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Telephone (513) 379-7144 • Fax (513) 229-6101

INTRODUCTION:

- After you sign it, this document is a contract between us which you may revoke in writing at any time. That revocation will be binding on me unless I have taken action in reliance on it; if there are obligations imposed on me by your health insurer in order to process or substantiate your claim; or if you have not satisfied your financial obligations.

APPOINTMENTS:

- Scheduled appointments are commitments between you and me. The fee for the initial consultation is \$ 135.00. After that, the fee will be \$ 110.00 per 45 minute session.
- If you must cancel a session, call at least 24 hours in advance,
- If you cannot attend a session at the last minute, please call my cell phone: 379-7144, so that I can put my time to good use. If you decide to stop attending sessions, please cancel any scheduled appointment.

FINANCIAL ARRANGEMENTS:

Clients Utilizing Insurance and EAP Clients: (Report Any Changes in Coverage IMMEDIATELY)

- Your written permission for me to contact your insurance carrier is essential. However, it is your responsibility to learn the amount and duration of your coverage. Please be certain that your insurance company gives you information specifically about mental health benefits, which may be very different from your other health benefits.
- Knowing the extent of your coverage is important because it may affect the length of your treatment, regardless of your readiness to stop attending sessions. Although you may then pay for my services yourself, some insurance carriers prohibit this practice.
- If you plan to use insurance, be clear that this is a contract between you and your insurance provider. You may file claims yourself, however, my billing service will file your claims using information you have provided. I do not, however, file secondary insurance.
- You have the responsibility to obtain any necessary authorizations/pre-certifications from your insurance carrier and you are responsible for your co-pay and any deductibles. If your company rejects some of the claims for your treatment, you are responsible for the usual covered amount.

Clients Utilizing Insurance:

- If you have a deductible, and do not know if it has been met, a \$50.00 charge will be made at each session until the correct amount is apparent.

Clients Utilizing Insurance and Self-Pay Clients

- You alone are responsible for paying any session fees, co-payments, deductibles, or other psychological services, although insurance may aid in payment.
- Payments are expected at the time of service. Payment can be made in cash, by check, or with MasterCard or Visa unless we have made another written arrangement. A zero-balance is maintained with each client, except for insurance carrier reimbursements.
- (Be aware that most insurance carriers do not reimburse for missed sessions)
- Unless you call to cancel at least 24 hours in advance, you will be billed for any scheduled session you fail to attend. The fee is \$50.00 for a missed session unless we can meet at another mutually agreeable appointment time available that same week. I will bill \$75.00 for any subsequent missed session. At my

discretion, I may make an exception when illness leads to a doctor visit or when severe weather has closed public schools in your area.

- Checks returned due to insufficient funds result in a charge to you of \$25.00, plus \$10.00 bank charges and the amount of the check.
- Your credit/debit card information, and signed authorization, are required to assure payment:
 - of any unpaid balance following your last session
 - for scheduled sessions which were not attended
 - for sessions cancelled without sufficient notice or
 - for checks returned due to insufficient funds
- I sometimes provide professional services, such as report writing, telephone conversations, consulting with other professionals at your request, preparing records or summaries of treatment, etc. These services are billed by breaking down my hourly fee in 15 minute increments if I work for less than an hour. If you become involved in legal proceedings that require my participation, you will be expected to pay for all of my professional time, including preparation and transportation costs, even if I am called to testify by another party.

COMMUNICATION:

- My cell phone is my primary source of contact. I check messages several times a day and I attempt to return your call within the next 24 hours. When leaving a message for me, please speak more slowly than usual and inform me of any time limits or other limits you wish to place on my return call or the messages I leave.
- Clients I work with do not typically require extensive, out-of-session contact. However, in the event of a crisis you may call my cell phone: **379-7144**, regardless of the time of day. I will respond as soon as I reasonably can.
- When I am unavailable for an extended period of time I will leave a message on my voice-mail box listing emergency options, including the name and telephone number of another licensed mental health professional.

PSYCHOTHERAPY:

Assessment:

- Initial sessions involve becoming acquainted and determining your concerns and needs through discussion and/or other means of assessment. Goals and methods are agreed upon.

