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OUTPATIENT SERVICES AGREEMENT

Welcome to the Family and Educational Wellness Center practice. This document contains important information about our professional services and business policies. Please feel free to ask us any questions you may have related to the document. Once you sign the document, it will represent an agreement between us.

PSYCHOLOGICAL SERVICES

Psychotherapeutic approaches and treatment goals will vary depending on the particular presenting difficulties, the age of the client, and family circumstances. Psychotherapy requires an active effort on your part and constant communication is essential to determining the progress of the treatment. Psychotherapy can have benefits as well as risks. You may experience some distress while discussing unpleasant aspects of your situation. However, research indicates that psychotherapy can be beneficial in addressing emotional difficulties. Therapy may often lead to improved sense of wellbeing, better relationships, and increased abilities to problem solve. However, there are no guarantees about the final outcomes.

During our first two or three sessions, we will discuss an evaluation of your needs. When therapy is sought for children, the first session will be for parents or caretakers only, the second session will include the child, and the third session will be used to discuss impressions and recommendations. As needed, additional sessions may be used for further evaluation. Once we discuss recommendations, you should consider this information along with your own opinions of whether you feel comfortable working with our clinician. If you have any questions about our procedures, we will be happy to discuss them at any time. If we are not able to establish a working relationship, we will assist you in finding another referral.

CLINICAL SESSIONS

If you decide to begin a therapy relationship with one of our clinicians, he/she will discuss with you how frequently sessions should be scheduled. Sessions last for 50 minutes. Once a session is scheduled, you will be expected to pay for it unless you provide 24 hours advance notice of cancellation (unless we both agree you were unable to do so given an emergency or circumstances beyond your control). We cannot guarantee rescheduling an appointment for that same week.

PROFESSIONAL FEES

Our hourly rate is ____. In addition to appointments, we charge this amount for other professional services you may need, though we will break down the hourly cost if we are engaging in work periods of less than one hour. Other services include report writing, telephone conversations lasting longer than 15 minutes, attendance at meetings with other professionals you have authorized, and preparation of records or treatment summaries.

BILLING AND PAYMENTS

You will be expected to pay for each session at the time it is held, unless we agree otherwise or unless you have insurance coverage which requires another arrangement. Payment schedules for other professional services will be agreed to when they are requested. [In circumstances of unusual financial hardship, we may be willing to negotiate a fee adjustment or payment installment plan.]

Not all our clinicians are currently covered by insurance panels – please communicate with our individual clinicians to review coverage with your plan. If we are not on your insurance panel and you would like to begin services with one of our clinicians, you will be required to pay privately. Payment is due at the time of the session.

If your account has not been paid for more than 60 days and arrangements for payment have not been agreed upon, we have the option of using legal means to secure the payment. This may involve hiring a collection agency or going through small claims court. [If such legal action is necessary, its costs will be included in the claim.] In most collection situations, the only information we release regarding a patient's treatment is his/her name, the nature of services provided, and the amount due.

INSURANCE REIMBURSEMENT

In order for us to set realistic treatment goals and priorities, it is important to evaluate what resources you have available to pay for your treatment. If you have a health insurance policy, it will usually provide some coverage for mental health treatment. We will fill out forms and provide you with whatever assistance we can in helping you receive the benefits to which you are entitled; however, you (not your insurance company) are responsible for full payment of our fees. It is very important that you find out exactly what mental health services your insurance policy covers.

You should carefully read the section in your insurance coverage booklet that describes mental health services. If you have questions about the coverage, call your plan administrator. Of course we will provide you with whatever information we can based on our experience and will be happy to help you in understanding the information you receive from your insurance company.

Due to the rising costs of health care, insurance benefits have increasingly become more complex. It is sometimes difficult to determine exactly how much mental health coverage is available. "Managed Health Care" plans such as HMOs and PPOs often require authorization before they provide reimbursement for mental health services. These plans are often limited to short-term treatment approaches designed to work out specific problems that interfere with a person's usual level of functioning. It may be necessary to seek approval for more therapy after a certain number of sessions. While a lot can be accomplished in short-term therapy, some patients feel that they need more services after insurance benefits end. [Some managed-care

plans will not allow me to provide services to you once your benefits end. If this is the case, we will do our best to find another provider who will help you continue your psychotherapy.]

You should also be aware that most insurance companies require you to authorize us to provide them with a clinical diagnosis. Sometimes we have to provide additional clinical information such as treatment plans or summaries, or copies of the entire record (in rare cases). This information will become part of the insurance company files and will probably be stored in a computer. Though all insurance companies claim to keep such information confidential, we have no control over what they do with it once it is in their hands. In some cases, they may share the information with a national medical information databank. We will provide you with a copy of any report we submit, if you request it.

Once we have all of the information about your insurance coverage, we will discuss what we can expect to accomplish with the benefits that are available and what will happen if they run out before you feel ready to end our sessions.

Our insurance billing is conducted through a third party. You are responsible for co-pays associated with your plans. Copays may be paid at the time of the session, or you may elect to have a monthly bill sent to you.

CONTACTING US

We are often not immediately available by telephone. When we are unavailable or seeing clients, our calls will be answered by voice mail. Please feel free to leave us a confidential voice mail. We will make every effort to return your call on the same day you make it, with the exception of weekends and holidays. If you are only available during certain time periods, please indicate so on your voice mail message, with specific information about when you are able to take a phone call. In case of an emergency, please contact your family physician or the nearest emergency room and ask for the mental health provider on call. If the provider with whom you are working will be unavailable for an extended period of time, coverage plans will be discussed with you prior to this time.

PROFESSIONAL RECORDS

The laws and standards of our profession require that we maintain treatment records. You are entitled to receive a copy of your records, or we can prepare a summary for you. If you wish to see your records, we recommend that we view them together first to discuss the contents.

MINORS

If you are under 18 years of age, please be aware that the law may provide your parents/guardians the right to examine your treatment records. If one of our clinicians feel that there is a high risk that you will seriously harm yourself or someone else, we will notify your parents/guardians immediately.

CONFIDENTIALITY

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

1. In most legal proceedings, you have the right to prevent your clinician from providing any information about your treatment. In some proceedings involving child custody and those in which your emotional condition is an important issue, a judge may order your clinician's testimony if he/she determines the issues demand it.
2. If one of our clinicians believes a child (or elderly or disabled person) is being abused, we are legally required to file a report with the appropriate state agency.
3. If one of our clinicians believes a client is threatening serious bodily harm to another, we are legally required to take protective actions. These actions may include notifying the potential victim, notifying the policy, or seeking hospitalization for the client.

It is important that we continue to have open communication about any concerns you may have regarding confidentiality. Please feel free to raise any questions you may have with your clinician.

Your signature below indicates that you have read the information in this document and agree to abide by its terms during our professional relationship.

_____
Client Name – please print

_____
Client Signature

_____
Parent/Guardian Name (if client is a minor) – please print

_____
Parent/Guardian Signature

_____
Today's Date

CONSENT FOR TREATMENT

I am a person over 18 years of age with full legal authority to consent to treatment. I give permission for _____(clinician) to provide treatment which may include assessment, advocacy, referral and mental health counseling.

Signature: _____

Print Name: _____

Date: _____

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CONSENT FOR CHILD TREATMENT

I am the parent/legal guardian of _____ with full legal authority to consent to treatment. I give permission for _____(clinician) to provide treatment for this child which may include assessment, advocacy, referral and mental health counseling.

Signature: _____

Print Name: _____

Relationship to Child: _____

Date: _____