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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. Once you sign this form, it will constitute a binding agreement between us.

## 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 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. However, there can never be guarantees about treatment outcome. 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 help you obtain a referral to another provider.

## APPOINTMENTS and SCHEDULING

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 emergencies sometimes arise and all we ask is that you do your best to notify our office in advance if you cannot keep your scheduled appointment in the event of an emergency. "No show" and last minute cancellations require that you pay a $50. fee 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 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 this expense. 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).

CONFIDENTIALITY AND PROFESSIONAL RECORDS

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 abuse or suspicion of child abuse, and court proceedings of any kind including child custody proceedings. Such situations rarely arise in my practice. However, should such a situation occur, I will be legally obligated to break confidentiality. _____ (your initials required here).

PAYMENT FOR EVALUATION AND TREATMENT SERVICES

**Due to ongoing challenges with insurance and managed care companies, our office does not participate as a provider with your insurance company.** 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 your 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.

MY PRACTICE IS COMMITTED TO PROVIDING HIGH QUALITY CARE

I strive to provide you, my patient, with the most current and effective techniques to assist you in achieving your expressed goals and overcoming any obstacles that you may be experiencing in your life. I will do everything in my power to provide quality clinical services to you. I often spend a great deal of time researching the most effective treatment interventions available outside of our sessions. In the event that I feel the need to consult with other professionals so that I may be able to further enhance my services to you, I will ask your permission before I do so. 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 appointment, and any subsequent appointments. I agree that you may use collection services to obtain payment from me in the event that I accumulate any outstanding balance due for my services with you. I have been informed and agree that payment is due at the time that services are rendered and agree to pay for today's visit at this time.**

Name _____

E-Mail Address:
_____

Date of Birth _____ Employer Name: _____

Home Address _____

City _____ State _____ Zip Code _____

Telephone (H) _____ (W) _____ Cell _____

How do you intend to pay for these services?
Cash _____ Credit Card _____ (please check one)

**In order to provide you, the patient, with more quality time, it is required that payment be made before today's session begins.**

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

Signature _____ Date _____