**Lilia Sheynman, PhD**
*Clinical Psychologist*
*Lic# PSY26066*

(562) 246-6276
www.CoastalTherapyLB.com Info@CoastalTherapyLB.com

## PSYCHOTHERAPY SERVICES AND POLICIES

This document contains important information about my professional services and business policies. Please read it carefully and ask me any questions that arise. When you sign this document, it represents an agreement between us.

### PSYCHOLOGICAL SERVICES

Psychotherapy varies depending on the particular problems you bring and the approach of the therapist. It is important to select a therapist that fits your style and goals. By the end of the intake evaluation, I will be able to offer you my recommendation of whether you can benefit from my services. Therapy involves a commitment of time, money, and energy, so you should make sure you feel comfortable working with me. If you have questions about our work together, we should discuss them whenever they arise.

### CONFIDENTIALITY

Your discussions with a licensed psychologist are considered *confidential,* which means that these discussions are protected by law. I may not disclose confidential information about you without your formal consent. There are situations, however, in which I am required to break confidentiality. These include the following circumstances: if you are in danger of harming yourself or another person; if you are unable to care for yourself; if there is suspected abuse or neglect of a child, older adult (65 or older), or dependent adult; if I am court-ordered to release information as part of a legal proceeding; or as otherwise required by law.

### PROFESSIONAL FEES, BILLING, AND PAYMENTS

Payments are to be made at the *beginning* of each individual appointment, program, or service. Cash, checks or credit cards are accepted. I accept Visa, MasterCard and American Express._Please make checks payable to Dr. Lilia Sheynman.

**Individual Sessions:** The initial session fee is $220. My session fee is $170. There will be no charge for ***brief*** telephone calls and ***quick*** e-mail exchanges (i.e., limited to updates and scheduling).

Other services include telephone consultations, report writing, psychological assessment (testing), or other services you may request of me at my regular rate, including travel time. I do not charge for typical consultations with other professionals involved in your car (i.e. psychiatrist). If you do become involved in legal proceedings that require my participation, you will be expected to pay for the professional time I spend preparing records or treatment summaries. You will also be expected to pay for my time spent testifying.

**Cancellation Policy:** There is a 24-hour cancellation policy for all appointments. Should you cancel or no-show with less than a 24-hour notice *for any reason,* you will be charged the full session fee.

**Late Fees:** There is a $15 fee for returned checks. A late fee will be added for any charges past due by 30

days, with additional charges accruing monthly. If your account has not been paid for more than 60 days, I may use legal means to secure the payment and include its costs in the claim.

## INSURANCE REIMBURSEMENT

Certain health insurance policies will provide some coverage for “out of network” mental health treatment, however, you (not your insurance company) are responsible for full payment of my fees. You will be provided with **superbills** that contain information your insurance company may require, however, it will be your responsibility to complete insurance forms and obtain reimbursement. It is very important that you find out exactly what mental health services your insurance policy covers and the status of your deductible. Of note, insurance companies typically do not reimburse for missed sessions.

## CONTACTING ME

You may contact me by phone at (562) 246-6276 or by email at info@coastaltherapylb.com. Although I am often not immediately available by telephone, I check my voicemail regularly. If you are unable to reach me and feel that you cannot wait for me to return your call, contact your family physician, your psychiatrist, or the nearest emergency room. It is important to note that I do not provide crisis services and am **not** available 24 hours a day. If you need immediate, emergency assistance, please call 9-1-1 or, if it is safe to do so, go to the nearest emergency room. I can provide you with a list of local hospitals.

It is important to note that although the internet provides a fast and convenient method of communication, confidentiality cannot be guaranteed through electronic mail, as e-mails can sometimes be intercepted. Similarly, it is possible for wireless phone conversations to be overheard. Please inform me in advance if you have concerns about privacy through e-mail or wireless phone use.

## ENDING THERAPY

You may end therapy at any time. A final individual session is important so that you have closure with me as your therapist.

Please Note: This policy is subject to change at any time; current clients will be kept updated.

I have read and understand this document and I have had my questions answered to my satisfaction. I accept, understand, and agree to abide by the contents and terms of this agreement. Please initial the statements below to indicate your agreement and sign below to indicate your consent for treatment:

______(initial) I understand that cell phone and e-mail correspondence can potentially be intercepted and is therefore not guaranteed to be confidential.

______(initial) I understand that individual therapy and consultation appointments must be cancelled more than 24 hours before the scheduled appointment to avoid paying the full fee. I further understand that once an appointed is scheduled, it is my responsibility to record the date and time. Reminders are not given.

______(initial) I understand that I will be charged for phone calls beyond 15 minutes and for lengthy e-mail exchanges. I will be warned of a charge beforehand.

______(initial) I understand that Dr. Sheynman does not directly bill insurance. Dr. Sheynman will provide me with a "superbill" to submit to a PPO insurance company periodically for past sessions. Insurance does not reimburse for missed sessions.

______(initial) I certify that a copy of Dr. Sheynman's Notice of Privacy Practices detailing the provisions of HIPAA and my privacy rights was made available to me.

______________________________
Name of Client (please print)

______________________________ ________________
Signature of Client/Legal Guardian Date