(NOTE: SIGN AND
RETURN IMMEDIATELY!)

AGREEMENT FOR SERVICES
(Informed Client Consent to Treatment)

In seeking psychological services from **The Psychology Center, Inc**. and its staff, I agree to certain therapeutic and financial arrangements for the treatment to be provided.

Although additional or other services may be required, it is currently anticipated that professional services will include a diagnostic assessment and psychotherapy. I understand that my Doctor will use his or her best efforts to provide a personalized treatment program to assist me. It is understood that although psychological treatment usually results in positive benefits, it can also involve considerable personal change, adjustments, or disruption of relationships with others that might be considered a "risk of treatment". I agree to cooperate to the best of my ability with the goals of therapy. I understand that good treatment is not a guarantee of a good outcome. Because the results of therapy depend importantly on my personal cooperation, I acknowledge that no guarantee concerning the length of therapy or promise of results can be responsibly set forth.

Communications made during therapy and treatment records will be treated confidentially in accordance with the law and with recognized professional standards. Exceptions to the confidentiality of information concerning therapy can include, but are not limited to, (1) information conveyed by telephone, mail, email, fax, or computer to my insurance program or to a billing service (in order to receive payment of benefits), and (2) to any other person or organization to which I request information be given. I consent to communicating confidential information to others concerning my therapy in accordance with law and reasonable professional judgment; for instance, when such communication appears necessary to protect me or others from harm (for example, reports of child abuse, elder abuse, or posing a threat to self or others), or in response to legal proceedings, or in any other proper circumstances in accordance with state law. However, I understand that cell phone or email/Internet communication about me or between the therapist and myself or others on my behalf are not necessarily confidential and the privacy of such exchanges cannot be guaranteed. Records from treatment are maintained confidentially according to doctor-client privilege, but may, at the Doctor's option, only be kept for 7 years after my last treatment session. Also, some staff persons at The Psychology Center, Inc may be under supervision and treatment supervisors will have access to all treatment records and may be included as co-therapists in some or all of my treatment.

The suggested frequency of therapy will usually be one session per week, which is the format usually expected by most insurance plans. I understand that some psychological testing or other assessment may be recommended to assist in diagnosis and treatment planning. The initial diagnostic interview (first session) may be billed at a one time rate charge which is higher depending on the amount of office time required to set up a treatment plan and insurance billing on my behalf. I understand that I can withdraw from therapy at any time by discussing my decision in person with my therapist, who can also refer me to another therapist if I so choose in order to pursue an alternative treatment method. I acknowledge that my Doctor has made me

aware through printed materials or personal discussion of his or her licenses and other professional qualifications, experience, professional affiliations, and areas of expertise. Although trained in multiple methods of therapy and assessment, the approach of the Doctors at "The Psychology Center" is primarily known as a cognitive-behavioral treatment approach with a view to family systems influences.

Also, specific kinds of treatments not offered or available from all therapists at **The Psychology Center, Inc.(**such as biofeedback, hypnosis, deep psychoanalysis, use of medications, repressed memories, etc.) have also been brought to my attention. I further understand that I have the right and responsibility to actively participate in decisions regarding treatment, and to decline treatment or parts of treatment suggestions if I wish. Since their Doctorate is in Clinical Psychology rather than medicine, the Doctors at "The Psychology Center" strongly encourage each client to see their physician before and, if indicated, during treatment at "The Psychology Center, Inc." to rule out other possible physical causes of symptoms. In the event of an emergency when the Doctor cannot be reached, I understand that I should contact a local hospital emergency room or my primary care physician.

The fee schedule is based on professional time spent and has been discussed, sent, or given to me. I agree to pay my estimated share of these fees at each session. **Any payments received from my insurance program will be credited to my account.** I understand that I am obligated to pay: (1) deductibles
(2) co-payments
(3) coinsurance
(4) and non-covered services that are outside my benefit plan
to the extent that they are not covered by my insurance program. I agree that any missed sessions will be charged for at the usual office visit rate, unless I provide "The Psychology Center, Inc." with 48 hour advance notice of cancellation or postponement (except in extreme emergencies when such advance notice cannot be reasonably given). I agree that my previous co-payments or deductible payments may be applied to pay charges for missed appointments.

I understand that I may be charged a total of $9 or more for any **returned checks**. And in the unlikely event that it becomes necessary to utilize a collection agency or the courts to communicate about or to collect any unpaid balance, I agree to pay reasonable attorneys' fees, and any and all court costs, collection agency fees, or charges which may be incurred by The Psychology Center, Inc. in connection therewith. **Client unpaid balances will incur interest charges of 1%/ month and a re-billing fee of $25 monthly.**

If I ever have a concern about causing harm to myself or others, I will first call any of "The Psychology Center, Inc." office or voice mail numbers, or the police at 911, and give the police permission to contact the Doctor on my behalf. Because I understand that there can be no guarantee that my Doctor will be able to respond to any call I might make to him or her, I also agree to contact any hospital emergency room or suicide hot-line in my area and request that they contact the Doctor on my behalf. I also understand that there are limits to the confidentiality of treatment under such circumstances, and that when there is a danger to self or others, actions

must be taken to protect everyone involved. I agree to hold my Doctor and "The Psychology Center" harmless in the event that I break or ignore this agreement between us, or if he or she is unable to respond to provide care as I would wish. Lastly, I instruct anyone else (family, friends, employer, etc) wishing to act on my behalf to likewise hold my Doctor harmless in the event that I choose to break or disregard this agreement, or if any harm results despite the presence of this agreement.

If my health insurance benefits involve a "managed care" arrangement where treatment recommendations made by my Doctor as a member of the approved provider network are subject to review or denial by the **managed care plan**, I understand that my Doctor may nonetheless suggest further treatment at my own expense in light of his professional obligation to me to put my interests as patient, first – even if this further treatment were to be denied for payment by my managed care plan.

I agree to be financially responsible for the prompt return of (1) any testing materials (test booklets, answer sheets - used or unused, etc.) and (2) for any audio/video tapes on loan to me from The Psychology Center's tape library. If not returned, I agree to pay for the replacement of these materials.

Finally, I agree to complete and promptly return a "Client Satisfaction/Treatment Outcome Survey" to be sent to me at the end of treatment.

The above information has been read, understood, and agreed to in order to authorize treatment:

Client signature	Date	Social Security Number
Client signature	Date	Social Security Number
Client signature	Date	Social Security Number
Client signature	Date	Social Security Number

 3/09