Sarah Hermann Russell, Ph.D., HSPP
Licensed Psychologist

INTRODUCTION TO PSYCHOLOGICAL SERVICES

Welcome to my practice. I am pleased to have the opportunity to work with you and hope that his handout will provide information helpful in making an informed decision about my services. Please ask any questions at any time, you are entitled to be fully informed.

Professional Background: I was awarded a Bachelor of Art degree in Psychology from Skidmore College in Saratoga Springs, NY. I received my Master's of Art degree in Child Development from Tufts University in Medford, MA. I completed my Ph.D. in Counseling Psychology at Temple University in Philadelphia, PA. I completed pre-doctoral clinical training at Hahnemann University Hospital in Philadelphia and post-doctoral training, specializing in child and family psychology, at the Medical College of Pennsylvania-Hahnemann University Hospital.

Appointments: My services are available by appointment only. Initial sessions are scheduled for 75 minutes. Individual sessions are scheduled for 45 minutes. Because the appointment is reserved for you, notice of cancellation must be received at least **24 hours** in advance of the scheduled appointment in order to avoid a charge equivalent to the appointment fee. Exceptions will be made when we mutually determine that the appointment was cancelled without notice due to an emergency. My practice is an individual private practice and although there are other therapists in the office suite, our clinical and financial policies may vary. My professional records are confidential and in accordance with the HIPAA privacy rule, no one may have access to them without your specific permission.

Messages: I do not accept phone calls while I am in session. When I am in session or out of the office, my calls are answered by my voicemail. I check my voicemail frequently and I attempt to answer all calls the same day I receive them. If you have an emergency, and cannot reach me at my office, please follow the instructions on my voicemail for clinical emergencies. When I am unavailable for extended periods of time, calls identified as "an emergency" will be returned by one of my colleagues who is also a licensed Health Service Provider in Psychology. I will return all other calls when I get back into the office.

Treatment: I expect and encourage you to obtain knowledge of the procedures, goals, and possible side effects of psychotherapy. Therapy is essentially a relationship between the client and therapist. The initial focus of therapy is to understand the thoughts, feelings, and life situations that concern you as a client. Therapy may then offer support, development of specific skills, and direction to facilitate your desired changes. As a client, you have the responsibility to decide your ultimate course of action. Formal and informal assessment of feelings and behavior, readings, structured experiences, journal writing, and other "homework" are often suggested to augment your therapy experience.

Client's Rights: At any time my clients may question and/or refuse therapeutic or diagnostic procedures, or obtain any additional information about the process and course of therapy. You also have the right to seek a second opinion form another clinician. Clients are assured of confidentiality that is protected by both professional ethical standards and Indiana State law. There are, however, important exceptions to confidentiality that are legally mandated and are in compliance with federal HIPAA regulations. In general terms, these exceptions include: 1) notifying relevant others (such as intended victim, parent, or police) if my client expresses intent to harm his or herself or another person; 2) reporting any suspected cases of child abuse, neglect, or sexual molestation; 3) reporting any incidence of abuse of the elderly; and 4) in legal cases, I or my records, may be subpoenaed by court order. Confidentiality will be respected in all cases within the legal and ethical limits of psychological practice. Any time there is a need to release information from your records, it will be discussed with you and you must sign a "Release of Information" form, even if you request the release.

70 E. 91st Street, Suite 201
Indianapolis, IN 46240
(317) 566-2802

When working with adolescents, I believe that therapy will be most effective if the adolescent experiences therapy as a private dialogue. Thus, when appropriate, I propose that confidentiality be maintained between the adolescent client and me, except when I deem it necessary to inform parents of the content of treatment. At those times, the adolescent client will be told that his or her parents must be informed of a specific issue and the client will participate in this conversation. Adolescent clients may be assured that I will respect their need for confidentiality. Parents should know that I will use my clinical judgment to determine when it is necessary to breach confidentiality to inform them of a particular therapeutic issue.

In the treatment of minors, my primary role is to form a therapeutic alliance with your child, so that I may respond to his/her emotional needs. I do not conduct custody evaluations or make determinations about such issues. Consequently, if the parents of a minor child are, or ever should become, involved in a divorce or custody dispute, I ask that parents understand and agree that I will not provide any psychological evaluations, court testimony, or custody recommendations. Providing these services is likely to undermine the minor's therapy. Should any such evaluations or testimony be required, an independent mental health professional should be consulted.

Termination: Termination of psychotherapy may occur at any time and may be initiated by either the client or therapist. I request that if a decision is being made to terminate treatment, that there be a minimum of one session notice so that the reasons for termination may be discussed. This phase of treatment is often a very constructive and useful process. If a referral for further services is warranted, it may be made at this time.

Charges: The charges for my services are based on the usual, customary, and reasonable fee profile for this area. My charges are $160.00 per 45-minute clinical hour, $175 for 60-minute family therapy session, and $200.00 for a 75-minute initial session. This fee includes my time on your behalf, including record keeping, session preparation, routine telephone calls, and professional phone calls to teachers and other health professionals. Periodically, I may deem it necessary to raise my hourly fee. You will be notified in person or by mail of any increases to my fee schedule. Fee information regarding psychological testing, school consultations or other services is available upon request. Payment is expected at the end of each session. I encourage you to make out your check in advance of the session so that we may spend all of our time discussing your concerns. Checks may be made out to Sarah Hermann Russell, Ph.D. Outstanding balances may be referred to a collection agency. Clients may be responsible for any attorney fees associated with collecting outstanding debt.

Insurance: If you have health insurance, your insurance company may reimburse some portion of the cost of your visit. Please be sure to check with your insurance company to clarify your policy's mental health coverage. I am willing to work with you to secure reimbursement from your insurance company; however, payment for services is ultimately your responsibility.

Consent for Mental Health Services

- I have read the materials presented in this introduction/disclosure statement. My signature indicates that I understand the information and agree with the conditions of therapy as stated or implied here.
- I agree and consent to participate in the mental health services provided by Dr. Russell, a psychologist, as defined in Indiana law.
- I understand that I am consenting to those mental health services that Dr. Russell is qualified to provide within the scope of her license, training, and experience.
- I understand that this agreement does not guarantee that we will attain my goals; however, I agree to pay Dr. Russell's fee for access to her resources as a psychologist and her willingness to apply those psychological resources in good faith.
- I further stipulate that this agreement will become a part of my psychological record that is accessible to Dr. Russell, and myself but to no other person without my written consent.

______________________________ ______________________________ __________

Name (printed) Signature Date

____

Sarah Hermann Russell, Ph.D., HSPP