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Therapy Contract

Welcome! I strive to provide a range of clinical behavioral science services to individuals, couples, families, and groups in all age ranges. Based on an in depth evaluation, my clinical philosophy is to utilize an integrated treatment plan including available medical, psychological, interpersonal, behavioral, and psychosocial approaches within my scope of practice in dealing with the whole individual.

Confidentiality: I recognize and appreciate the confidence you place in me and I have the highest respect for your privacy. Except for a few conditions as listed below, no information will be communicated to anyone without your knowledge and consent. The exceptions include:

1. Intent to harm oneself.
2. Intent to harm another person/place/object.
3. Child abuse – physical and/or sexual.
4. Abuse of an elder or dependent adult.
5. Domestic violence.
6. Third Party Payers
7. Worker's Compensation Reports

Please indicate here that you understand the limits of confidentiality _____(initial here).

Appointments: Please make every effort to keep your scheduled appointments. My cancellation policy requires 48 hours notice in order to avoid being charged for a "missed" appointment. I reserve the appointment time for you and often have patients who could fill your appointment slot should I have adequate time to notify them. Please give me that time. **For missed appointments, cancellations within 48 hours of your appointment, or failure to show on time for your appointment when billing your insurance for the full time of your appointment is not possible, you will be billed directly and expected to pay at the time of your appointment. My current fee for 50 minute therapy session is $175.00. I reserve the right to periodically adjust my fee. _____(initial here).**

Office Hours: I do not hold regular office hours. However, If you have a life-threatening emergency, call 9-1-1 or go to your local emergency room. I am not able to provide 24 hour availability but will likely be able to return an urgent call within 24 hours.

Financial Policy: In my continued effort to contain costs, my financial policy is to expect payment in full at the time of service (except for any contracted insurance plans, in which case you will only be responsible for your co-insurance amount). Upon your clinical visit, you may request a "superbill" so that you will have all the information you need to submit to your insurer for reimbursement. Should your account at any point have a positive balance, we will be glad to carry the credit or provide you a refund per your request.

If your insurance company changes, you become ineligible for coverage, or you needed a referral or authorization which you did not obtain prior to your visit, it is your responsibility to let me know, otherwise you are responsible for any charges incurred without authorization. _____(initial here).

If you are here due to a worker's compensation claim and your claim is denied or you become ineligible for benefits, any charges to your account are your responsibility to pay directly to me. _____(initial here).

If your account becomes delinquent (past 30 days) I may begin collection procedures. I will attempt to collect from you directly. However, if your account remains delinquent I may utilize their services of an outside collection agency, retain an attorney, or a small claims court action may be taken.

Litigation Charges: If I am required to attend a deposition, hearing or other legal proceeding in the capacity of your current or past therapist, you will be billed at $350.00 per hour for my time, including preparation and travel time as well as the time I spend at the legal proceeding. If you are a current or past client, my testimony will not include any forensic opinions.

Telephone Contact: Telephone calls exceeding 10 minutes will be billed on a pro rata basis based on your 50 minute session fee. At your request and with your written authorization, I may communicate with people other than you. If any of these calls exceed 10 minutes, you will be billed on a pro rata basis based on your 50 minute session fee. Insurance companies and managed care organizations will not be billed for telephone time.

Written Reports: You may request that I write a report or fill out forms on your behalf. If so, you will be billed on a pro rata basis based on your 50 minute session fee.

Email or Texting: Other than scheduling appointments, I will not accept, review or respond to emails or texts from you or someone on your behalf. Please limit email or text communication to scheduling only. If it's an emergency, please call.

Maintenance of Records: Your records will be maintained within the guidelines of the Health Insurance Portability and Accountability Act (HIPAA) and the American Psychological Association.

You have been provided with a copy of the notice regarding HIPAA regulations. Please indicate here that you have read and understand this information _____(initial here).

Consent for Treatment: By signing this contract, you are giving me your consent to treat you for your psychological condition. In doing so, I may provide you with diagnostic or therapeutic services including evaluations, assessments, consultations, psychotherapy, EMDR, or other therapies as appropriate. You are also consenting to allow me to obtain consultation with another therapist, physician or psychiatrist as necessary regarding your case without disclosing identifying information in order to provide you with the best treatment possible.

Treatment Compliance: By signing this contract, you agree to comply with treatment plan and goals and work toward improvement as discussed in our mutually agreed upon treatment goals. You agree to arrive on time to your appointments as well. Arriving late to your appointment interferes with my ability to provide you with adequate treatment. Arriving more than 20 minutes late to your appointment will be deemed as forfeiture of your appointment time and you will be billed for the full amount of the reserved appointment time.

Credit Card Authorization:

A credit card is used to hold your appointment time and/or pay for services. Please indicate here that information and your signed authorization for charges agreed upon within this contract.

Name on Card:_____

Card Type: _____ Number: _____

CVV Code: _____ Exp. Date: _____

Signature: _____

I have read the above, fully understand, and agree to abide by these policies outlined above.

I have been provided with a copy of the Notice of Health Information Privacy Practices(HIPPA) for this office.

_____ _____

Signature Date