Change Process:

- Psychotherapy is a relationship that promotes change in troublesome thoughts, emotions, and behaviors to help the client find satisfaction, relief, or acceptance. Although the goal is feeling better, sometimes the client feels worse before feeling better. In other words, old ways of coping may no longer work as new understandings become apparent. Treatment may involve learning about a particular psychological problem, learning new coping methods, formal assessment, attendance at a support group, or referral to a specialist. Regardless of the particular goals, regularly attendance and active effort, both in and out of sessions, are important.

Client/Therapist Relationship:

- The client-psychotherapist relationship is built on mutual respect, with the client feeling understood, valued, and validated.
- If you have questions or doubts about me as your therapist, now or later, please bring them up as soon as possible. An increased positive understanding may result, although you may seek referral to another mental health professional. Being comfortable with your therapist is essential.
- Confidentiality and attention to boundaries is essential, in part because the sharing of sensitive thoughts and feelings often leads to feelings of vulnerability in the client. Although engaging in psychotherapy may feel like being in a close friendship, it is essentially a relationship in which one person, the client, seeks help and the other, the therapist, tries to provide that help. The therapist makes every effort to respect the client's autonomy and confidentiality.

Complaints and Concerns:

- Please discuss concerns about our interactions, your bill, or any other aspect of your work with me as soon as they arise. I welcome your questions and comments.
- I respect your freedom to leave psychotherapy at any time and to refuse any recommendation that I may make. Ideally, before therapy ends, we can discuss gains and losses experienced during psychotherapy and the potential impact of ending treatment.

PRIVACY & THE LIMITS OF CONFIDENTIALITY:

- The privacy of communication between a client and a psychologist is protected. I can only release information about your treatment to others if you sign a written authorization form that meets certain legal requirements. There are other situations that require only that you provide written, advance consent. They are:
 - You desire to authorize me to provide or share information with a third party. At your request you may limit any of this information.
 - I may consult with another mental health professional about a case. When I do I make every effort to avoid revealing the client's identity. The other professional is, likewise, legally bound to keep information confidential. Any consultations will be noted in your file and I will inform you about them, if you wish.
 - On those occasions when another mental health professional may be contracted to provide substitute or emergency coverage for me, I may need to share some protected information with these individuals for clinical purposes. Any mental health professional I contract with is also bound by the same rules of confidentiality.
 - A billing service manages the accounts of my clients who rely on third party payments. The confidentiality of client data is maintained, except as specifically agreed upon or required by law. I will provide you with information for contacting the service at your request. Minimal client information is necessary for billing.
- Some situations permit or require me to disclose information without either your consent or authorization:
 - If you are involved in a court proceeding and a request is made for information concerning your evaluation, diagnosis, or treatment, such information is protected by the psychologist-client privilege law. I cannot provide any information without your (or your personal or legal representative's) written authorization, or a court order.
 - If a government agency requests the information for health oversight activities, I may be required to provide it.
 - If a client files a complaint or lawsuit against me, I may disclose relevant information regarding that client in order to defend myself.
 - If a client files a worker's compensation claim, the client must execute a release so that I may release the information, records, or reports relevant to the claim.
 - In some situations I am legally obligated to take actions that I believe are necessary in order to attempt to protect others from harm. These situations are rare in my practice, however, if one occurred, I might have to reveal some information about a client's treatment. If I know or have reason to suspect the physical or mental abuse or serious neglect of:
 - a child under age 18,
 - a mentally retarded, developmentally disabled, or physically impaired child under 21 years of age,
 - an elderly adult,

I am required by law to report my belief to the appropriate government department or agency. Once a report is filed; I may be required to provide additional information.

- If I know of or have reasonable cause to believe that a client has been the victim of domestic violence, I must note that knowledge or belief, and the basis for it, in the client's record.
- If I believe that a client presents a clear and substantial risk of imminent serious harm to self or to someone else, and I believe that disclosure of certain information may serve to protect that individual, then I must disclose that information to appropriate public authorities, and/or the potential victim, and/or professional workers, and/or the family of the client. If such a situation arises, I will make every effort to fully discuss it with you before taking any action and I will limit my disclosure to what is necessary.
- When I am working with a couple or family, I do not guarantee that communications made to me outside of sessions or by an individual will not be shared with the other individual or family members. My primary responsibility is the welfare of the couple or family as a whole.
- If I become aware of ongoing domestic violence or intimidation in a couple or family with whom I am working, I will halt treatment and make appropriate referrals.

