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## OUTPATIENT SERVICES CONTRACT

Counseling Services: Psychotherapy is not easily described in general statements. It varies depending on the personalities of the therapist and patient, and the particular problems you bring forward. There are many different methods used to deal with the problems you hope to address. Psychotherapy is not like a medical doctor visit. Instead, it calls for a very active effort on your part. In order for the therapy to be most successful, you will have to work on things we talk about both during our sessions and between sessions.

Psychotherapy can have benefits and risks. Since therapy often involves discussing unpleasant aspects of your life, you may experience uncomfortable feelings like sadness, guilt, anger, frustration, loneliness, and helplessness. On the other hand, psychotherapy has also been shown to have benefits for people who go through it. Therapy often leads to better relationships, solutions to specific problems, and significant reductions in feelings of distress. But there are no guarantees regarding how your life might change as the result of therapy.

Our first few sessions will involve an evaluation of your needs. By the end of the evaluation, I will be able to offer you some first impressions of what our work will include and a treatment plan to follow, if you decide to continue with therapy. You should evaluate this information along with your own opinions of whether you feel comfortable working with me. Therapy involves a large commitment of time, money, and energy, so you should be very careful about the therapist you select. If you have questions about my methods, we should discuss them whenever they arise. If your doubts persist, I will be happy to help you set up a meeting with another mental health professional for a second opinion.

PLEASE INITIAL: \_\_\_\_\_

### Charges:

**Once an appointment is scheduled, you may be charged a fee for it unless you provide 24 hours advance notice of cancellation.**

**My standard rate per psychotherapy hour is \$125. However, this varies depending on insurance coverage and some scholarships may be available.**

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 that requires another arrangement (e.g. co-pay). Payment schedules for other services will be agreed to when they are requested.

If your account has not been paid for more than 60 days and arrangements for payment have not been agreed upon, I 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 collections situations, the only information I release regarding a patient's treatment is his/her name, the nature of the services provided, and the amount due.

PLEASE INITIAL: \_\_\_\_\_

Contacting me: The office has a receptionist during most weekday business hours who would be happy to assist you. When you begin services you will be provided with an after-hours number through which I can be reached. Please do not use this number except in emergencies. In the case of a medical emergency or life-threatening situation please call 911 FIRST.

Please be advised that there will be a \$15.00 minimum charge for each after hours call for the first 1-15 minutes. After that, you will be charged \$15.00 for each additional quarter hour.

Non-emergency calls should be left on my office voice mail and will be returned the same day if possible or the next business day. If you are difficult to reach, please inform me of the best times to return your call.

PLEASE INITIAL: \_\_\_\_\_

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. Once your coverage and benefits are verified, and treatment authorized, I will submit to your insurance company a claim for the services provided to you via electronic billing. 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 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, I will provide you with whatever information I can based on my experience and will be happy to help you in understanding the information you receive from your insurance company. If it is necessary to clear confusion, I will be willing to call the company on your behalf.

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 HMO's and PPO's 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 they need more services after insurance benefits end.

You should also be aware that insurance companies require you to authorize me to provide them with a clinical diagnosis. Sometimes I 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, I have no control over what they do with it once it is in their hands. I will provide you with a copy of any report I 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. It is important to remember that you always have the right to pay for any services that are not covered by your insurance company. If your insurance company does not cover my services you must pay for services at the time they are provided.

PLEASE INITIAL: \_\_\_\_\_

Professional Records: The laws and standards of my profession require that I keep treatment records, or a treatment summary. Because these are professional records, often utilizing technical language, they can be misinterpreted and/or upsetting to untrained readers. In some cases, this can damage the therapeutic relationship or create unnecessary emotional distress. If you feel it is essential for you to see your records, I recommend that you review them in my presence so that we can discuss the contents. I will also be happy to send the summary or records to another mental health professional who is working with you and that person can review the records with you.

PLEASE INITIAL: \_\_\_\_\_

MINORS: For patients under eighteen years of age, please be aware that the law provides the parents the right to examine the minor's treatment records. It is my policy to request an agreement from parents asking that they agree to give up access to your records. If parents agree, I provide parents with only general information about my work with the minor, unless I feel there is a high risk that the minor will seriously harm him/herself or someone else. In these cases, I notify the minor of my concerns. Before giving parents any information, I will discuss the matter with the minor, if possible, and do my best to handle any objections the minor may have with what I plan to discuss.

PLEASE INITIAL: \_\_\_\_\_

CONFIDENTIALITY: In general, the law protects the privacy of all communications between a patient and a psychologist, and I can only release information about our work to others with your written permission, but there are a few exceptions.

In most legal proceedings, you have the right to prevent me 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 my testimony if he/she determines that the issues demand it.

There are some situations in which I am legally required to take action to protect others from harm, even if I have to reveal some information about a patient's treatment. For example, if I believe that a child, elderly, or disabled person has been or is being abused, I must file a report to the appropriate agency (e.g. Department Children and Families (DCF), police department).

If I believe that a patient is threatening serious bodily harm to another, I am required to take protective actions. These actions may include notifying the potential victim, contacting the police; or seeking hospitalization for the patient. If the patient expresses intent to harm him/herself, or I believe the patient is at risk for self-harm, I am obligated to seek hospitalization or to contact family members or others who can help provide protection. I make every effort to discuss this with the patient fully, if this can be done safely, before taking any action.

I may occasionally find it helpful to consult other professionals about a case. During a consultation, I make every effort to avoid revealing the identity of my patient. The consultant is also legally bound to keep the information confidential. Unless I feel that it is important to our work together, I will typically not discuss consultations with you. Please inform me if you have any objections to this.

If you need more specific advice, you may wish to seek formal legal counsel regarding the laws governing confidentiality.

PLEASE INITIAL: \_\_\_\_\_

Your signature below indicates that you have read the information in this document, agree to abide by its terms during our professional relationship, and give your consent to treatment and/or evaluation.

Signature: \_\_\_\_\_

Name Printed: \_\_\_\_\_

Date: \_\_\_\_\_