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Agreement/Consent for Psychological Services

(***Please read and sign at the bottom.)***

Welcome. I hope that this will provide you with information to help you make an informed decision concerning my services. If you have any questions or concerns about these policies or any other aspect of my practice, please feel free to discuss them with me at any time.

This document (the Agreement) contains important information about my professional services and policies. It also contains summary information about the Health Insurance Portability and Accountability Act (HIPAA), a federal law that provides privacy protections and patient rights with regard to the use and disclosure of your Protected Health Information (PHI) used for the purpose of treatment, payment, and health care operations.

APPOINTMENTS: Individual counseling sessions are to be provided by me, Neesha Patel, Ph.D., a licensed psychologist in the state of California (PSY #21861). Once we determine a regular time, I will expect to meet with you during that time, unless other arrangements are made. To schedule, cancel or change your appointment, please call (510) 725-4145. You may leave a voicemail message for me as needed. Calls will generally be returned by the next business day. Please note that I have a part-time practice and therefore have limited availability for clinical appointments.

CANCELLATIONS: I will not bill you for missed sessions as long as I have at least 48 hours notice. This includes sessions missed for any reason, including vacations, illness and work emergencies. Please let me know of any planned vacations or travel as soon as possible and I will do the same. **Once an appointment is scheduled, a minimum of 48 hours notice is required for rescheduling or cancellation of an appointment**. A fee of $85 will be charged for missed sessions without at least 48 hours notification. Please note that many insurance companies will not provide payment for missed sessions or late cancellations. If you miss or cancel three consecutive appointments without prior notice, I will close your case, and a letter will be sent to your home address indicating that treatment has been discontinued.

ELECTRONIC COMMUNICATION: Please note that e-mail and other forms of electronic communication are not a confidential means of communication. Please do not cancel appointments via email as I cannot ensure that such messages will be received or responded to in a timely manner. Please keep in mind that email is not a substitute for telephone or face-to-face communication. For these reasons, you are discouraged from using e-mail or other forms of electronic communication to communicate with me. **Please note that I cannot be reached by text messages**.

PROFESSIONAL FEES: My fee is $200 for a 50 min individual therapy session. My fee for an initial evaluation is $250. Phone sessions/consultations over 15 minutes are billed at an hourly rate of $250.

If you become involved in legal proceedings that require my participation, you will be expected to pay for my professional time, including preparation and transportation costs, even if I am called to testify by another party. I do not voluntarily appear in court on clients' behalf unless we have discussed the matter thoroughly and we both agree that the court appearance will not interfere with our treatment relationship. Because of the difficulty of legal involvement, I charge $800.00 per hour for participation in any legal proceeding, and I generally require payment of all or part of such fees in advance.
Please note that as a general policy, I do not conduct fitness for duty evaluations and do not provide documentation for work or school related issues.

PAYMENT FOR SERVICE: Payment is due at the time services are provided and may be made by check or cash. **Clients are responsible for payment of all fees even if planning to use insurance.** Clients are responsible for all fees incurred due to returned checks. If you think you may have trouble paying your bills on time, please discuss this with me as soon as possible. In order to maintain the integrity of our work together, I may stop treatment with you until the balance is settled. If your account has not been paid for more than 30 days and we haven't agreed upon arrangements for payment, I have the option of using legal means to secure the payment. Unpaid bills for over 30 days may, at my option, be construed as a termination of treatment. Unpaid accounts may be turned over to a collection agency or small claims court as a final resort for non-payment, and your balance due will reflect incurred costs. By signing this document, you agree and consent to unpaid bills related collection and court proceedings being filed in therapist jurisdiction and waive any right to claim improper jurisdiction and/or venue or claims regarding confidentiality regarding such a suit.

EMERGENCIES: In case you need urgent care in-between sessions, if you are unable to reach me, please make use of the appropriate emergency services including: a) your family physician or psychiatrist, b) go to the nearest emergency room and ask for the psychologist or psychiatrist on call, c) call 911, or d) call the Alameda County Crisis/Suicide Hotline #1-800-309-2131.

CONFIDENTIALITY: To the degree allowed by law, no information about your contact with me will be disclosed to any person or organization unless you give me a specific, written release to do so. There are, however, some situations written into law that deny me complete control over confidentiality of communication as follows:

- If you show imminent danger of harming yourself, someone else, or another's property;
- If there is suspected abuse or neglect of a child, the elderly, or dependent adult, whether by yourself or someone else;
- If you are deemed to be gravely disabled and in need of hospitalization;
- If a court of law issues a legitimate court order.
- If your insurance company or an auditor requires it or for proceedings related to unpaid bills.

This list is not exhaustive, but these are the most common circumstances which may occur. The situations outlined above are out of the ordinary and have no impact on the large majority of people seeking professional mental health services. I share this information with you so that you can be fully informed and your questions and concerns can be addressed.

PSYCHOLOGICAL SERVICES: Participation in therapy can result in a number of benefits to you, including a better understanding of your personal goals and values, improvement of interpersonal relationships and resolution of the specific concerns that led you to seek therapy. Working toward these benefits, however, requires your very active involvement. In order for the therapy to be most successful,

you will need to work on things we talk about both during our sessions and outside of sessions. I view my role as facilitator and supporter of your learning and growth, and see you as ultimately responsible for your choices and behavior.

