Welcome to my office. I am pleased to have the opportunity to work with you. I hope this handout will provide helpful information about my services. If you have any questions or concerns, I would like to discuss them with you.

IN CASE OF EMERGENCY

In psychiatric emergencies, please attempt to contact me directly at my office. I check for messages frequently. In extreme emergencies, go directly to your local hospital's emergency room. When I am on vacation, I will give you the name of a colleague covering my practice.

BILLING AND PAYMENT OF FEES

Payment is expected at the time of your appointment unless other arrangements have been discussed and agreed upon in advance. Your health insurance company may reimburse me for your psychotherapy. However, you are responsible for any deductible, co-payment or balance applicable to your individual policy.

INDEPENDENT PRACTICE

I am a psychotherapist in independent practice. I am the sole professional responsible for my treatment with you. No person or organization has clinical responsibility for my work with you.

CLIENT RECORDS AND CONFIDENTIALITY

Clients are assured of confidentiality, which is protected by ethical practice and law. In general, the law states that all communication between a licensed practitioner and his/her client are confidential. Any information shared will require your signed consent except where disclosure is required by law. Some legal exceptions to maintaining confidentiality are:

- Federal regulations allow me to disclose necessary data from your record in order to obtain payment from your insurance company
- If I have reason to suspect a child or elderly person is being abused or neglected.
- In circumstances in which, to the best of my professional judgment, I believe that you may be a danger to yourself or another.
- If your own mental or emotional health an issue in a court case.
- If your account is overdue and arrangements for payment have not been negotiated, a collection agency will be provided with dates of service, type of service provided and a total amount due.

Name & Address

____ Primary Care Physician
____ Organization
____ Address
____ City, State Zip

Primary Care Physician Communication Form

I, ____ authorize __________________________
PRINT CLIENT'S NAME DATE OF BIRTH THERAPIST

to release to my Primary Care Physician as described below:

Please check: ____ only the information on this page
____ no information

I understand that this authorization is voluntary and that I have the right to refuse to disclose this information. I understand that my healthcare and payment of my healthcare will not be affected by this form.

____ ______________________________
SIGNATURE OF CLIENT OR GUARDIAN DATE

OFFICE USE:

Date treatment initiated: ___________________

Provisional Diagnosis: ____

____

Provider name: ___________________________ Phone number _________________

Initial Treatment Plan:
Type of treatment ______________ Frequency _______________

Prohibition on Redisclosure
To persons receiving released information: This information has been disclosed to you from records protected by federal regulation which prevents you from making any further disclosures without specific written consent of the person to whom it pertains.