

Dr Judy Chamberlin LCSW, PsyD

Individual, couples and family psychotherapy

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PSYCHOTHERAPY SERVICES CONTRACT

This document contains important information about my professional services and business policies. Please read it carefully and note any questions you may have so that we can discuss them at our next meeting. When you sign this document, it will represent an agreement between us.

PSYCHOTHERAPY SERVICES

Psychotherapy is not easily described in general statements. It varies, depending on the personalities of the therapist and the client, and the particular problems you want to address in session. Your feelings about the psychotherapy experience and your therapist are very important. I encourage you to discuss any questions, confusion, or frustrations you experience. I believe you are the best authority on whether or not a treatment relationship is working for you.

Our first few sessions will involve an evaluation of your needs and problems. If we decide to continue working together, I will offer you some first impressions and I will make suggestions for treatment. This will include my recommendations for frequency of appointments ranging from weekly psychotherapy visits to multiple sessions per week for psychoanalysis. Please evaluate this information along with your own opinions as to whether you feel comfortable working with me. If you decide not to continue, I encourage you to share your concerns and I will be happy to offer you some referrals for other mental health professionals that may be better suited to your needs.

Initial _____

BENEFITS and RISKS

This section includes a discussion about the benefits and risks of psychotherapy.

The ***benefits*** may include reduced stress and anxiety, a decrease in negative thoughts and self-defeating behaviors, improved relationships, increased comfort in social, school and/or family settings, increased self-confidence, increased self awareness, and a more hopeful attitude towards life.

The ***risks*** may include recalling or recounting painful memories and experiences, discomfort in analyzing distress and problems, and the possibility of experiencing strong feelings of sadness, anger, fear or other difficult emotions. As your therapist, I may from time to time challenge your assumptions or perceptions and offer a different perspective.

Changes in your perspective, thoughts or feelings may have unintended outcomes, including changes in personal relationships. During the course of therapy, it is often the case that you will feel worse before you feel better; this is natural and expected in any healing process.

Personal growth is sometimes difficult and slow, and sometimes easy and swift. When we sign this agreement together, I commit to helping you through the entire process of psychotherapy. This will

Client Name _____

mean helping you to achieve the goals you initially state, but other issues or problems may arise during the course of our work together that will require further exploration and analysis. If this happens, we will work together to revise the goals as appropriate and work towards a satisfactory treatment of your problems.

There is no guarantee that psychotherapy or psychoanalysis will yield any or all of the benefits listed above. Neither is there any certainty that the risks listed above will be encountered during the course of our work together. Psychotherapy is an open and dynamic process, and its course is dependent upon our mutual willingness to collaboratively continue the process and, to a certain extent, upon life events that cannot be foreseen.

Initial _____

CONFIDENTIALITY

In general, the privacy of all communication between a client and a psychotherapist is protected by law and I can only release information about our work to others with your written permission. However, there are a few exceptions.

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 your emotional condition is an important issue, a judge may order my testimony if he/she determines that the issues demand it.

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 client's treatment. For example, if I believe that a child or an elderly or disabled person is being abused, I am required to file a report with the appropriate state agency.

If I believe that a client is threatening serious bodily harm to another, I am required to take protective actions. These actions may include notifying the potential victim(s), contacting the police, or seeking hospitalization for the client. If the client threatens harm to him/herself, I may be obligated to seek hospitalization for him/her or to contact family members or others who can help provide protection.

These situations have occurred from time to time in my practice. If a similar situation occurs, I will make every effort to discuss it with you before taking any action.

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. Please find a copy of my HIPAA Privacy Practice for your information on the forms page of my website, which includes a more comprehensive explanation of how and when your private information may be used. Upon request, I will print a copy for you. Your initials on this section indicate that you have been provided information regarding your HIPAA rights to privacy.

