HILLCREST
COUNSELING CENTER
1919 Stearns, Kalamazoo, MI 49008
Phone: 269.979.3881
hillcrestcounseling.com

OUTPATIENT SERVICES CONTRACT

Welcome to my psychology practice. The purpose of this document is to provide you with information about my professional services and business policies. It also contains summary information about the *Health Insurance Portability and Accountability Act (HIPAA)*. HIPAA provides new privacy protections and patient rights with regard to the use and disclosure of "Protected Health Information" (PHI) used for the purpose of treatment payment of services, and healthcare operations. Please read it carefully and jot down any questions you might have so we can discuss them at our next meeting. When you sign this document, it will represent an agreement between us.

PSYCHOLOGICAL SERVICES

Counseling is not easily described in a general statement. It will vary greatly depending on the personalities of the psychologist and the patient, and the particular problems that are brought forward. Counseling is not like a medical doctor visit. Instead it calls for a very active effort on your part. Results of counseling are likely to be affected by your level of participation. It is further expected that you will be prompt in attendance and completely engage in the counseling sessions.

Counseling is a personal exploration and may lead to major changes in your life perspectives and decisions. These changes may affect significant relationships, your job, and/or your understanding of yourself. You may at times feel distressed during this process, usually only temporarily, by some of the things you learn about yourself or some of the changes you make. Although the exact nature of changes resulting from counseling cannot be predicted, I intend to work with you to achieve the best possible results for you. Depending on the goals that you and I decide upon, you may be asked to complete homework assignments which are designed to support the counseling process.

Our first few sessions will involve evaluating your needs. By the end of the evaluation process, 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 remain in counseling. At any time you may initiate with me a discussion of possible positive or negative effects of entering, not entering, continuing, or discontinuing counseling. Although I expect you to benefit from counseling, I cannot guarantee any specific results

APPOINTMENTS

I normally conduct an evaluation and planning process that will last about 2 to 4 sessions. During this time we can both decide if we are the best team to help you meet your treatment goals. If counseling is to continue, I will typically schedule one 45-60 minute session per week at a time we agree on. Although our sessions may be very intimate psychologically, ours is a professional relationship rather than a social one. Some sessions may be longer or more frequent. Once an appointment hour is scheduled, you are asked to provide 24 hours' notice of cancellation or a fee of $50 may be charged. Your insurance policy would not cover this fee. If it is possible, I will try to find another time to reschedule the appointment.

CONTACTING YOUR THERAPIST

I am often not immediately available by telephone. While I am usually in my office between the hours of 9:00 am and 5:00 pm, I probably will not answer the phone when I am with a patient. You may leave a message on my voicemail. I will make every effort to return your call on the same day you make it, with some exceptions of weekends and holidays.

In emergencies, notify the phone service and they will contact me. If they are unable to reach me and you feel you cannot wait for me to return your call, contact your family physician, the nearest emergency room and ask for the psychiatrist n call, or call 911. If I will be unavailable for an extended time, I will provide you with the name of a colleague to contact.

PROFESSIONAL FEES

My hourly fee for individual counseling is $150.00. In addition to weekly counseling appointments, I charge amount for other professional services you may need. Other services include report writing, telephone conversations that last longer than 15 minutes, attendance at meetings with other professionals you have authorized, and time spent performing other services you may request such as testing. If you become involved in legal proceedings that require my participation, you

will be expected to pay for my professional time. Because of difficulty and time required with legal involvement, I charge $250.00 per hour for preparation and attendance at any legal proceedings.

INSURANCE REIMBURSEMENT, BILLING, PAYMENT

If you have a health insurance policy, it will usually provide some coverage for mental health treatment. If you have questions about your coverage, please contact your plan administrator. I will file claims and provide you with whatever assistance I can in helping you receive the benefits to which you are entitled. However, you are ultimately responsible for full payment of my fees.

If you do not have insurance coverage for mental health services, you will be expected to pay for each session at the time it is held unless other arrangements are made.

If an outstanding balance occurs, and no payment has been made within 60 days, we reserve the right to assess a finance charge and submit your financial account to Small Claims Court of Kalamazoo County.

PROFESSIONAL RECORDS

The laws and ethics of my profession require that Protected Health Information be included in Clinical Records. My records include information regarding your reason for seeking therapy symptoms, diagnosis, medical history, and brief notes documenting each session.

You are entitled to receive a copy of your records, or I can prepare a summary for you as well. If you wish to see your records, please make a request in writing. I will review the record with you so that we can discuss the contents. Patients will be charged an hourly fee for any time spent in preparation and review of information requests.

MINORS

It is my policy to request that parents or legal guardians waive access to a minor's treatment records. I am willing to provide general information about our work, unless I feel there is a high risk that you will seriously harm yourself or someone else. In this case, I will notify them of my concern. Before disclosing any information about a minor, I will discuss that matter with the patient.

CONFIDENTIALITY

Discussions between you and I, including the fact that you are in counseling with me, are confidential. In general, the privacy of all communications between a patient and a psychologist is protected by law, and I can only release information about our wok to others with your written permission. I will make every effort to fully discuss it with you before taking action. There a few exceptions:

1. 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 emotional condition is an important issue, a judge may order my testimony if he/she determines that the issues demand it.
2. There are some situations in which I am legally obligated 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 a child, elderly or disabled person is being abused, I will report with the appropriate state agency.
3. 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 threatens to harm his/herself I may be obligated to seek hospitalization and/or contact family members or others who can help provide protection.

I may occasionally find it helpful to consult with another professional about a case. During a consultation, I make every effort to avoid reveling identity of my patient. The consultant is also legally bound to keep the information confidential.

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

_____ _____

Printed Name of Patient/Parent/Guardian *Date*