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Clinical Psychologist
PSY10597

Welcome to my practice. This document contains important information about my professional services and business policies. It also contains summary information about the Health Insurance Portability and Accountability Act (HIPAA), a federal law that provides privacy protections and patient rights about the use and disclosure of your Protected Health Information (PHI) for the purposes of treatment, payment, and health care operations. Although these documents are long and sometimes complex, it is very important that you understand them. When you sign this document, it will also represent an agreement between us. We can discuss any questions you have when you sign them or at any time in the future.

APPOINTMENTS

Appointments will ordinarily be 50 minutes long, once per week at a time we agree on, although some sessions may be more or less frequent as needed. More frequent meetings may be arranged to facilitate more intensive work or may be recommended in order to meet your particular needs.

If you need to cancel or reschedule a session, I ask that you provide me with 24 hours notice. If you miss a session without canceling, or cancel with less than 24 hour notice, you will be responsible for payment [unless we both agree that you were unable to attend due to circumstances beyond your control]. It is important to note that insurance companies DO NOT provide reimbursement for cancelled sessions. Please note that if you are late, your appointment will still need to end on time.

My standard fee is ____$200.00_____ and you are responsible for paying at the time of your session unless prior arrangements have been made (ie Medicare). If you have a co-payment with your insurance, please be prepared to pay for it at each session. Payment must be made by ZELLE, check or cash; I am not able to process credit card charges as payment. Any checks returned to my office are subject to an additional fee of up to $25.00 to cover the bank fee that I incur. If you refuse to pay your debt, I reserve the right to use an attorney or collection agency to secure payment.

INSURANCE

If you have a health insurance policy, it will usually provide some coverage for mental health treatment. With your permission, my billing service and I will assist you to the extent possible in filing claims and ascertaining information about your coverage, but you are responsible for knowing your coverage and for letting me know if/when your coverage changes.

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 advance authorization, without which they may refuse to 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.

AUTHORIZATION FOR PAYMENT TO PROVIDER

_____ _____
Signature of Patient or Personal Representative Date

COMMUNICATION

For appointment scheduling or rescheduling, it is best to leave both an email and a phone message on my voice mail. If I haven't responded to your phone call within 8 hours, please call me again. I will do my best to respond to you as quickly as I can. Please be aware that I am working at CSU Northridge three days a week and will often not be able to respond to your message until the evening.

YOUR RIGHTS AS A CLIENT

My job and goal as a therapist is to help you identify and work towards achieving your goals. If at any time, you are not happy with what is happening in therapy, I hope you will talk with me so that I can respond to your concerns. If you feel that these concerns cannot be resolved, you may request that I refer you to another therapist. You may end therapy at any time. You have the right to ask questions about any aspects of therapy and about my specific training and experience. You have the right to expect that I will not have social or sexual relationships with clients or with former clients.

Before signing, please feel free to ask me any questions about any of the above information.

CONSENT TO PSYCHOTHERAPY

Your signature below indicates your consent for treatment and that you have read this Agreement and the Notice of Privacy Practices and agree to their terms.

_____
Signature of Patient or Personal Representative

_____
Printed Name of Patient or Personal Representative

Date _____