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ABOUT THE OFFICE

Welcome to my practice. I have found that many people have questions about office procedures. Hopefully this document will answer those questions. It contains important information about my professional and business policies. Please read it carefully and ask me any questions. When you sign this document it will represent an agreement between us.

PSYCHOLOGICAL SERVICES

Our first few sessions will involve a thorough history and evaluation of your current needs. If a problem requires professional services beyond the scope of my work, I will discuss this with you and recommend appropriate treatment resources. By the end of the evaluation, I will be able to offer you some first impressions on a conceptualization of the problem, what our work will include and a treatment plan we mutually agree on. At that point you should evaluate this information, along with your opinions of whether you feel comfortable working with me, in order to determine whether you would like to continue therapy. If you have any questions about my procedures we should discuss them whenever they arise.

CANCELLATION POLICY

Once an appointment hour is scheduled, you will be expected to pay the full session fee for appointments cancelled with less than 24 hours notice. I realize that situations arise that can make late cancellations or missed appointments unavoidable. Though I understand that issues come up at the last minute, I also expect reimbursement for time that has been reserved for you. I hope you understand and appreciate this policy. It is important to note that insurance companies do not provide reimbursement for cancelled sessions. Please sign here indicating that you understand and accept our policy regarding charging for late cancellations and missed appointments.

X_____

PROFESSIONAL FEES

The fee for an initial interview (60 minutes) is_____. The fee for 45 minute psychotherapy session is_____. The fee is also charged for other professional

services you may need, though I will prorate the fee for periods of less than 45 minutes. These other services include:

Extended psychotherapy sessions
Telephone calls more than 10 minutes
Report or letter writing
Review of psychological reports and/or testing material
Preparation of records, forms, or treatment summaries as requested by you or, with written permission by your insurance company
Attendance at school meetings as authorized by you
Attendance at meetings with other professional as authorized by you
Transportation and time spent to and from above meetings

I do not usually work in court involved cases. However, if you become involved in legal proceedings that require my participation, you will be expected to pay for my professional time. Fees for involvement in legal proceedings are different than the above and will be presented when requested.

BILLING AND PAYMENT

Full payment for psychotherapy is expected at the end of each session. Payment is made to me directly, NOT through your insurance company. I do not accept assignment from insurance companies. Coverage for outpatient mental health services is variable. A call to your insurance company should tell you whether these services are reimbursable within your insurance plan. The bill I will give you at the end of the session is designed to give the information requested by most insurances. However, insurance companies are variable in the amount of information they request. Some require a simple bill, others require a brief checklist of symptoms, while still others require detailed records of your diagnosis, treatment, and progress. As detailed in the section, “Professional Fees”, completion of insurance packets taking more than 15 minutes will be charged to you as a fraction of the normal session rate.

DIVORCE, CUSTODY, AND VISITATION ISSUES

I do not testify in court for the above issues. Although I routinely work with children and adults going through these difficult times, the laws of the state of New York prohibit the “treating” psychologist from being the evaluating psychologist. I do not perform evaluations, but can provide referrals to qualified professionals who can help you.

USE OF E-MAIL

At times, we may communicate via e-mail. Transmitting confidential client information by e-mail, however, has a number of risks, both general and specific, that you should consider. General e-mail risks include: E-mail may be received

by many intended and unintended recipients, recipients can forward e-mail messages to other recipients without the original sender's permission or knowledge, users can easily misaddress an e-mail, e-mail is easier to falsify than handwritten or signed documents, and backup copies of e-mail may exist even after the sender or recipient has deleted his or her copy. Specific client e-mail risks include: Employees do not have an expectation of privacy in e-mail they send or receive at their place of employment and clients who send or receive e-mail from their place of employment risk having their employer read their email; clients have no way of anticipating how soon their therapist will respond to a particular e-mail; although I try to read and respond to e-mail promptly, I cannot guarantee that any particular message will be read and responded to within any particular period of time.

Conditions for the Use of E-mail:
I will use reasonable means to protect the security and confidentiality of e-mail information. But, I am not liable for improper disclosure of confidential information not caused by our gross negligence or wanton misconduct. Additionally, because of the risks outlined above, I cannot guarantee the security and confidentiality of e-mail communication. Thus, clients must consent to the use of e-mail for confidential medical information after having been informed of the above risks. Finally, clients must not use e-mail in a medical or psychiatric emergency.

CLIENT RIGHTS

HIPAA (Health Insurance Portability and Accountability Act) provides you with several new or expanded rights with regard to your clinical records and disclosures of protected health information. Please see the attached form for these rights.

CONFIDENTIALITY AND PRIVACY OF INFORMATION

I will make every effort to safeguard the privacy of information concerning your work together. It is a violation of the District of Columbia Mental Health Information Act of 1978, as well as the Ethical Principles of the American Psychological Association, to disclose any information regarding the treatment of clients. For information to be disclosed, written consent from you must be provided.

There are several specific exceptions to the rules of confidentiality. These are listed below:
• You may authorize me to release records or other information to individuals of your choosing. I may only do this with your expressed written consent.
• Under ethical and legal requirements, I may be required to break confidentiality in the event of a clear and imminent danger to yourself or another person.

• In the event that you disclose information that provides evidence of current abuse or neglect of minor children or a vulnerable adult, the law requires that I make a report to the appropriate state agency.
• In certain legal proceedings, confidential information may be disclosed by court order. This is a rare occurrence and would not happen without your knowledge.
• If full payments are not made for sessions, your name and contact information as a client will be given to a credit collection agency.

HOW TO CONTACT ME

The best way to reach me is by telephone (914) 646-9030. I am not always available by telephone but I will make every effort to return your call the same day as you make it, with the exception of weekends and holidays. If I am unavailable for an extended period of time I will provide you with a name of a colleague to contact if necessary.

ACKNOWLEDGMENT

Your signature below indicates that you have read the information in this entire Agreement and agree to abide by all its terms during our professional relationship.

_____ _____

Signature Date

_____ _____

Signature (Of Parent, if above is under 21) Date