Clarity Psychological Services, LLC
9500 Brooktree Road Suite 207, Wexford, PA, 15090
412-628-2818

DISCLOSURE STATEMENT & AGREEEMENT FOR SERVICES

INTRODUCTION:

Welcome to Clarity Psychological Services (CPS). It is my pleasure and privilege to work with you. This form provides information about CPS's services; please review it carefully and feel free to ask any questions about this form.

CONFIDENTIALITY:

All communication and records are held in strict confidence. Information may be released, in accordance with all applicable state and federal laws, when (1) the client signs a written release indicating consent to release; (2) the client expresses serious intent to harm self or someone else; (3) there is reasonable suspicion of abuse against a minor, elderly person, or dependent adult; (4) to acquire payment for services or for billing purposes, or (5) a subpoena or court order is received directing the disclosure of information. To protect your privacy to the greatest extent of the law, it is CPS's policy to assert either (a) privileged communication in the event of #5 or (b) the right to consult with clients, if at all possible, before mandated disclosure in the event of #2 or #3. If you participate in marital or family therapy, I will not disclose confidential information about your treatment unless all person(s) who participated in the treatment with you provide their written authorization to release. If you participate in family and/or marital/couples therapy, I use a "no secrets" policy, which means I am permitted to use information obtained in an individual session or telephone conversation that you may have had with me, when working with other members of your family, at my discretion.

MINORS AND CONFIDENTIALITY:

Communications between me and clients who are minors (under the age of 18) are confidential. However, parents and other guardians who provide authorizations for their child's treatments are often involved in their treatment. Consequently, I, in the exercise of my professional judgment, may discuss the treatment progress of a minor patient with the parent or caretaker. Parents who are minors and their parents are urged to discuss with me any questions or concerns that they have on this topic.

COMMUNICATIONS:

Electronic communications, both telephone and Internet (including email), are not secure methods of communication, and there is some risk that one's confidentiality could be compromised with their use. However, I sometimes may need to communicate with you by telephone, mail, or other means. Please indicate below your consent by checking the

choices listed below (*Please initial when appropriate if it is acceptable to leave a recorded message)*:

___ My therapist may call me at my home. My home number is: _____

___ My therapist may call or text me on my cell phone. My cell number is: _____

___ My therapist may call me at work. My work number is: _____

___ My therapist may email me. My email address is: _____

___ My therapist may send mail to me at my home address.

FEES:

Any payments, insurance co-pays, or deductibles are due at the beginning of your session. If your insurance company fails to provide reimbursement, you will be responsible for the full cost of services provided. The initial visit is typically 55-60 minutes long (the "intake" session) and the fee is $150.00 if you are seeing a doctoral level psychologist and $120.00 if you are seeing a master's level therapist/clinician. Subsequent sessions are $150.00 per 50-55-minute session and $125.00 per 45-minute session when seeing a doctoral level psychologist and $120.00 per 50-55 minute session and $90.00 per 45-minute session when seeing a master's level therapist. Outstanding balances not paid within 30 days are subject to a $10.00 per month rebilling fee. Any questions about fees should be discussed with me as soon as possible. If you are unable to pay on time, please discuss this with me as soon as possible. Payments can be made in cash or check. When paying by check, I suggest you make out your check before each session begins, so that our time will be used best. There is a $25 charge for returned checks.

For any services not covered by insurance (phone contact, reports, conference calls with schools or other third parties, etc.), you will be responsible for payment at the rate of $35 per 15 minutes increment.

- Reports, Evaluations, Assessments, Consultations, and Court Appointments: These ancillary services are frequently requested in addition to therapy. They will be billed at the rate of $150 per hour on a time-used basis. In regards to court testimonies or appointments, this is not covered by insurance and I do *not* provide this service.

- If you provide notice of cancellation or rescheduling less than 48 hours before your appointment time, you may be charged for the appointment (your insurance will not cover this).

CANCELLING APPOINTMENTS:

Please try not to miss any sessions if you can possibly help it. When you must cancel, please give me at least a 48 hour notice. Your session time is reserved for you. I am

rarely able to fill a cancelled session unless I know far in advanced. Failure to provide such notice may result in you being charged $40.00 for a missed appointment. Your insurance will not pay for this. I am also unable to extend time if you are late. This ensures that therapy services are on time and available to all clients. Please know that exceptions to this policy may be made in the instance of a serious medical emergency, or serious family emergency.

PLEASE NOTE: When treating a child, I am usually not able to determine which parent is responsible for payment, nor any split payment (or other provision) that may be court ordered. Whichever parent brings in the child will be responsible for payment at the time of service.

EMERGENCIES:

If you need to contact me, please leave a message on my voice mail. I check messages frequently during the weekdays, and at least once each evening, weekends, and holidays. If this is a life threatening emergency, please call 911 or go to the emergency room of your local hospital *immediately*. If you live in Allegheny County you can call Resolve Crisis Network at 1888-796-8226.

TERMINATION OF THERAPY:

Most of my clients see me once a week for 3 to 4 months. After that, we meet less often for several more months. Therapy then usually comes to an end. The process of ending therapy, called "termination," can be a very valuable part of our work. Stopping therapy should not be done casually, although either of us may decide to end it if we believe it is in your best interest. If you wish to stop therapy at any time, I ask that you agree now to meet then for at least one more session to review our work together. We will review our goals, the work we have done, any future work that needs to be done, and our choices. If you would like to take a "time out" from therapy to try it on your own, we should discuss this. We can often make such a "time out" be more helpful.

INFORMED CONSENT FOR SERVICES:

Your signature below indicates that you have read this agreement for services carefully and understand and agree to its contents. Please ask me to address any questions or concerns that you have about this information before you sign.

_____
Print name of client

If patient is a minor, please print name of person signing and relationship to minor:

_____

_____ _____
Signature Date