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Licensed Psychologist
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Client Agreement

Please read the following information carefully. It contains important information regarding policies of this practice, including payment, missed appointments and emergency coverage.

INFORMED CONSENT TO TREATMENT: Psychotherapy creates a unique, more intimate type of professional relationship. This relationship functions most effectively which it remains strictly professional. As your therapist, I can best serve your needs by focusing solely on therapy and avoiding any type of social or other business connections. Counseling and psychotherapy are beneficial, but as with any treatment there are inherent risks. During counseling, you will have discussions about personal issues which may bring to the surface uncomfortable emotions such as anger, guilt, and sadness. The benefits of counseling can far outweigh any discomfort encountered during the process. Some of the possible benefits are improved personal relationships, reduced feelings of emotional distress, and specific problem solving. I cannot guarantee these benefits, however, it is my desire to work with you to attain your personal goals for psychotherapy.

Missed Appointments/Late Cancellations: The time at which we have agreed to schedule our appointments is a shared responsibility. I have set this time aside specifically for you and you agree to attend sessions. When you know of a situation that will require you to cancel the appointment, I request **24 hours notice**. This will allow me to arrange to use that time in your absence. You will be charged **$85.00** for appointments missed without adequate notice. This charge is your responsibility and cannot be billed to your insurance. I realize that emergency situations do occur, so please contact me to explain the circumstances requiring you to miss our appointment.

PAYMENT: Payment is due at the time of service. You may choose to use your health insurance if I am a contracted provider with your insurance company for Mental Health Services under your plan. I will bill your insurance company for services provided. You are responsible for deductibles and/or copayments, which are due at the time of your appointment. If I am not a contracted provider with your carrier, then the cost of services will be your responsibility and is due at the time of the appointment. Usual and customary fees for psychotherapy services are as follows:

FEE SCHEDULE:	Diagnostic & Evaluation Session (1st visit)	$195.00
	Individual psychotherapy (45-50 minutes) (Adult, Child, and Adolescent)	$130.00
	Family Sessions (45-50 minutes)	$145.00
	Brief Psychotherapy (25-30 min)	$ 65.00
	Returned check fee per check	$ 25.00

Professional Fees: There is a charge for written correspondence requested by clients. This would include letters to other practitioners, disability applications, report writing, attorney requests, etc. This service is billed at $150.00/hour with a 2 hour minimum. Insurance will not pay for written correspondence. I do not charge for customary insurance billing. Services provided outside of the office, such as school consultations, legal proceedings, etc. are charged by the hour at $150.00/hour plus travel expenses.

Fees for requested record copies will be billed at $.78/per page up to 100 pages, $.40 in excess of 100 pages, plus $25 clerical fee, and postage. There is a charge for phone consultation and phone sessions lasting longer than 10-15 minutes. Phone sessions are billed at $130/hour. here is a $25.00 fee for any returned check.

EMERGENCY COVERAGE: You can reach me by calling my office phone number 617-909-3744 during regular office hours. As I may have clients scheduled back to back, it may be necessary for me to call you after hours or before I start for the day. I will make every effort to return all non-urgent messages within 24 hours. Messages left after 8 pm and on weekends will be returned on the next business day. I will also accept and return text messages. Given that text messages are not protected by HIPAA (the privacy laws), I am only comfortable using them for scheduling purposes. In the event of a clinical emergency, please call me at 617-909-3744 and I will return your call as soon as I am able. If you cannot reach me or cannot wait for my return call, please get yourself safely to the nearest emergency room or call 911. Please also contact me to notify me of your situation. When I am scheduled to be away from the office or out of town, I will have the name of a covering therapist on my voicemail.

CONFIDENTIALITY: I follow all ethical standards prescribed by state and federal law. I am required by practice guidelines and standards of care to keep records of your counseling. These records are confidential with the exceptions noted in the Notice of Privacy Practices provided to you. Discussions between a therapist and a client are confidential. No information will be released without your written consent unless mandated by law. By signing this Client Agreement, you are giving consent to the therapist to share confidential information with all persons mandated by law and the insurance carrier responsible for providing your mental health care services and payment for those services, You are also releasing and holding harmless the undersigned Therapist from any departure from your right of confidentiality that may result.

INCAPACITY OR DEATH: I understand that, in the event of the death or incapacitation of the undersigned Therapist, it will be necessary to assign my case to another therapist and for that Therapist to have possession of my treatment records. By my signature on this form, I hereby consent to another licensed mental health professional, selected by the undersigned Therapist, to take possession of my records and provide me copies at my request, and/or to deliver those records to another therapist of my choosing.

Signature Page

CONSENT TO TREATMENT: By signing this Client Agreement as the Client or Guardian of said Client, I acknowledge that I have read, understand, and agree to the terms and conditions contained in this form. I have been given appropriate opportunity to address any questions or request clarification for anything that is unclear to me. I am voluntarily agreeing to receive mental health assessment, treatment and services for myself or my child, and I understand that I may stop such treatment or services at any time.

_____ _____

Signature – Client/Parent Date

_____ _____

Signature – Spouse/Partner/Parent Date

_____ _____

Therapist Date

I hereby authorize the release of necessary medical information for insurance reimbursement purposes.

_____ _____

Client/Parent Date

I authorize the payment of medical benefits to the provider of services.

_____ _____

Client/Parent Date