

PROFESSIONAL FEE INFORMATION & PSYCHOLOGIST/CLIENT CONTRACT

OUTPATIENT SERVICES CONTRACT: Welcome to my practice. This document contains important information about my professional services and business policies. Please read it carefully and discuss any questions or concerns with me. When you sign this document, it will represent an agreement between us.

PSYCHOLOGICAL SERVICES: *Psychotherapy:* Psychotherapy is not easily described in general statements. It varies depending on the personalities of the psychologist and the client and the particular problems you bring forward. There are many different methods I may use to deal with the problems that you hope to address. In order for therapy to be most successful, you will be working not only during our sessions, but also between sessions, on the information we discuss during our sessions. Psychotherapy can have benefits and risks. Since therapy often involves discussing unpleasant aspects in your life, you may experience uncomfortable feelings such as sadness, guilt, anger, frustration, loneliness, and helplessness. On the other hand, psychotherapy has also been shown to have benefits for people such as better relationships, solutions to specific problems, a decrease in problematic behaviors, and significant reductions in feelings of distress, or other negative emotions. 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 so that you can decide if you would like to begin therapy with me. Therapy involves a large commitment of time, money, and energy, so you should be mindful about the therapist you select. If you feel you would like a referral to another therapist at the end of our evaluation, or I feel your needs are best met by another medical or mental health professional and/or other community services, referrals will be made at that time. Referrals may also be made at any other time throughout treatment as I deem appropriate.

Psychological Assessments: Psychological assessments typical require two to three sessions for information gathering/testing and a final session for feedback. I also typically spend one to three weeks drafting the assessment.

FEES: *Psychotherapy:* The fee for the initial visit is \$180.00. The fee for on-going psychotherapy is \$150.00 per session. A sliding scale is offered for those who qualify and are paying out of pocket. Proof of income is mandatory for use of the sliding scale and the sliding scale is applied systematically for those who qualify. Sessions are 45 minutes in length and typically are scheduled once a week. In some instances, sessions are scheduled twice a week.

Psychological Assessments: Fees for psychological assessments are \$150.00/hour. This fee applies to all time spent gathering information/testing, interpreting testing, drafting the assessment, the feedback session, and communicating findings to anyone you sign a release of information for regarding the outcome of the evaluation.

Therapy and Psychological Assessments: If an insurance company with which I am contracted insures you, I accept its fee structure. **However, please be aware that you (not your insurance company) are responsible for full payment of fees.** It is important that you find out exactly what mental health services your insurance policy covers. Additional professional services such as report writing, telephone conversations which last longer than 10 minutes, attendance at meetings or consultations with other professionals which you have authorized, preparation of records, treatment summaries, or letters, or the time required to perform any other service which you may request of me or I determine is necessary for your care are charged in 15-minute prorated intervals basis on the \$150.00 base fee. If your insurance company does not cover these additional services, you will be responsible for payment in full. These additional fees will be discussed with you prior to my completion of the service.

If you become involved in litigation that requires my participation, you will be expected to pay for the professional time required even if I am compelled to testify by another party. Because of the complexity and difficulty of legal involvement, I charge \$300.00 per hour for all services related to any legal proceeding.

PAYMENT: Payment is due at the time services are rendered. For psychotherapy services, payment is expected at each session so please come prepared. If you have insurance, you will be responsible for your copay at each session. For assessment services, payment is expected at the time of our first appointment. You may pay by cash or check made payable to Dr. Monika Peterson. **I CAN NOT ACCEPT DEBIT OR CREDIT CARDS AT THIS TIME.** If you have an insurance plan with which I am contracted, I will bill them directly. I am then reimbursed directly by the health plan and you are responsible only for the copay. If your insurance plan is one with which I am not contracted, you will be responsible for paying me the full fee directly at the time of service. You can then apply for reimbursement from your plan. Please be advised there is no guarantee from me that your plan will cover my fees. It is your responsibility to inform me of any changes to your insurance coverage. Failure to do so may result in your liability for your total account balance. If you pay by check and the bank refuses it, a charge of \$30.00 will be assessed in addition to the original amount of the check. Unpaid balances more than 90 days overdue may be sent to a collection agency and

its cost added to your bill. Ongoing unpaid balances may result in a change to your treatment plan.

MISSED SESSIONS: If you must cancel a psychotherapy or assessment appointment, please provide notice at least 24 hours in advance of the beginning of your appointment time or by the Friday before a Monday appointment (before beginning of Monday appointment time). Without such advance notice, you will be billed for a psychotherapy session at the full rate or an hour of an assessment appointment at the full rate (See **FEES** above). Your insurance plan will not reimburse missed sessions so you will be responsible for the full session fee.

EMERGENCY SERVICES: My office hours are Mondays, Tuesdays, and Thursdays from 9:00 a.m. to 5:00 p.m. If you need to contact me in between sessions, leave a message on my confidential voicemail. Please inform me if your call is an emergency and do this for true emergencies only. Keep in mind that I do not have a 24-hour crisis service; however, I will make every effort to return your call as soon as possible. Please be advised that there may be times in which I may not be able to return the call until the next business day. If your call is urgent, you are unable to reach me directly, and you feel that you can't wait for me to return your call, please go to your nearest emergency room or call 911. You may also call UNM Psychiatric Services at 505-272-2920, which is available 24 hours, or 1-888-920-6333, which is also a 24-hour crisis line. Please also be advised that I use a cell phone for all phone calls with clients and as such, there may be limits to secure communication/confidentiality via telephone communication. **Your initials here and signature on this form indicate that you recognize the above sources are the only reliable sources for emergency services and you agree to utilize one of them if needed. Initials: _____**

CONFIDENTIALITY: In most situations, all information shared in therapy is confidential and you will need to sign a release of information for that information to be disclosed.

