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Consultation and Psychotherapy Services Agreement

Please read the following sections regarding important guidelines for the provision of consultation and psychotherapy services in this practice. In order for our work to be most productive and effective, it is important that you have a clear understanding of your rights and responsibilities as a patient, as well what you can expect in terms of the structure of sessions, confidentiality, clinical records, scheduling, and payment.

I. Intake/Consultation: It is helpful to view the first 1-3 sessions as part of an initial consultation, during which we will determine together whether further work together would be beneficial. This is an opportunity for me to gather information and clarify the presenting concerns, and also a chance for you to ask any questions regarding my professional background, training, and credentials.

II. Psychotherapy: The psychotherapy process is collaborative and interactive, and I endeavor to create an environment of safety and security to address presenting concerns. We will discuss the frequency of sessions with the focus on determining to plan that is most helpful for resolving these concerns. Sessions are typically 45 minutes in length and take place in person.

III. Patient Rights: The Health Insurance Portability and Accountability Act (HIPAA) is a new federal law that provides privacy protection and patient rights with regard to the use and disclosure of your clinical records, also called Protected Health Information (PHI), used for the purpose of treatment, payment, and health care operations.

Please carefully review the Confidentiality section below. You will be asked to provide your signature to acknowledge your understanding of your rights under the privacy policy. Please feel free to raise with me any questions you have about these rights.

IV. Confidentiality: Confidentiality is a keystone of our work together, ensuring that you can address your concerns with the assurance that information addressed in session is protected. In general, law strictly protects the confidentiality of all communications between a patient and psychologist. With the exceptions noted below, I will release information about your treatment to others only if you sign a written consent. There are situations that require only that you provide written, advance consent, and your signature on this agreement provides that consent for the following:

- At times it can be productive to consult with other health and mental health professionals, without revealing any identifying information about you. Other professionals are also legally bound to keep this information confidential.
- Disclosures required by health insurers or to collect fees, as noted elsewhere in this agreement.
- If a patient threatens to harm him/herself, I may be obligated to seek hospitalization for him/her, and/or to contact family members or others who can help provide protection.

There are some situations in which I am legally obligated to take actions that I believe are necessary to attempt to protect others from harm, and I may have to reveal some information about a patient's treatment:

- If I receive information in my professional capacity that gives me reasonable cause to suspect abuse or neglect of a child, the law requires that I report this to the appropriate governmental agency, usually the statewide central register of child abuse and maltreatment, or the local child protective services office. Once such a report is filed, I may be required to provide additional information.
- If a patient communicates an immediate threat of serious physical harm to an identifiable victim, 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.

These situations are rare in my practice. If any such situation arises, I will make every effort to fully discuss it with you before taking any action, and I will limit my disclosure to what I deem necessary.

V. Clinical Records: As required by law, I maintain clinical records of our sessions containing Protected Health Information (PHI). All records are kept secure in compliance with the Health Insurance Portability and Accountability Act (HIPAA).

VI. Scheduling: Your scheduled appointment time is reserved for you, and due to the difficulty of scheduling during open appointment times on short notice, I require a 24 hour notification if you cancel an appointment. If appointments are cancelled within 24 hours, or missed, I reserve the right to charge appointment fee for this appointment. If you have provided me with your credit card information for billing, I reserve the right to make these charges to your credit card. Please bear in mind that most insurance companies do not reimburse for cancelled or missed appointments.

VII. Insurance reimbursement: For all insurances, I will provide the needed paperwork/statements for you to submit to insurance. I will collect the full fee

directly from you, and you will be reimbursed by the insurance company for any covered expenses.

VIII. Payment: Unless we make other arrangement, payment is due at the time of service, whether a co-payment or the full fee for services. If at any point during the treatment, you anticipate difficulty with payment on the agreed upon schedule, please raise this as soon as possible so that we can develop a plan in response to the change.

IX. Informed Consent:

Your signature below indicates that you have read this agreement and agree to its terms.

_____
Printed Name

_____
Signature

_____
Date