OUTPATIENT SERVICES CONTRACT

Welcome! This document contains important information about my professional services and business policies. Please read 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 not easily described in general statements. It varies depending on the personalities and the therapist, patient, and the particular problems you bring forward. There are many different methods that may be used to deal with the problems that you hope to address. Therapy is not like a medical doctor visit. Instead, it calls for a very active effort on your part. In order for therapy to be most successful, you will have to work on things we talk about both during our sessions and at home.

Therapy 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, therapy has also 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. But there are no guarantees of what you will experience.

Our first sessions will involve an evaluation of your needs. By the end of the first sessions, 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 continue therapy. You should evaluate this information along with your own opinions of whether you feel comfortable working with me. If you have any questions about my therapeutic process, please share our thought in order for us to discuss them whenever they arise. If your doubts persist, I will be happy to refer you to another mental health professional.

OFFICE POLICIES

Hours: Office hours and counseling sessions are by appointment only. ***Based on the nature of my practice, I am unable to provide counseling services to clients who require 24-hour care. My priority is always the confidentiality of my clients so I do not conduct any sort of therapeutic interaction via text message. Text messages are only to be used as communication regarding scheduling or scheduling changes***. I also check my confidential voicemail several times per day and strive to return phone calls within 24 hours. Calls made over the weekend will be returned on Monday (unless I am on vacation).

Emergencies: The practice of private outpatient psychotherapy with adults makes the assumption that clients are functioning, self-responsible individuals with legitimate concerns,

needs and pain. Private outpatient psychotherapy cannot, by its structure, assume responsibility for day-to-day functioning of its clients in the same way agencies and inpatient institutions can. At times, however, some clients may require special attention or assistance. I do not carry a pager and am not ordinarily available for therapy or crisis calls apart from our scheduled appointments. I will, however, consider exceptions to this policy as the appropriate need arises. If you have a counseling emergency and I am not available, please go to the nearest emergency room, contact the police or dial 911.

Records: Records are safely stored with attention to your privacy for at least 10 years, as required by Missouri Statute. They will only be released with your written permission and direction. If you were seen in a Couple's or Family Session, all adults present would have to authorize the release of that record. 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 review them in my presence so that we can discuss the contents. Patients will be charged an appropriate fee for any professional time spent in responding to information requests.

Court Proceedings: I am unwilling to be a witness in any child custody, divorce, or any other domestic, civil, or criminal court proceedings. These are services that are NOT provided in my practice. These include custody evaluations, visitation recommendations, voluntary court testimony, written recommendations, voluntary consultations to Child Family Investigations (CFI), voluntary consultations with the legal system, and the preparation of reports for legal purposes. Experience has shown that testimony by therapists in domestic cases cause damage to the clinical relationship between therapist and client. Testimony on other issues also has the potential; of damaging the clinical relationship as well.

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 my policy to request an agreement from parents that they agree to give up access to your records. If they agree, I will provide them only with general information about our work together, 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 concerns. I will also provide them with a summary of your treatment when it is complete. Before giving them any information, I will discuss the matter with you, if possible, and do my best to handle any objections you may have with what I am prepared to discuss.

Credentials: I hold a Bachelor of Science in Interpersonal Communication from the University of Kansas. I received a Master of Arts in Marriage and Family Therapy (MFT) which I received from Kansas State University. I am a licensed Marriage and Family Therapist registered with the state of Missouri (MO #2012040797). I specialize in Sex Therapy with both couples and individuals as a Certified Sex Therapist and Diplomat of the American Academy of Clinical Sexologists (DAACS).

Fees and Insurance: Sessions are typically held one time weekly. It is difficult to predict how many sessions will be needed. Research shows the average person seeking therapy attends 15 -18 therapy sessions. This will depend on you and the nature of your goals for therapy. The hourly fee for a 50-minute session is based on a sliding scale fee. Payments can be made with cash, check or credit/debit card at the time of service. If you are late for a session, your time may be shortened but you will be charged for the entire time schedule. Phone consultations are billed in 15-minute increments ($15.00 minimum). You will be expected to pay for each session at the time it is held, unless we agree otherwise. If your account becomes delinquent, I have the option of using legal means to secure payment. This may involve hiring a collection agency or going through small claims court. This requires the release of names, addresses, phone numbers, and financial information to these agencies. Your signature on this form gives your consent for such information to be released for collection purposes. If a collection procedure must be utilized, you are responsible for additional collection costs involved as well as any legal fees. If a collection agency is used, we have no control over the confidentially of information released to them.

Many insurance policies provide at least partial coverage for counseling services, however, in order to receive reimbursement, health insurance companies require that I diagnose the issues for which you are coming to counseling by indicating that you have a "psychological disorder" or "mental illness" which will remain part of your permanent records. If you wish to be reimbursed by your insurance company, my billing assistant can file your insurance for you and your insurance company may be able to reimburse you.

Appointments: I understand that at times it may be necessary to cancel an appointment. If you are unable to keep a scheduled appointment, you must notify me 24 hours ahead of time in order to avoid being charged the full fee for the time.

Name on Card _____
Card Number _____ Exp Date _____
Security Code _____
Billing Address including Zip Code _____

___ Yes, I would like to pay my regular session fees with the above debit/credit card. (All debit/credit card information is kept securely on file).
___ No, I have another debit/credit card I would like to use to pay my regular session fees
___ No, I would not like to pay my regular session fees with my debit/credit card

AGREEMENT

1. I have read the above policies and agree to them

2. I have been informed of my therapist's credentials. I have also read the preceding information and understand my rights as a client

3. A copy of this agreement will be given upon request

Signed_____ Date_____

Signed_____ Date_____

(Client, parent, or guardian)