relationships and solve problems. Research indicates that people who benefit most are those who are willing to look honestly at themselves and willing to modify ways of thinking or behaving. Psychotherapy is different than visiting a medical doctor in that the treatment requires a very active effort on your part. In order to be most successful, you will have to work both during our meetings and between meetings.

Psychotherapy has both benefits and risks. Risks sometimes include experiencing uncomfortable feelings such as sadness, guilt, anxiety, anger and frustration. Psychotherapy often requires discussing unpleasant aspects of your life. While my commitment to you is to do my best to help you solve the problems that led you to therapy, I cannot guarantee that you will benefit.

Our first several meetings will involve an evaluation of the problem and your therapy needs. During this initial time, I will be able to offer you some initial impressions of what our work will include and an initial treatment plan. You should evaluate this information along with your own assessment about your comfort in working with me. If you have any questions about our work together at any time, please discuss them with me. It is generally most helpful to meet weekly for an hour, although sometimes sessions can be longer or more or less frequent depending on your treatment needs. If I assess that the problems you are having are beyond the scope of my expertise or that the therapy I can offer is unlikely to benefit you, I will help you with a referral to another competent mental health professional or suggest other options.

PROFESSIONAL FEES AND CANCELLATION POLICY. For office appointments, payment is to be made in full with a personal check, cash or credit card at the time of the appointment. It is my policy to also charge on a prorated basis for other professional services such as report writing, lengthy telephone conversations, consultations with other professionals which you have authorized, and for preparation of records or treatment summaries. Therapy is a significant personal and financial commitment. Please do not hesitate to discuss any concerns you have with me. If you have difficulty paying for therapy under the conditions outlined here, then you and I should discuss alternate plans. I ask that you give me as much notice as possible if you need to cancel or change your appointment. You will be charged for the time you have reserved if you do not provide 24 hours notice.

INSURANCE BILLING. Fees are payable at the time of service. As I am an out-of-network provider for most insurance companies, it is not my policy to submit claims to your insurance company. I will provide you with a monthly statement which you can use to submit a claim to your insurance company. The exception to this is for patients covered by Medicare. If you have Medicare coverage, I will submit claims directly. You should be aware that insurance companies require a clinical diagnosis and sometimes require additional clinical information, such as a treatment plan or summary, or in rare cases, a copy of the entire record. This information will become part of the insurance company files, and it may be computerized. All insurance

companies claim to keep such information confidential, but once it is in their hands, I have no control over what they do with it.

CONTACTING ME. I check my messages frequently and will make every effort to return your call on the same day, except weekends and holidays. If you cannot reach me on my regular line and you feel your call constitutes an emergency, you may call my exchange at (800) 274–2612. Please understand that, even using my emergency line, I may not be immediately available. If you cannot wait for a call back, you should call your physician, the emergency room at the nearest hospital and ask for the doctor on call, or call 911. If I am on vacation or away from the office for an extended period of time, I will have a trusted colleague on call for me.

CONFIDENTIALITY. In general, all communications between a client and psychologist are protected by law and I can only release information about our work to others with your written permission. However, in some circumstances, as in proceedings in which your emotional condition is an important element, a judge may require my records or testimony. There are some situations in which I am legally required to take actions to protect others from harm. If I am given information that suggests that a child, an elderly person, or a disabled person may have been abused, I must contact the appropriate state agency and file a report. If I am given information that a client is threatening serious bodily harm to another, I am required to take protective actions, which may include notifying the potential victim, notifying the police or seeking appropriate hospitalization. If a client threatens to harm him or herself, I may be required to seek hospitalization for the client, or contact family members or others who can help provide protection. These situations have rarely arisen in my practice. Should such a situation occur, I will make every effort to discuss it with you before taking any action. To provide the highest quality services to my clients, I occasionally find it helpful to consult with other professionals. In these instances, I make every effort to avoid revealing the identity of my clients. The consultant is, or course, also legally bound to keep the information confidential.

MINORS. If you are a parent of a child under 18 years of age, or you are reading this consent and you are a minor, please be aware that the law provides parents with the right to examine their child's treatment records. It is my policy to request an agreement from parents that you will not request access to your child's records. This policy is to ensure that children have a private place to discuss their concerns and feelings, which is especially important in cases where parents are divorcing or involved in child custody evaluations or conflicts. I ask that parents consent to this plan, with the understanding that I will provide you with general information about my work with your child. The exception to this is that, if I assess that there is a high risk that your child may seriously harm him/herself or someone else, I will notify you of my concern. Sometimes it is very helpful for parents to have additional information. I will make every effort to discuss this with your child and resolve any objections your child may have about what I feel needs to be discussed with you.

Your signature below indicates that you have read this consent and agree to the conditions and policies of treatment as outlined above.

Signature: _____ Date: _____

Signature: _____ Date: _____