The following situations **do not** require a release of information:

- If there is a clear and present danger to someone's life, such as suicidal or homicidal threats.
- If information is disclosed to me of apparent abuse or neglect to a child (under 18) or vulnerable adult as I must report the abuse to the proper authorities.
- If records are subpoenaed by law.
- If you are involved in or initiate a court proceeding, the records may be used in court. **If you are involved in or contemplating litigation, you should consult with your attorney to determine whether a court would be likely to order me to disclose information.**
- If you file a complaint or lawsuit against me.
- If a government agency is requesting the information for health oversight activities.

Should a need to break confidentiality arise, I will make every effort to inform you first.

PROFESSIONAL RECORDS: The laws and standards of my profession require that I keep Protected Health Information (PHI) about you in your Clinical Record. Except in unusual circumstances that involve danger to yourself and/or others or where information has been supplied to the therapist confidentially by others, you may examine and/or receive a copy of your Clinical Record, if you request it in writing. Because these are professional records, they can be misinterpreted and/or upsetting to untrained readers. For this reason, it is recommended that you initially review them in my presence, or have them forwarded to another mental health professional so you can discuss the contents. In most circumstances, I am permitted to charge a copying fee of \$0.25 per page (and for certain other expenses such as my time).

SOCIAL MEDIA POLICY:

Email: I prefer using email only to arrange or modify appointments. Please do not email me content related to your therapy sessions, as email is not completely secure or confidential. If you communicate with me by email, be aware that all emails are retained in the logs of your and my Internet service providers. While it is unlikely that someone will review these logs, they are, in theory, available to be read by the system administrator(s) of the Internet service provider. You should also be aware that emails may be part of your clinical record and thus, may be released when a release of records is requested.

Social Networking Sites: I do not accept friend or contact requests from current or former clients on any social networking sites. I believe that adding clients as friends or contacts on these sites can compromise your confidentiality and our respective privacy. It may also blur the boundaries of our therapeutic relationship. Though it is not my standard practice to do so, at times I may use social networking sites or google to search for my clients before the beginning of treatment or during treatment. If you have questions about this, please bring them up when we meet and we can discuss this policy further.

****PARENTS AND MINORS: Please read and sign separate form entitled Parents and Minors. This form outlines my policy regarding treatment of minors and parental involvement in treatment.**

If you have questions about fees, payment plans, insurance, or other financial concerns, please discuss these with me. Please be sure, as well, to read the **Notice of Privacy Practices** accompanying this form.

1) I have read, understand, and agree with the above Professional Fee Information and Psychologist/Client Contract.

Signature _____ Date _____

Print name: _____

If applicable (Guardians):

Signature of guardian: _____

Print guardian name: _____ Date: _____

2) I have read and understand the Notice of Privacy Practices and have been offered a copy to retain for my records.

Signature _____ Date _____

Print name: _____

If applicable (Guardians):

Signature of guardian _____

Print guardian name _____ Date _____

If you would like me to file insurance for you, please read and sign the following statements (3 and 4). It is your responsibility to make sure I have the insurance information needed to file the claim.

3) I authorize the release of any medical, mental health, or other information necessary to process this claim.

Signature _____ Date _____

If applicable (Guardians):

Signature of guardian: _____ Date _____

4) I authorize payment of medical/mental health benefits to Monika Peterson, Ph.D., LLC.

Signature _____ Date _____

If applicable (Guardians):

Signature of guardian _____ Date _____

INFORMED CONSENT

I have chosen to receive psychological services from Monika Peterson, Ph.D., LLC. My choice has been made voluntary and I understand that I may terminate therapy at any time. I understand alternative treatment methods are available to me.

I understand that it takes time to feel better and not all patients feel better. Because psychological treatment is a cooperative effort between me and my therapist, I will work with my therapist to the best of my ability to resolve my difficulties.

I understand that during the course of my treatment, material may be discussed that will be upsetting in nature and that this may be necessary to help me resolve my problems.

I understand that the ability of my therapist to provide useful feedback and guidance to me is dependent upon the accuracy of the information I provide about myself.

I understand that records and information collected about me will be held or released in accordance with state and federal laws regarding confidentiality of such records and information.

I understand that state and local laws require that my therapist report all cases of abuse or neglect of minors or vulnerable adults.

I understand that state and local laws require that my therapist report all cases in which there exists a danger to self and/or others.

I understand that there may be other circumstances in which the law requires my therapist to disclose confidential information.

I understand that I may be contacted by my doctor to ensure continuity and quality of my treatment and/or after the completion of treatment to assess the outcome of treatment and continue to follow my recovery.

I understand that my therapist will be required to provide basic clinical information, including diagnoses, to my insurance company in order to receive payment for services, and that my therapist has no control over how my insurance company handles my private information and that my therapist cannot be held liable for the actions of the insurance company.

My rights include:

- The right to be informed of the steps and activities involved in receiving services
- The right to confidentiality under federal and state laws relating to the receipt of services
- The right to humane care and protection from harm, abuse or neglect
- The right to make an informed decision whether to accept or refuse treatment
- The right to contact and consult with counsel at my expense
- The right to select practitioners of my choice at my expense

Signature of patient: _____

Print patient name: _____

Date: _____

If applicable (Guardians):

Signature of guardian: _____

Print guardian name: _____

Date: _____