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OUTPATIENT SERVICES CONTRACT

Welcome to my practice. This document contains important information about my professional services and business policies. Please read it carefully and jot down any questions you might have so that we can discuss them. When you sign this document, it will represent an agreement between us.

THERAPEUTIC SERVICES

Psychotherapy is not easily described in general statements. It varies depending on the personalities of the psychologist and patient, as well as the particular problems you bring forward. There are many different methods I may use to address the problems you hope to address. Psychotherapy is not like a medical doctor visit. Instead, it calls for an active effort on your part. In order for the therapy to be most successful, you will have to work on things we talk about both during our sessions and at home

Psychotherapy can have benefits and risks. Since therapy often involves discussing unpleasant aspects of your life, you may experience uncomfortable feelings like sadness, anger, frustration, and helplessness. On the other hand, psychotherapy has also been show to have benefits for people who pursuit it. Therapy often leads to better relationships, solutions to specific problems, and significant reductions in feelings of distress; however, there are no guarantees of what you might experience.

Our first session or two will involve an evaluation of your needs. By the end of the evaluation, I will present some initial impressions of what our work will include and we will collaborate in developing a treatment plan. You should also evaluate this information with your own opinions of whether you feel comfortable working with me. Therapy involves a significant commitment of time and energy, so I urge you to be very selective about the therapist you choose. If you have questions about my procedures, we shall discuss them whenever they arise.

MEETINGS

An initial evaluation may last for one to two sessions. During this time, we can both decide if I am the best person to provide the services you need to meet your treatment goals. If psychotherapy is begun, sessions will be scheduled collaboratively and last between 45 and 60 minutes.

BILLING AND PAYMENTS

A monthly billing statement will be sent for charges payable out of pocket or applied to your deductible. The balance is expected within 30 days. Co-insurance amounts and copayments are collected at each appointment. I accept Visa, Mastercard, cash, or personal checks. If a personal check does not clear your bank, a $25 fee will be added to your balance and no further checks will be accepted.

INSURANCE REIMBURSEMENT

Your health insurance policy will usually provide some coverage for mental health treatment. I recommend you contact your insurer directly to get information about outpatient mental health benefits including coverage, deductible amounts, and copayments.

CONTACTING ME

I am frequently not immediately available by phone. While I am in my office Monday, Tuesday, Thursday, and Friday, I will not answer the phone when I am with a patient. When I am unavailable, my telephone is answered by a secure Google voicemail. I will make every effort to return your call the same day, with the exception of weekends

and holidays. If you have an emergency situation, and are unable to reach me, please contact your primary care physician or the nearest emergency room.

PROFESSIONAL RECORDS

The laws and standards of my profession require that I keep treatment records. Because these are professional records, they can be misinterpreted and/or upsetting to untrained readers. I recommend that we review them together so that we can discuss the contents.

MINORS

If you are under 19 years of age, please be aware that the law provides your parents or guardians the right to examine your treatment records. It is my policy to request an agreement from parents that they waive access to your records. If they agree, I will provide them only with general information about our work together. A significant exception to this situation is whether I feel there is a high risk that you may harm yourself or someone else. If this occurs, I must honor my role as a mandated reporter, but will discuss this with you beforehand.

CONFIDENTIALITY

In general, the privacy of all communications between patient and psychologist is protected by law and I can only release information about our work with your written permission. However, there are a few exceptions.

In most legal proceedings, you have the right to prevent me from providing any information about your treatment. In some proceedings involving child custody or those in which your emotional condition is an important issue, a judgment may order my testimony if he/she determines that the issues demand it.

There are some situations when I am legally obligated to take action to protect others from harm, even if I must reveal some information about a patient's treatment. Examples include abuse of a child, an elderly person, or a disabled person. In these cases, I must file a report with the appropriate state agency.

If I believe that a patient is threatening serious bodily harm to another, I am required to take protective actions. These may include notifying the potential victim, contacting the police, or seeking hospitalization for the patient. If a patient threatens to harm himself/herself, I may be obligated to seek hospitalization for him/her or to contact family members or others who can provide protection. Such actions have rarely occurred in my practice.

I occasionally may find it helpful to consult other professionals about a case. During a consultation, I make every effort to avoid revealing the identity of my patient. The consultant is also legally bound to keep the information confidential. If you don't object, I will not tell you about these consultations unless I feel it is important to our work together.

In the event of my untimely death or incapacitation, your file will be transferred to and released to my designee.

While this written summary of exceptions to confidentiality should provide helpful information, I encourage you to address any questions or concerns that you may have.

Your signature below indicates that you have read this Outpatient Services Contract and agree to abide by its terms during our professional relationship.

Printed Name	Signature	Date Signed
(if Minor) Printed Name of Parent/Guardian	Parent/Guardian Signature	Date Signed