Welcome to my practice. This document contains important information about my professional services and business policies. Please read it carefully and note down 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. 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 24 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.
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). Since most behavioral health insurance policies will not reimburse for testing, you agree to pay for any supplemental fees to cover this expense. If you become involved in litigation which requires my participation, you will be expected to pay for my professional time even if I am compelled to testify by another party.

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 child custody proceedings. Such situations rarely arise in my practice. However, should such a situation occur, I will be legally obligated to break confidentiality.

PAYMENTS AND INSURANCE REIMBURSEMENT

The majority of patients at our office will be paying in full at the time that services are rendered. If requested, we will be happy to provide a “super bill” including diagnosis and procedure code, which you can file with your insurance company for reimbursement directly to you.

Due to ongoing challenges with insurance and managed care companies, our office has chosen to work with only a very small number of selected companies. In those cases, our office will file the claims with these selected companies. There is frequently a required co-payment which will vary by plan and coverage. All co-pays are required at the time that services are rendered. There may also be annual deductible costs to be met before insurance coverage applies. In such cases, you will be required to make payments until your deductible is satisfied at the time that services are rendered. If, for any reason, your insurance company authorizes treatment visits but later declines to reimburse us for the services rendered, you agree to be fully responsible for all remaining balances. You should be aware that insurance companies frequently provide information that is not correct, or can change their coverage for you without warning, and that my practice cannot therefore know for certain if we will receive any payments from them on your behalf. If, for any reason, your account is more than 45 days in arrears and suitable arrangements for payment have not been made, you agree to pay us in full, and that we have the option of using legal means and/or collections to secure payment. In the event of default of payment, you agree to pay all attorney fees and collection costs, as well as late fees.

Your signature below indicates that you have read the information in this 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. If I do not have adequate health insurance to cover my charges, if my insurance expires or changes in any way, or if my insurance company declines to cover me for any reason, or delays over 45 days to reimburse your office for my balance due, I agree to pay you directly for all costs incurred from my treatment, and/or any balances which remain following insurance payment. I agree that you may use or disclose/release my records, notes and psychological test results to my insurance company or other entities involved in collecting amounts owed for treatment services. I agree that you may use collection services to obtain payment from me if I do not clear my balance within the 45 day period noted above.

Name __________________________________________________________

E-Mail Address: __________________________________________________

Insurance ID# ____________________ Group # ______________________

Date of Birth ___________ Employer Name: _______________________

Home Address __________________________________________________

City _______________________ State _______ Zip Code _____________

Telephone (H) _____________ (W) _____________ Cell _____________

How do you intend to pay for your visits?

Cash ______ Check* _______ Credit Card _______ (please check one)

*Checks returned for insufficient funds will be assessed a $35.00 fee to cover costs charged by our bank. _____________ (your initial is required here)

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 your cooperation.

Signature __________________________________ Date ________________

Treatment contract 2/2015