PROFESSIONAL RECORDS:

- In compliance with HIPAA, I keep your Protected Health Information (PHI) in two sets of records.

Clinical Record:

- Presenting problem, impact of problems on life, diagnosis, treatment goals, progress, medical and social history, treatment history, past treatment records, reports from professional consultants, billing records, reports sent to others, reports to your insurance carrier.
- Except in unusual circumstances that involve danger to yourself and others, you may examine and/or receive a copy of your Clinical Record if you request it in writing and the request is signed by you and dated not more than 60 days from the date it is submitted. Because these are professional records I recommend that you first review them in my presence, or have them forwarded to another mental health professional who can assist you. In most circumstances, I am allowed to charge a copying fee of \$1 per page for the first ten pages, 50 cents per page for pages 11 through 50, and 20 cents per page for pages in excess of fifty, plus \$15 fee for records search, plus postage. Exceptions to this policy are contained in the [Notice of Psychologists' Policies and Practices to Protect the Privacy of Your Health Information](#) which I provide to you.

Psychotherapy Notes:

- These notes are for my professional use and are designed to assist me in providing you with the best treatment. They vary with the client, including information we discuss, how it influences your behavior in the session and in your daily life, how we interact, and matters of attendance and scheduling. They may contain sensitive information that I do not place in your Clinical Record. These notes are kept separate from the clinical record and cannot be released unless you sign a release. Insurance companies are prohibited from requiring your authorization as a condition of coverage and cannot penalize you in any way for your refusal. You may examine and/or receive a copy of these psychotherapy notes.
- HIPAA designates your right to request that I amend your record: requesting restrictions on what information from your clinical record 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 may be 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 HIPAA Notice form, and my privacy policies and procedures.
- I am available to discuss these rights with you at any time. A copy of the HIPAA Notice Form is posted in the waiting room of my office.

● **HIPAA:**

I have been informed that I have access to the HIPPA Notice form, the Notice of Psychologists' Policies and Practices to Protect the Privacy of Your Health Information, which is posted on the wall in the waiting room of Dr. Allemang's office. I understand that I will be given a written copy at my request.

● **FINANCIAL RESPONSIBILITY: REQUIRED FOR ALL CLIENTS, EXCEPT FOR EAP CLIENTS**

- I will pay any session fees, co-payments, and deductibles at the time of service. I will pay \$50.00 for the first and \$75.00 for any subsequent scheduled sessions which I did not attend, or which were canceled without 24 hours notice.
- I will pay any unpaid balance at the conclusion of treatment, for example, in the event that my company rejects some of the claims for my treatment.
- If I have a deductible, and do not know if it has been met, I will pay \$50.00 at each session until the correct amount is apparent.
- I am providing my credit/debit card information, and my signed authorization, to insure payment of any unpaid balance, and payment for scheduled sessions which were not attended or were canceled without sufficient notice.

Credit Card Number: _____

Print Name as it Appears on Card: _____

Expiration Date: _____ 3-Digit Code on Back of Card: _____

Authorization: _____
(Signature of Client) (Today's Date)

- OPTIONAL: I choose to use my credit/debit card to pay for my session fees, co-payments, and/or deductibles. (Circle One) **Y N**

● **PSYCHOLOGICAL SERVICES CONTRACT:**

I have read and I understand the information in this document and I agree to abide by its terms during the duration of my professional relationship with Dr. Allemang.

(Signature Required for All Clients) (Today's Date)

● **THIRD PARTY/INSURANCE COVERAGE: (ONLY FOR THOSE USING INSURANCE)**

- I choose to use my insurance coverage to pay for some or all of the services I receive and I understand that my insurance is a contract between my insurance provider and me.
- I am responsible for obtaining any necessary authorizations/pre-certifications from my insurance carrier and for understanding the extent of my insurance coverage.
- I authorize Dr. Allemang to exchange information with my insurance company to facilitate the use of my benefits.

(Signature of Client) (Today's Date)