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PATIENT AGREEMENT AND NOTIFICATION

This document contains important information about my professional services and business practices. Please read it carefully. It notifies you of many of your rights and responsibilities and will represent an agreement between us, unless it is amended or terminated in writing.

PROFESSIONAL SERVICES

Treatment may include discussion of issues that are uncomfortable for you. While I am using my best professional judgment for your wellbeing, I cannot guarantee that you will obtain the results you seek. You have the right to challenge any aspect of the treatment I recommend. If you believe I have mismanaged your treatment or your privacy please discuss this with me and you may also report any concerns you have to the Board of Psychology at 800-633-2322 and/or the U. S. Department of Health and Human Services at 877-696-6775.

CONFIDENTIALITY

In general, the confidentiality of all communications between a patient and a psychologist is protected by law and I can only release information about your treatment to others with your written permission. However, there are some situations in which I am legally entitled or even required to release patients' protected health information without their authorization. To improve your treatment, I can release this information so I can consult with other professionals. Unless you instruct me otherwise, I will not tell you when I have these consultations. If applicable, I may release information to your insurance company to obtain authorization for treatment, payment or for other purposes, such as for quality improvement programs. In these cases, I will release only the minimum information necessary to accomplish the specific purpose for which the information was requested. In some situations, I can also be compelled to release patient records by the courts and by the Board of Psychology.

In the following situations, I must take action to protect people from harm, even though that requires revealing some information about a patient's treatment. If I believe that a child, an elderly person, or a disabled person is being abused, I must file a report with the appropriate agency. If I believe that a patient is imminently dangerous to themselves or to another, I am required to take protective actions which may include contacting authorities, family members or others who can help provide protection. I will inform you of these reports.

The standards of my profession require that I record and maintain appropriate treatment records. You are entitled to request a copy of any protected health information or any communication from me in a variety of means and locations. You have the right to request that your information be amended or restricted from certain uses and disclosures. While I will seek to honor your requests, I may decide that it is not prudent for me to agree to your requests.

FEES

By engaging in treatment you are agreeing to pay my fee of $150 for the initial visit and $250 for conjoint and $150 for individual visits each 45-minute sessions. If an appointment is missed or canceled with less than 24 hours notice, you will be billed $75 with few exceptions.

Your signature indicates that you have received a copy, read, understood, and are willing to abide by the above agreement and acknowledge receipt of the notice of your privacy rights.

_____ _____
Signature Date

_____ _____
Full Name Phone Number