

KESSLER PSYCHOLOGICAL SERVICES, LLC.

OUTPATIENT SERVICES CONTRACT

WELCOME TO KESSLER PSYCHOLOGICAL SERVICES. This document contains important information about our professional services and business policies. Please read it carefully and jot down any questions you might have so that we can discuss them at our next meeting. When you sign this document, it will represent an agreement between us.

PSYCHOLOGICAL SERVICES

Psychotherapy is a process that is difficult to describe. Therapy depends on the personalities of the therapist and patient, and the particular problems you bring forward. There are many different methods we may use to deal with the problems that you hope to address. Psychotherapy is not like a medical doctor visit. Instead, it calls for a very active effort on your part. In order for the therapy to be most successful, you will have to work on things we talk about both during the sessions and at home.

Psychotherapy can have benefits and risks. Since therapy often involves discussing unpleasant aspects of your life, you may experience uncomfortable feelings like sadness, guilt, anger, frustration, loneliness, and helplessness. On the other hand, psychotherapy has also been shown to have benefits for people who go through it. Therapy often leads to better relationships, solutions to specific problems, and significant reductions in feelings of distress. There are no guarantees to the outcome of your experience. Changes do come about as a result of therapy but they may not be exactly what you r anticipated.

Our first few sessions will involve an evaluation of your needs. By the end of the evaluation, your therapist will be able to offer you some first impressions of what your work will include and a treatment plan will follow. You should evaluate this information and decide if you feel comfortable working with us. Therapy involves a large commitment of time, money, and energy, so you should be very comfortable with the therapist and the approach. If you have questions about our procedures, please feel free to discuss them as they present themselves. If you find that you are not well matched with your therapist, we will be happy to help you set up a meeting with another mental health professional for a second opinion.

MEETINGS

We normally conduct an evaluation that will last from 2 to 4 sessions. During this time, we can both decide if your therapist is the best person to provide the services you need in order to meet your treatment goals. Once psychotherapy has begun, we usually schedule one 50-minute session (one appointment hour of 50 minutes duration) per week at a time we agree on, although some sessions may be longer, more frequent, or less frequent. Once an appointment hour is scheduled, you will be expected to pay for it unless you provide **24 hours advance notice of cancellation** (unless we both agree that you were unable to attend due to circumstances beyond your control).

PROFESSIONAL FEES

Our fee for the initial visit is \$160 and our hourly fee for subsequent visits is \$115. In addition to weekly appointments, we charge this amount for other professional services you may need, though we will break down the hourly cost if the work takes less than one hour. Other services include report writing, telephone conversations lasting longer than 10 minutes, attendance at meetings with other professionals you have authorized, preparation of records or treatment summaries, and the time spent performing any other service you may request of us. If you become involved in legal proceedings that require our participation, you will be expected to pay for professional time even if we are called to testify by another party. Because of the difficulty of legal involvement, we charge \$200 per hour for preparation and attendance at any legal proceeding.

INSURANCE REIMBURSEMENT

You should be aware that most insurance companies require you to authorize us to provide them with a **clinical diagnosis**. Sometimes we have to provide additional clinical 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 and will probably be stored in a computer. Though all insurance companies claim to keep such information confidential, we have no control over what they do with it once it is in their hands. In some cases, they may share the information with a national medical information databank. We will provide you with a copy of any report we submit, if you request it.

CONTACT BETWEEN SESSIONS

If you are difficult to reach, please inform us of alternative times and ways to reach you, (phone#/email). If you are unable to reach us and feel that you can't wait for us to return your call, contact your family physician **or go to the nearest emergency room** and ask for the psychologist (psychiatrist) on call. If your therapist will be unavailable for an extended time, we will provide you with the name of a colleague to contact, if necessary in his/her absence. We are often not available by telephone. During office hours, therapists are usually with clients. When we are unavailable, our telephone is answered by the secretary or voice mail. We monitor our voice mail frequently and will make every effort to return your call that day.

PROFESSIONAL RECORDS

The laws and standards of this profession require that we keep treatment records. You are entitled to receive a copy of the records unless we believe that seeing them would be emotionally damaging, in which case we will be happy to send them to a mental health professional of your choice. Because these are professional records, they can be misinterpreted and/or upsetting to untrained readers. We recommend that you review them in your therapist presence so that we can discuss the contents. Patients will be charged an appropriate fee for any time spent in preparing information requests.

MINORS

If you are under eighteen years of age, please be aware that the law may provide your parents the right to examine your treatment records. It is our policy to request an agreement from parents that they agree to give up access to your records. If they agree, we will provide them only with general information about our work together, unless we feel there is a high risk that you will seriously harm yourself or someone else. In this case, we will notify them of this concern. We will also provide parents with a summary of your treatment when it is complete. Before giving parents any information, we will discuss the matter with you, if possible, and do our best to handle any objections you may have with what we are prepared to discuss.

CONFIDENTIALITY

In general, the privacy of all communications between a patient and a psychologist is protected by law, and we can only release information about our work to others with your **written permission**. But there are a few exceptions.

In most legal proceedings, you have the right to prevent us from providing any information about your treatment. In some proceedings involving child custody and those in which your emotional condition is an important issue, a judge may order our testimony if he/she determines that the issues demand it.

There are some situations in which we are legally obligated to take action to protect others from harm, even if we have to reveal some information about a patient's treatment. For example, if we believe that a child (elderly or disabled person) is being abused, we must file a report with the appropriate state agency.

