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INFORMED CONSENT

Consent to Treatment: Our psychotherapy relationship is entirely voluntary and you may decide to end it and/or consider alternative modes of treatment any time you wish. While it's expected that you will benefit from the therapy, individual responses vary and you might, at times, experience uncomfortable feelings. Should questions regarding the treatment arise during its course, I encourage you to discuss them with me.

Limits of Confidentiality: Therapy sessions between a psychologist and client are confidential and release of Protected Health Information requires your written permission, except under certain legally defined situations: If I become aware that a client intends to self-harm, harm another or if s/he is unable to provide self-care at a level necessary for basic survival, I am ethically and legally bound to take appropriate action to protect against such dangers. State law requires the report of suspected child, vulnerable adult or otherwise dependent abuse or neglect when there is reasonable belief that it has occurred. In response to a court order, I may have to release records or testify. If you are utilizing an insurance company to reimburse you for out-of-network benefits, you will be required to consent to the release of information such as your clinical diagnosis, and your records may be reviewed. If a client files a complaint or lawsuit against me, I may disclose relevant information regarding that client in order to defend myself. At times I may employ administrative staff to help with scheduling and quality assurance practices. I may need to share protected information, such as your name and telephone number, with these individuals for purely administrative purposes. Regarding collection situations (see payment, below), I am permitted to release your name, the nature of services provided, and the amount due. Finally, on occasion to benefit the treatment, I may consult with another clinician. This is done with great respect for your privacy and identifying information is omitted whenever possible.

Professional Records: I am required to keep written treatment records. You are entitled to review and/or receive a copy of the records unless I believe seeing them would be emotionally damaging. In this case I would be happy to summarize them and/or send them to a mental health professional of your choice. Because they are professional records and might be written in technical language I suggest your review be done in my presence so that we can discuss the contents and I can answer any questions you might have.

In addition, I also keep a set of psychotherapy notes. These notes are for my own use and are designed to assist me in providing you with the best treatment. While the contents of psychotherapy notes vary from client to client, they can include the contents of our conversations, my analysis of those conversations, and how they impact your therapy. They may also contain particularly sensitive information that you may reveal to me that is not required to be included in your clinical record, and information supplied to me confidentially by others.

Your psychotherapy notes are kept separate from your clinical record. Your psychotherapy notes are not available to you, and cannot be sent to anyone else, including insurance companies, without your written, signed authorization. Insurance companies cannot require your authorization as a condition of coverage, and they cannot penalize you in any way for your refusal to provide them.

Payment and Fees: Payment for therapy, paid directly to the psychologist by check, credit card or cash is expected at the end of each session. The fee for an initial evaluation is $275 (these evaluations are 90 minutes in duration). Subsequent **individual therapy sessions** are billed at a rate of **$185 per 50 minute session** unless otherwise arranged. **Couples/ marriage and Extended Individual therapy sessions** are **75 minutes in duration and are billed at a rate of $250 per session**. If you have insurance with a company for which I am not a network provider, I will be pleased to forward any applicable information to them at your request and any reimbursement will be sent to you directly by your carrier (See below). If your account has not been paid for more than 60 days I have the option of using legal means (a collection agency or small claims court) to secure the payment.

Insurance Reimbursement: If you have a health insurance policy, it will usually provide some coverage for mental health treatment. You must file your own insurance claims. I do not employ anyone to file insurance claims. I will provide you with whatever assistance I can in helping you receive the benefits to which you are entitled; however, you, not your insurance company, are responsible for full payment of my fees. It is very important that you find out exactly what mental health services your insurance policy covers.

You should also be aware that your contract with your health insurance company requires that I provide it with information relevant to the services I provide to you. A clinical diagnosis will be required for reimbursement. Sometimes I am required to provide additional clinical information such as treatment plans or summaries, or copies of your entire clinical record. In such situations, I will make every effort to release only the minimum information about you that is necessary for the purpose requested.

This information will become part of the insurance company's files and will probably be stored in a computer. Though all insurance companies claim to keep such information confidential, I have no control over what they do with it once it is their hands. In some cases, they may share the information with a national medical information databank. I will provide you with a copy of any report I submit, if you request it in writing. By signing this Agreement, you agree that I can provide requested information to your carrier.

Patient Rights: HIPAA provides you with several new or expanded rights with regard to your clinical record and disclosures of protected health information. These rights include requesting that I amend your record; requesting restrictions on what information from your clinical record is disclosed to others; requesting an accounting of most disclosures of protected health information (PHI) that you have neither consented to nor authorized; determining the location to which protected information disclosures are sent; having any complaints you make about my policies and procedures recorded in your records; and the right to a paper copy of this Agreement, the attached Notice Form, and my privacy policies and procedures. I am happy to discuss any of these rights with you.

Appointments and Cancellation Policy: Please be aware that I will begin and end the hour according to the scheduled time and cannot add time to the end of your hour if you arrive late. In the event of a late arrival you will be charged for a full session. If you need to cancel an appointment, please notify me at least 24 hours in advance. If I do not receive such notice you will be charged for that session. Your insurance carrier will not be responsible for payment under this circumstance.

Telephone Accessibility and Emergencies: I will return calls as soon as possible or within 1 business day, should you need to speak with me between sessions. I carry an urgent message pager that can be used if you do not feel it can wait until our next session but this is not designed for life-threatening emergencies. Should a phone contact exceed 15 minutes it will be considered a full therapy session and you will be billed accordingly. Please note that while I will attempt to contact you as soon as possible, I do not provide formal emergency services. In a life-threatening situation you should either call 911 or the Broward County's crisis counseling line at 211. You can also go directly to a hospital emergency room for evaluation. If I will be unavailable for an extended time, I will provide you with the name of a qualified colleague to contact if necessary.

YOUR SIGNATURE BELOW INDICATES THAT YOU HAVE READ THIS AGREEMENT AND AGREE TO ITS TERMS. YOUR SIGNATURE ALSO SERVES AS AN ACKNOWLEDGEMENT THAT YOU HAVE RECEIVED THE HIPAA NOTICE FORM DESCRIBED ABOVE.

Signature_____

Date_____