INFORMED CONSENT AND PROFESSIONAL SERVICES CONTRACT

In the interest of full disclosure about the psychotherapy you will be receiving, please read through this following agreement, sign, and date at the bottom. This form must be signed in order to begin therapy.

Psychotherapy

Psychotherapy can involve a number of different approaches. Outpatient psychotherapy is voluntary and requires an active effort on your part. Psychotherapy has both benefits and risks. It can often lead to a significant reduction of distress, improved relationships, and improvement or resolution of specific problems. It also sometimes requires recalling unpleasant aspects of your history and sometimes this means you may initially feel uncomfortable before you feel better. By the end of the intake session, your psychologist will be able to provide initial impressions and treatment recommendations.

Sessions

Regular sessions are either 45 minutes or 55 minutes, which includes scheduling and payment of services during that time. If you are late to your session, this time is lost in your treatment. Once an appointment is scheduled, you will be expected to pay for it unless you provide 24-hour advance notice of cancellation.

Confidentiality

By state law, clients have a right to confidentiality and privileged communication. However, the law provides that confidentiality must be broken if the client intends to take harmful or dangerous actions against another human being or if the client is a danger to himself or herself. In addition, if your psychologist believes that a child, an elderly person, or a disabled person is being abused, your psychologist is required to file a report with the appropriate state agency. Further, a court of law may, under certain circumstances, require the psychologist to testify and/or release client files. In the consideration of my clients, I will strongly advise against my participation in any court action involving your case.

Release of Information

A completed Release of Information Form is required before any therapeutic information is shared.

Counseling/Treatment of Minors

Clients under the age of 18 must have the permission of a parent/legal guardian to receive counseling or psychological services. The psychologist will involve parents in treatment as deemed appropriate. While parents have the right to access their child's file, confidentiality between the psychologist and minor is strongly encouraged. When counseling teenagers, they are made aware when their parents have called the psychologist to discuss their case and the general nature of the discussion. Issues of safety of which a psychologist is aware will be discussed with a parent. Issues of safety include but are not limited to engaging in dangerous behavior such as the use of illicit drugs or the use of inappropriate medications, suicidal thoughts or plans, and running away. If you have a question concerning what constitutes a safety concern for a particular child, please discuss this with your psychologist.

Cancellation Policy

Client's session times are reserved exclusively for them. I require 24 hours notice in order to cancel or reschedule an appointment. *Failure to do so will result in full session fee charged for the missed appointment.* Appointments scheduled on Monday need to be cancelled by 12:00 p.m. on the previous Friday in order to prevent being charged. This charge must to be paid before or at the time of your next appointment. **Reminder calls are not made prior to the scheduled appointment**. Exceptions are made for sudden illness, emergencies and severe inclement weather. Thank you for your consideration regarding this important matter.

_____***(Initials) I understand that I will be billed for the full amount if I miss a scheduled appointment without 24-hour notice.***

Urgent Needs
I am not available on an emergency basis. If you have an urgent concern that involves your personal safety, call 911 or go to the nearest Hospital Emergency Room. You may also call the numbers listed below for help:

Suicide Prevention Hotline: 1-800-SUICIDE (784-2433)
Mental Health Crisis Line: 1-888-279-8188

Communication
Therapy occurs during schedule sessions and will not be conducted over the telephone. If you need to contact your psychologist, please call, leave a voicemail message and your call will be returned as soon as possible. Text messages are not received on this landline phone. Due to privacy concerns, your psychologist does not correspond with clients via email, with the exception of scheduling or rescheduling appointments. The office is closed on Fridays and weekends. If there is an emergency, please refer to the Urgent Needs section of the contract.

Financial Agreement
Therapy fees are due at the time of service unless other arrangements are made in advance. The fee is $175 for an initial intake, $150 for individual/family therapy sessions (45-50 minutes) and $175.00 for individual/family therapy sessions (55-60 minutes). Please make checks payable to: Deborah L. Carle, Ph.D., LLC. There is a $25 fee for returned checks. Clients will be charged for court appearances at the rate of $300 per hour. In the event that an account balance is not paid within 90 days of the service date, the psychologist will give the balance to a collection agency.