Psychotherapy can have benefits and risks. Since therapy often involves discussing or remembering unpleasant aspects of your life, you may experience uncomfortable feelings like sadness, guilt, anger, frustration, fear, and helplessness or you may experience discomfort such as insomnia, anxiety, and depression. Attempting to resolve issues that brought you to therapy in the first place, such as personal or interpersonal relationships may result in changes that were not originally intended. While there is no guarantee that psychotherapy will yield positive or intended results, most people who take these risks find that therapy is helpful.

Our first few sessions will involve an evaluation of your needs. I do not accept clients who, in my opinion, I cannot help. In such a case, I will give you a number of referrals that you can contact. 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 to follow, if we agree to continue with therapy. You should evaluate this information along with your own opinions of whether you feel comfortable working with me. Therapy involves a large commitment of time, money, and energy, so it is important to be very careful about the therapist you select. If you have questions about my procedures, we should discuss them whenever they arise. If at any time you want another professional's opinion or wish to consult with another therapist, I will assist you in finding someone qualified, and if I have your written consent, I will provide this professional with the essential information needed.

The duration of therapy is something that is very difficult to predict in advance. Some clients may get the help they need in only a few sessions, while others may choose to continue therapy for several months or years. Please feel free to discuss this with me if you have any questions or concerns.

You have the right to ask questions about anything that happens in therapy. I am always willing to discuss the rationale for my approaches, and to consider alternatives that might work better. You can ask me about my training for working with your concerns, and you can request that I refer you to someone else if you decide that I am not the right therapist for you. You are free to leave therapy at any time.

INSURANCE REIMBURSEMENT: In order for us to set realistic treatment goals and priorities, it is important to evaluate what resources you have available to pay for therapy. If you have a health insurance policy, it may provide some coverage for mental health treatment. Regardless of your insurance coverage status, you (not your insurance company) are responsible for full payment of the psychotherapy fees. It is very important that you find out exactly what mental health services your insurance policy covers.

Some insurance plans require authorization before they provide reimbursement for mental health services. Some plans may require you to receive treatment from a therapist who is on their provider panel. These plans are often limited to short-term treatment approaches. It may be necessary to seek approval for more therapy after a certain number of sessions. While a lot can be accomplished in short-term therapy, some clients feel that they need more services after insurance benefits end. To find out more about your specific insurance coverage and benefits, please call your insurance company.

You should also be aware that most insurance companies require you to authorize me to provide them with a clinical diagnosis. Sometimes I have to provide additional information such as treatment plans or summaries, or copies of the entire record (in rare cases). This information will become part of the insurance company files. Though all insurance companies claim to keep such information confidential, I have no control over that information once it is released to them.

HIPAA This document (the Agreement) contains important information about my professional services and policies. It also contains summary information about the Health Insurance Portability and Accountability Act (HIPAA), a federal law that provides privacy protections and patient rights with regard to the use and disclosure of your Protected Health Information (PHI) used for the purpose of treatment, payment, and health care operations. HIPAA requires that I provide you with a HIPAA Notice of Privacy Practices (the Notice) for use and disclosure of PHI for treatment, payment, and health care operations. The Notice, which accompanies this Agreement, explains HIPAA and its application to your personal health information in greater detail. The law requires that by the end of this session I obtain your signature acknowledging that I have provided you with this information. Although these documents are long and sometimes complex, it is important that you read them carefully before our next session. We can discuss any questions you have about the procedures at that time. When you sign this document, it will also represent an agreement between us. You may revoke this Agreement in writing at any time. That revocation will be binding on me unless: a) I have taken action in reliance on it; b) there are obligations imposed on me by your health insurer in order to process or substantiate claims made under your policy; or c) if you have not satisfied any financial obligations you have incurred.

HIPAA provides you with several new or expanded rights with regard to your Clinical Records and disclosures of protected health information. These rights include requesting that I amend your record; requesting restrictions on what information from your Clinical Records is disclosed to others; requesting an accounting of most disclosures of protected health information that you have neither consented to nor authorized; determining the location to which protected information disclosures are sent; having any complaints you make about my policies and procedures recorded in your records; and the right to a paper copy of this Agreement, the attached Notice form, and my privacy policies and procedures. I am happy to discuss any of these rights with you.

PROFESSIONAL RECORDS: You should be aware that, pursuant to HIPAA, I keep Protected Health Information about you in my professional records. This is your Clinical Record. It includes information about your reasons for seeking therapy, a description of the ways in which your problem impacts on your life, your diagnosis, the goals that we set for treatment, your progress towards those goals, your medical and social history, your treatment history, any past treatment records that I receive from other providers, reports of any professional consultations, your billing records, and any reports that have been sent to anyone, including reports to your insurance carrier. Except in unusual circumstances in that disclosure would physically endanger you and/or others, or makes reference to another person (unless such other person is a health care provider), 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. If you wish to see your records, I recommend that you initially review them in my presence, or have them forwarded to another mental health professional so you can discuss the contents. There will be a copying fee of 25 cents per page. The exceptions to this policy are contained in the HIPAA Notice of Privacy Practices Form.

Your signature below indicates that you have read, understand and agree to this Agreement and its terms and also serves as an acknowledgement that you have received the HIPAA Notice of Privacy Practices Form described above.

Client's Signature: _____ Date: _____

Client's Name: (Please print.)_____