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Informed Consent for Therapy Services

PSYCHOLOGIST-CLIENT SERVICE AGREEMENT

Welcome to my practice. This document contains important information about my professional services and business policies. It also contains a summary of the Health Insurance Portability and Accountability Act (HIPAA), a federal law that provides privacy protections and patient rights about the use and disclosure of your Protected Health Information (PHI) for the purposes of treatment, payment, and health care operations. Although these documents are long and sometimes complex, it is very important that you understand them. When you sign this document, it will also represent an agreement between us.

PSYCHOLOGICAL SERVICES

Therapy is a relationship between people that works in part because of clearly defined rights and responsibilities held by each person. As a client in psychotherapy, you have certain rights and responsibilities that are important for you to understand. There are also legal limitations to those rights that you should be aware of. As your therapist, I have corresponding responsibilities to you. These rights and responsibilities are described in the following sections. Psychotherapy has both benefits and risks. Risks may include experiencing uncomfortable feelings, such as sadness, guilt, anxiety, anger, frustration, loneliness and helplessness because the process of psychotherapy often requires discussing the unpleasant aspects of your life. However, psychotherapy has been shown to have benefits for individuals who undertake it. Therapy often leads to a significant reduction in feelings of distress, increased satisfaction in interpersonal relationships, greater personal awareness and insight, increased skills for managing stress and resolutions to specific problems. However, there are no guarantees about what will happen. Psychotherapy requires a very active effort on your part. In order to be most successful, you will have to work on things we discuss outside of sessions. The first 1-3 sessions will involve a comprehensive evaluation of your needs. By the end of the evaluation, I will be able to offer you some initial impressions of what our work might include. At that point, we will discuss your treatment goals and create an initial treatment plan. You should evaluate this information and make your own assessment about whether you feel comfortable working with me. If you have questions about my procedures, we should discuss them whenever they arise. If your doubts persist, I will be glad to help you set up a meeting with another mental health professional for a second opinion or to obtain their services for subsequent care.

APPOINTMENTS, CANCELLATION, AND NO-SHOW POLICY

Appointments will ordinarily be 45-50 minutes in duration, once per week at a time we agree on, although some sessions may be more or less frequent as needed. The time scheduled for your appointment is assigned to you and you alone. If you need to cancel or reschedule a session, I ask that you provide me with 24 hours notice. If you miss a session without canceling, or cancel with less than 24-hour notice, my policy is to collect the full session amount [unless we both agree that you were unable to attend due to circumstances beyond your control]. It is important to note that insurance companies do not provide reimbursement for cancelled sessions; thus, you will be responsible for the portion of the fee as described above. In addition, you are responsible for coming to your session on time; if you are late, your appointment will still end on time.

If you have no-showed and have not scheduled an appointment after 30 days, I will assume you are ending treatment and may close your file at that time. I will consider you no longer an active client if 1) 60 days have passed, 2) you do not have an appointment with me, and 3) you have not responded to my three attempts to reach you via phone or email. You may contact me to set up an appointment to become an active client again.

PROFESSIONAL FEES

The fees per session are as follows: $160 for a 45-minute neurofeedback session, $185 for a 45-minute psychotherapy session, $235 for a 60-minute individual, couples, or family session, and $360 for a 90-minute individual, couples, or family session. You are responsible for paying at the time of your session unless we have discussed prior arrangements via cash, check, credit card, or automatic bank payment processing. Any checks returned to my office are subject to an additional fee of up to $25.00 to cover the bank fee incurred. If you refuse to pay your debt, I reserve the right to use an attorney or collection agency to secure payment.

In addition to weekly appointments, I charge this amount on a prorated basis for other professional services that you may require such as report writing, telephone conversations that last longer than 15 minutes, attendance at meetings or consultations which you have requested, or the time required to perform any other service which you may request of me. If you anticipate becoming involved in a court case, I recommend that we discuss this fully before you waive your right to confidentiality. If your case requires my participation, you will be expected to pay for the professional time required even if another party compels me to testify.

INSURANCE

Because I am a licensed clinical psychologist, most services are covered under major medical health plans. However, you may wish to contact your insurance provider and ask some very specific questions to determine your exact coverage, such as:

- Do I have mental health benefits?
- What is my annual deductible and has it been met?
- Is my mental health services deductible separate from the deductible covering physical health?
- How many psychotherapy sessions per calendar year does my plan cover?
- How much does my plan cover for an out-of-network provider?
- If coverage is expressed as a percentage, is that percentage based on the actual fee?
- If my coverage is a percentage based on "reasonable and customary fees," what is the maximum fee for a 45-minute individual psychotherapy session -- CPT or service code 90834? This varies considerably among insurance companies (sometimes based on market research and sometimes arbitrarily low) and may cap the actual sum that you will be reimbursed.

As an “out-of-network provider," I collect fees directly from you, and provide you with a statement that you can file an insurance claim for reimbursement. I can also provide your insurance company with any additional information about me that they need to process your claim. You will find that many health insurers provide very similar mental health reimbursements for in- and out-of-network providers.

CLIENT RECORDS

I am required to keep appropriate records of the psychological services provided. I maintain your records in a secure location IAW HIPAA regulation. HIPAA provides special protections to certain medical records known as “Psychotherapy Notes.” They are defined as notes recorded by a mental health provider documenting or analyzing contents of conversation during individual, group, joint, or family psychotherapy sessions. These notes recorded in any medium must be kept by the author and filed separately from the other PHI to maintain a higher standard of protection. Exclusions include medication monitoring, start and stop times/dates, modality and frequency of treatment, results of clinical tests, and summary of diagnosis, functional status, treatment plan, symptoms, prognosis, and progress to date. In order for me to release “Psychotherapy Notes” to a third party, the client must sign an authorization specifically for notes separate from release of other PHI or medical records.

PARENTS & MINORS

While privacy in therapy is crucial to successful progress, parental involvement can also be essential. It is my policy not to provide treatment to a child under age 16 unless s/he agrees that I can share whatever information I consider necessary with a parent. I request an agreement between the client and the parents allowing me to share general information about treatment progress and attendance, as well as a treatment summary upon completion of therapy. All other communication will require the child’s agreement, unless I feel there is a safety concern (see also above section on Confidentiality for exceptions), in which case I will make every effort to notify the child of my intention to disclose information ahead of time and make every effort to handle any objections.

NON-EMERGENCY & EMERGENCY CONTACT

I am often not immediately available by telephone as I may be in with another client. You may leave a non-urgent message on my confidential voice mail and I will return your call as soon as possible. If, for any number of unseen reasons, you do not hear from me or I cannot reach you, and you cannot wait for a return call or feel unable to keep yourself safe, 1) call 911 and ask to speak to the mental health worker or 2) go to your Local Hospital Emergency Room. I will make every attempt to inform you in advance of planned absences and provide you with the name and contact information of the mental health professional covering my practice.

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Informed Consent for Therapy Services

I acknowledge receipt of Dr. Pearl Zurich & Associates Notice of Informed Consent for Therapy Services.

We have discussed these policies, and I understand that I may ask about them at any time in the future.

I consent to accept these policies as a condition of receiving mental health services.

Please sign, print your name, and date this acknowledgement form.

_____ _____

Signature of Patient or Personal Representative Date

_____

Printed Name of Patient or Personal Representative