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PSYCHOLOGIST SERVICES INFORMED CONSENT CONTRACT FOR EVALUATION AND TREATMENT

Welcome to my practice. This document contains important information about my professional services and business policies. Please read it carefully and note any questions that you might have so that we may discuss them.

PSYCHOLOGICAL SERVICES

Psychological treatments vary and often depend on the particular problems for which assistance is requested. There are a number of different approaches which can be utilized to address the problems you may hope to resolve. In order to be most successful, you may be asked to work on things we discuss both during our sessions and in between appointments. Cognitive, behavioral and insight-oriented therapies have benefits and risks. Risks sometimes include experiencing uncomfortable feelings such as sadness, guilt, or anxiety because treatment often involves discussing unpleasant aspects of your life. Psychological evaluation often leads to a much better understanding of difficulties, while therapy and counseling often lead to a significant reduction in feelings of distress, better relationships, reduced stress, improved functioning, and resolution of specific problems. While these and other improvements are among the goals of treatment, there can never be guarantees about treatment outcome, and you are accepting the risk(s) that treatment may not improve your situation or circumstances. If you have any questions about my procedures, we should discuss them whenever they arise. If you are not satisfied with your progress in treatment, I will be happy to discuss this with you and even help you obtain a referral to another provider.

APPOINTMENTS, SCHEDULING, CANCELLATIONS

After an appointment is made, that time is reserved for you. It is important you understand that in the event you need to cancel or change your scheduled appointment, our practice requests a minimum of 48 hours' notice so that your time slot can be filled with somebody else**.** We do understand that a need to change or cancel an appointment sometimes occurs and all we ask is that you notify our office in advance if you cannot keep your scheduled appointment. "No show" and last-minute cancellations will be charged for the hourly rate to cover the cost of your missed appointment as your time slot has been reserved for you and will go as an unused appointment if you do not appear or do not notify us at least 48 hours in advance that you cannot attend.

PROFESSIONAL FEES

Besides the fee for scheduled treatment, it is standard practice to charge on a prorated basis for other professional services you may require such as psychological testing, preparation of records and treatment summaries, or extra time for your appointment beyond what is standard (45-50 minutes). You agree to pay for any supplemental fees to cover these additional expenses. If you become involved in litigation which requires my participation, e.g., if I am served a Subpoena Duces Tecum concerning your treatment records, or if you are involved in litigation that requires me to provide a deposition, testimony or written report, you agree to pay for my professional time, in advance, in the form of a retainer to me, even if I am compelled to testify by another party. _____ (your initials required here).

PSYCHOLOGICAL TESTING, CONFIDENTIALITY AND TREATMENT RECORDS

As is the standard in the practice of psychology, when standardized tests are performed and used as part of an evaluation, raw testing data from these standardized tests will not be provided to you, your attorney, and/or any other party for any reason, and you agree not to seek the production of any such raw testing data yourself or by your attorney on your behalf. Should you be involved in a lawsuit or other action where an opposing or related party seeks to force the production of raw testing data from this office, you agree to oppose any such request for production and indemnify this office for any attorney's fees and costs associated with this office opposing any such request for production.

In general, the confidentiality of all communications between patient and psychologist is protected by law, and I can only release information about our work to yourself or others with your written permission. However, exceptions to this include: dangerousness to self and others, child/elder abuse or suspicion of child/elder abuse, and certain court proceedings that involve mental health issues, such as child custody proceedings. Such situations rarely arise in my practice. However, should such a situation occur, I may be legally obligated to break confidentiality ____(please initial).

PAYMENT FOR EVALUATION AND TREATMENT SERVICES

Due to ongoing challenges with insurance and managed care, our office has chosen not to participate with insurance companies. However, at your request, our office will be happy to provide you with a receipt including diagnosis and procedure code so that you may file a claim form on your own for reimbursement directly through your insurance company. Please keep in mind that once you send in this receipt, your insurance company may request a copy of our treatment records, including all notes from our visits. If you desire that we release your treatment records to your insurance company or any other entity, e.g., your employer, your attorney, etc., you will be required to sign an authorization for release of confidential treatment records.

Please do not hesitate to ask me any questions that you may have either today or at any future appointments that we may have together.

Your signature below indicates that you have read the information in this 3-page document and agree to abide fully by its terms during our professional relationship.

Financial Responsibility and Informed Consent Agreement for Psychological Treatment

I agree to full financial responsibility for this psychologist in person or virtual (e.g., telehealth) appointment, and any subsequent appointments. I have been informed and agree that payment is due on the day of my appointment and agree to pay for today's visit. Please print the following information:

Name: _____

E-Mail Address:
_____

Date of Birth: _____

Home Address: _____

City _____ State _____ Zip Code _____

Telephone (Cell) _____ (Work) _____

How will you pay for visits?

Cash: _____ Credit Card _____ (please circle one: Amex or Visa?)

Credit card #: _____Security Code: _____ Expiration date: _____

Zip Code: _____

Thank you for consulting my practice. I look forward to working with you to assist you in achieving your goals.

Signature _____ Date _____