If we believe that a patient is threatening serious bodily harm to another, we are 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 himself/herself, we may be obligated to seek hospitalization for him/her or to contact family members or others who can help provide protection. These situations occur only rarely. If a similar situation occurs, we will make every effort to fully discuss it with you before taking any action.

If we believe that you are at risk of killing yourself, our only treatment goal is going to be to keep you safe and alive. We will do whatever we need to do to protect you, including notifying and involving members of your family. If this is unacceptable to you, then we will need to refer you elsewhere.

We may occasionally find it helpful to consult other professionals about a case. During a consultation, we make every effort to avoid revealing the identity of our patients. The consultant is also legally bound to keep the information confidential. If you don't object, we will not tell you about these consultations unless we feel that it is important to our work together.

While this written summary of exceptions to confidentiality should prove helpful in informing you about potential problems, it is important that we discuss any questions or concerns that you may have at our next meeting. We will be happy to discuss these issues with you if you need specific advice, but formal legal advice may be needed because the laws governing confidentiality are quite complex, and we are not attorneys.

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

Client

Witness

Date

How Did You Hear About Us?

Please check the appropriate box.

- | | | | |
|---|---|--|--|
| <input type="checkbox"/> Self-Referral | <input type="checkbox"/> Current Client | <input type="checkbox"/> Former Client | <input type="checkbox"/> Other Psychologists |
| <input type="checkbox"/> Primary Care Physician | | <input type="checkbox"/> Insurance | <input type="checkbox"/> Court Ordered |
| <input type="checkbox"/> Web site | <input type="checkbox"/> Yellow Pages | <input type="checkbox"/> Employer | |
| <input type="checkbox"/> Other _____ | | | |

Kessler Psychological Services, LLC.

Thank you for choosing Kessler Psychological Services, LLC as your provider. We are committed to providing you with quality and affordable mental health care. Our practice financial policy is as follows:

1. **Insurance.** We participate in many managed care plans. If you are insured by a plan that we do not participate with, payment in full is required at each visit. If you are unable to provide Kessler Psychological Services, LLC with an up-to-date insurance card, payment in full for each visit will be required until we can verify your coverage. Contact your managed care plan directly for any questions regarding your coverage. By signing this form you authorize Kessler Psychological Services, LLC to release the necessary information in order to complete and process your insurance claims.
2. **Claims Submission.** We will submit a claim to your managed care plan if you provide a current insurance card at each visit. Please note that the insurance coverage is between you and your insurance carrier; we will file the claim for you, but the balance is your responsibility if your plan does not pay after 30 days. We do not offer third party billing; the patient or the patient's responsible party is responsible for handling all third party billing.
3. **Non-covered Services.** I understand that some and perhaps all of the services I receive may not be covered by my insurance company or not considered reasonable or necessary by Medicare or other insurers. I agree to pay for any services which have been determined by my insurance plan to be "non-covered". Payment in full is generally due at each visit or immediately after you receive your first Kessler Psychological Services, LLC statement from us.
4. **Copays and Deductibles.** You are required to pay for your visit at the time of service if you have not yet met your annual deductible. If we do not know your contracted rate yet, a minimum of \$20.00 is due at time of service. We will provide you with a receipt. Copays are always due at the time of service. This arrangement is part of your contract with your insurance company. The exception would be if your plan does not require copay for the visit.
5. **Updates.** Our staff will ask you to verify billing information prior to your first visit and as needed thereafter. Current information is essential in order for us to contact you regarding your treatment and for obtaining timely payment from your insurance company.
6. **Knowing Your Plan.** Patients should know the requirements of their individual current plans. Your plan may change annually and you should always know what your plan intends to pay for services and your financial responsibility. The billing department at Kessler Psychological Services, LLC does pre-certify your visits as a courtesy.
7. **Missed Appointments.** We charge for missed appointments, as that appointment time could have been given to another patient that needed to be seen. This is not billable to your insurance. If you call 24 hours prior to appointment, you will not be billed. For Monday appointments please leave a voice mail on Sunday, it is time stamped.
8. **Forms of Payment.** We accept Cash, Check, Money Order, Visa, Mastercard, and Discover.
9. **Non-sufficient Funds Checks.** You will be charged a \$30.00 processing fee for NSF checks presented to the practice.
10. **Additional Information.** We do charge for copying medical records and form completion. If you have any billing questions, please contact our office staff at: 330-877-2093. I have read and understand the financial policy and agree to abide by its guidelines.

Printed Name of Patient

Patient's Date of Birth

Signature of Patient or Responsible Party

Date

**KESSLER PSYCHOLOGICAL SERVICES, LLC.
311 SOUTH PROSPECT AVE.
HARTVILLE, OH 44632
PHONE: 330-877-2093
FAX: 330-877-2104**

PERMISSION FOR TREATMENT

I hereby authorize Kessler Psychological Services,LLC. to provide the following services:

- _____ Individual Psychotherapy
- _____ Psychological Testing/Evaluation
- _____ Family Counseling
- _____ Other

I understand that mental health services sometimes carry a risk of undesirable side effects. I am aware that I am entitled to an explanation of such side effects. I also understand that only those services listed above will be provided unless I give signed authorization for additional services.

Signature of Client or Parent/Legal Guardian

Relationship to Client

Signature of Witness

Date

Client Rights, Responsibilities, and Grievances/Notice of Privacy Practices

I have received a copy of Kessler Psychological Services,LLC. Client Rights, Responsibilities, and Grievance Procedures and a copy of Notice of Privacy Practices (HIPAA). A member of the staff has offered to explain the policies and procedures to me.

Signature of Client

Date

Signature of Staff

Date