Other professional services that are not reimbursable by insurance, such as telephone conversations that last longer than 10 minutes, consultation with other professionals that you have authorized or requested, preparation of records or treatment summaries and/or the time required to perform any other services which you may request of your psychologist will be charged on a prorated basis.

_____***(Initials)*** An encrypted credit card number will be kept on file for payment. Any co-pay, deductible, late charge or no-show fees will be charged. If an HSA/FSA card is being used, a secondary credit card must also be kept on file.

Please choose ONE of the following:

_____***(Initials)*** I am a PRIVATE PAY CLIENT – I am responsible for the full fee on date of service.

_____***(Initials)*** I am using my insurance benefits- I am responsible for balance not paid by insurance.

Insurance
Most health insurance plans provide coverage for mental health visits. It is your responsibility to contact your insurance company to determine your outpatient mental health benefits. You MUST BRING YOUR INSURANCE CARD to the INTAKE APPOINTMENT. If your insurance company requires prior authorization and you have not obtained this, YOU are financially responsible for the FULL FEE at the time of service.

I will file a claim for benefits to be paid directly to Deborah L. Carle, Ph.D., LLC, 11111 Nall Ave., Suite 224, Leawood, KS 66211. *An insurance claim cannot be filed until you provide a copy of your insurance card and you sign the required paperwork*. Unless the psychologist is in-network with the client's insurance company, the client will be expected to pay the full fee for services rendered at the time of service. If out-of-network benefits are available, I will send a claim for services rendered. There is no guarantee of benefits or coverage by insurance. Client is responsible for payment of any money the insurance company does not pay. Any disputes with regard to copays, deductibles, or level of benefit must be resolved between you and your insurance company. Upon insurance rejection, client is responsible for payment

within 30 days. Please notify me if there is any change in your insurance coverage during your course of treatment. Failure to do so may result in out-of-pocket expense for you. Receipts for office visits can be obtained upon request.

Financial Responsible Party

I recognize that many children live with two separate families. While you and your child's other parent may have an agreement about paying for health-related appointments, I am not able to be an intermediary in that process. The parent who signs the paperwork at the initial visit will be considered the responsible party for all client balances.

EAP (Employee Assistance Program Clients)

If you have benefits through an Employee Assistance Program, I will bill your authorized visits to that program for you. If, during the course of treatment, you find that you are entitled to an EAP benefit that you were not aware of, I will begin billing your EAP with your NEXT session. I am unable to bill the EAP for sessions that have been completed before I was informed of your EAP benefit, regardless of the start date of the authorization.

Referral Policy/Disclaimer

Clients will be referred outside when treatment required is beyond the scope of care available. Though I strive to be responsible and professional in the referral process, it is your full right and responsibility to select the professional of your choice. Deborah L. Carle, Ph.D., is not liable for any services provided or not provided by the referral professional.

My signature below indicates that I have read and agree to the contact in its entirety and hereby give informed consent to receive therapy services from Deborah L. Carle, Ph.D. and in addition, I agree to all of the following:

1. **If I am using insurance, I authorize Deborah L. Carle, Ph.D. to release information required by my insurance company in order to process the claim. I authorize payment directly to Deborah L. Carle, Ph.D.**
2. **I agree to pay any remaining fee that insurance does not cover; in the event insurance is being submitted on my behalf.**
3. **I give Deborah L. Carle, Ph.D. permission to use the fax machine to correspond with those with whom I have given written permission to consult. I give Deborah L. Carle, Ph.D. permission to contact me on a cellular or cordless phone. I understand that confidentiality of communication cannot be insured on cellular or cordless phones.**
4. **I have received a copy of the Privacy Notice, which now is mandated by federal law and the Health Insurance Portability and Accountability Act (HIPAA). The notice explains HIPAA and its application to my personal health information.**
5. **If I have not been seen in eight (8) weeks and do not have an appointment scheduled, I am considered terminated from therapy.**

Client Name: _____

Client/Guardian Signature: _____ Date: _____

Print Guardian Name: _____

Witness: _____ Date:_____