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Licensed Psychologist

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OUTPATIENT SERVICES CONTRACT
AND
CONSENT TO TREATMENT

The following information is provided to help you understand the policies of my office. Please read it carefully and jot down any questions or concerns you might have so that we may discuss them.

PSYCHOLOGICAL SERVICES

Psychology is not easily described in general statements. It varies depending on the personalities of the psychologist and patient, and the particular problems or concerns you bring forward. There are many different methods I may use to deal with the problems and concerns you hope to address. Psychology is not like a medical visit. Instead 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 things we talk about about during your session as well as at home.

Therapy can have benefits and risks. The risks of therapy involve the unpleasant feelings (such as guilt, sadness, anger, and loneliness) that may arise due to discussing difficult aspects of your life. On the other hand, the benefits of therapy include improved relationships, increased control over one's behavior, decrease in distress, and solutions to specific problems. However, please be advised, there are no guarantees of what specific outcomes you will experience.

In addition to my experience and training as a psychologist, I have seen the benefits of many complimentary activities that are outside the scope of psychotherapy. These may include certain types of extracurricular activities, different types of therapies, and the use of alternative homeopathic remedies. I may bring these alternatives up in session but you may also ask me about complimentary activities at any time. It is your responsibility to research and determine whether or not these activities are appropriate for you and your family. You are in no way required to engage in any of these complimentary activities

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Initial

CONFIDENTIALITY

The privacy of most communications between a patient and psychologist are protected by law. Generally, I can only release information about our work together to others with your written permission. However, there are exceptions to this. If I believe that a child, elderly person, or disabled person is being abused, I am mandated to file a report with the appropriate agency. Additionally, if I believe that a patient is threatening serious harm to him/herself or others, I may be required to take protective actions. These actions may include contacting family members, police, or seeking hospitalization for the patient. If a situation arises in which I am obligated to divulge confidential information I will make every effort to discuss this with you before taking any action.

If you are engaged in Equine Assisted Psychotherapy (EAP) you will be working with a therapy team that includes an equine professional (EP) and myself. To aid in the therapeutic process, I ask for your permission to speak freely with the EP.

Often psychologists consult other professionals about their cases. During such a consultation, every effort is made to avoid any identifying information. The consultant is also legally bound to keep the information confidential. If you don't object, I will not tell you about these consultations unless I feel that it is important to our work together.

While this written summary of exceptions to confidentiality should prove helpful in informing you about potential problems, it is important that we discuss any questions or concerns that you may have.

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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 practice to request an agreement from parents that they give up access to your records. If they agree, I will provide them only with general information about our work together and your progress, unless I feel that you are at risk of harming yourself or others. If this occurs, I will notify your parents of my concern. Additionally I will provide your parents with verbal updates of your treatment and a summary when our work is complete. Before speaking to your parents about our sessions, I will discuss the matter with you, if possible, and do my best to handle any objections you may have.

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Initial

CANCELLATIONS

When you schedule an appointment with me, I am reserving my professional time only for you. If you do find that you need to cancel or reschedule an appointment, please give me as much notice as possible. I will do the same for you if I need to cancel or change your appointment.

Late cancellations (with less than 24 hours notice)or missed appointments will be charged at the full rate, unless we are able to reschedule for another time that week.

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Initial

PROFESSIONAL FEES

I work on a "fee for service" arrangement. This means that I expect payment for each session at the time it is held.

An initial visit/evaluation typically lasts 75-90 minutes and my charge is $375. After the initial visit, a typical session is 45 minutes long and my charge is $220. My rate for Equine Assisted Psychotherapy is $290. It is my practice to raise my rate every January in order to adjust for inflation.

If you become involved in legal proceedings that require my participation, you will be expected to pay for my professional time. It is my practice to charge the party who requests my participation. Because of the difficulty of legal involvement, I charge $400 per hour for preparation and attendance at any legal proceedings (including travel time). Additionally, I charge $400 per hour for consulting with attorneys/Guardian Ad Litems and writing letters to the court or the attorneys/Guardian Ad Litems. I also may need to collect a retainer before completing any legal work. When asked to testify, I block off at least half of the day for the hearing. Because of this, I have a minimum charge of $800 for any testimony in which I have blocked off half the day, and if I have needed to block off the whole day, there is a charge of $1500. This minimum is charged even for canceled hearings, unless I am given 48 hours notice. If my attendance is requested for an out of town trial, and I am able to attend the trial and return home in one day, the above charges will occur. If I am needed to stay overnight, my hourly rate will apply to travel time and work hours from 8am-6pm. Additionally, any travel expenses such as hotel, mileage, and meals will be charged.

Although I do not bill insurance companies directly, I will be happy to provide you with an invoice after each session for you to submit directly to your insurance company. In order to be reimbursed by most insurance companies, I will need to provide a clinical diagnosis. In some instances, insurance companies will require additional clinical information including treatment plans and summaries. In rare cases the insurance company may request the entire record in order to reimburse you for my services. This information will then become part of the insurance company's record and although insurance companies claim to keep this information confidential, I have no control over what they do

with the information once it is in their hands.

You have the right to pay for my services yourself in order to avoid the problems described above.

While payment is expected at the time of service, if for some reason 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 payment. This may involve hiring a collection agency or going through small claims court. If such legal action is necessary, its cost will be included in the claim. In most situations, the only information I release regarding a patient's treatment is his/her name, the nature of the service provided, and the amount due.

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Initial

CONTACTING ME

When I am with a patient, I will not answer my phone but you may leave a confidential voice mail message for me at (512) 940-7311.

I will make every effort to return your call on the same day you make it, with the exception of weekends and holidays. If you are unable to reach me and feel that you cannot wait for me to return your call, please contact your family physician or the nearest emergency room and ask for the psychologist or psychiatrist on call.

PROFESSIONAL RECORDS

The laws and standards of my profession require that I keep treatment records. You are entitled to receive a copy of the records unless I believe that seeing them would be emotionally damaging, in which case I will be happy to send them to a mental health professional of your choice. Because these are professional records, they can be misinterpreted and/or upsetting to untrained readers. I recommend that you review them in my presence so that we can discuss the contents. Patients will be charged an appropriate fee for any time spent in preparing information requests.

TERMINATION AND FOLLOW-UP

You are free to end our psychotherapy relationship and your work here at any time. However, good professional practice dictates that we do this in person, not over the phone. At the time you decide to end our work together, I will request that you schedule at least one more session for the purpose of bringing our work together to a close.

Your growth in life is never-ending. psychological needs continue to arise. You should feel free to

return for “tune-ups” or further work.

If your needs change or you feel your therapy work could be more effective with someone else, I will be glad to help you with a referral to another therapist.

Your signature indicates that you have read, understand, and agree to entering into a professional treatment relationship while abiding by the above policies.

Signature:_____Date:_____

Parent's Signature (if patient is a minor):_____Date:_____

CREDIT CARD AUTHORIZATION CONSENT FORM

Patient Name:_____

Parent/Guardian:_____

Exact name on Credit Card:_____

Card Number:_____--_____--_____--_____

3/4 digit on back of card:_____ expiration date _____

Card Holder’s Billing Address

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By signing this form, you agree as outlined in my informed consent policy, you will be charged my full session fee automatically for any no-show or cancellation less than 24 hours in advance of the appointment time. (Unless there are extenuating circumstances for which you have notified the provider and an agreement has been negotiated).

Card Holder’s Signature:_____Date:_____

The above information will only be used by this provider to obtain payment for services and will remain confidential. When services are terminated, the above information will be shredded.