Initial _____

APPOINTMENTS AND CANCELLATIONS

Psychotherapy and psychoanalytic sessions last 45 minutes. Frequency of appointments depends on your needs. Typically appointments are scheduled weekly or more frequently as needed. Appointments must be made in advance.

Once our appointment time is set, this time is reserved for you, and thus, you will be expected to pay the full session fee unless you provide advance notice of cancellation. If you are unable to make your scheduled appointment time due to travel plans or a scheduled medical procedure I require one week

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notice to waive your session fee for that period of time. To reschedule your appointment for a different day or time, I ask that you provide 48 hours notice (or as close to that as possible) and I will do my best to find another time to make up for the missed session whenever possible.

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PROFESSIONAL FEES

My standard fee is \$175 per 45 minute session
Longer sessions are available on a prorated scale, (i.e., \$218/60min or \$350/90min).

I raise my fees on an annual basis according to increases in the cost of maintaining my practice. I make every effort to keep my fees affordable and I will provide advance notice of any changes.

In addition to appointments, I charge \$200 per hour for other professional services I provide. Payment for these services will be due at the time of service. Other services include report writing, attendance at meetings with other professionals you have authorized, preparation of records or treatment summaries, and the time spent performing any other service outside of session time. If you become involved in legal proceedings that require my participation, you will be billed for the time I participate on your behalf.

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BILLING AND PAYMENTS

Payment is expected at the time of each session, unless we agree otherwise. In certain circumstances of unusual financial hardship, I may be willing to offer a payment plan or discounted option. You will be responsible for all fees connected with my professional services due at the time of services or at termination, until all fees are paid. Unpaid fees may be subject to legal action or referral to a collection agency.

I utilize Therapy Partner, an online billing system that allows me to accept checks, cash, and **Visa/Mastercard/Discover** Cards. An Electronic Payment Authorization form is included with the new client forms along with an explanation of how your payments will be handled. Please complete this form today and include it with this agreement. This billing system provides monthly email statements. This is why I ask you to include your email address and you will receive a monthly statement on the 5th of each month from Therapy Partner.

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INSURANCE REIMBURSEMENT

My wish is to dedicate my time and efforts to meeting your psychotherapy needs. For this reason and due to the complexities of managed care, with excessive paperwork and third party decision-makers, I prefer not to subscribe to any HMO or PPO insurance panels or in any government or state run programs.

However, if you have PPO health insurance that covers mental health services provided by **Out-of-Network Providers**, your monthly statement is an insurance ready form. You may use this statement to seek direct reimbursement from your insurance company. You are responsible for payment of services, whether or not your insurance company reimburses for services rendered, in whole or in part.

Please also note that mental health insurance plans are often limited to short-term treatment approaches and may require updates from me in order to continue approving a few sessions at a time. These often have a calendar year maximum number of visits covered.

Client Name _____

You should also be aware that most insurance companies will only approve mental health services for individuals with a diagnosed mental disorder. This may mean that I may have to provide additional clinical information such as treatment plans or summaries of the work we are doing in session. This information will become part of the insurance company's file, your medical history file, and will probably be stored in a computer. Though all insurance companies claim to keep such information confidential, I have no control over what they do with this information once it is in their hands. I will provide you with a copy of any report I submit, if you request it.

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PROFESSIONAL STANDARDS AND CONSULTATION

To ensure the highest level professional standards and ethical care, it is imperative that psychotherapists and psychoanalysts seek professional consultation and opportunities for continuing education. This may include discussing confidential clinical material with other mental health professionals and at times, I may opt to record sessions for my own review. In these cases, I take the utmost care and precautions to protect your privacy so that your identity will be kept completely confidential. If you have any questions or concerns, please don't hesitate to bring them to my attention.

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

Client Signature or Guardian if Client is a Minor

Date

Revisions to above agreement:

I agree to revise the above agreement as follows: _____

Psychotherapist Judy Chamberlin LCSW

Date

I agree to the revision(s) noted above.

Client Signature or Guardian if Client is a Minor

Date