



KNOW. GROW. HEAL.

Empowering psychological services for children, adolescents and adults

Psychotherapy Services Agreement

Welcome to Know. Grow. Heal., Inc. This document contains important information about my professional services and business policies. Please read it carefully and discuss any questions you may have with me. When you sign this document, it will also represent an agreement between us.

Psychotherapy Benefits and Risks

Psychotherapy can have benefits and risks. Since psychotherapy can involve discussing unpleasant aspects of your and/or your child's life, you or your child may experience uncomfortable feelings. Psychotherapy can, however, help to solve problems, improve symptoms and functioning, increase personal awareness and insight, and reduce feelings of distress. But there are no guarantees or assurances of what you or your child will experience.

The first few sessions will involve a comprehensive evaluation of you or your child's needs. We will discuss goals you and/or your child would like to work towards and create an individualized treatment plan.

Confidentiality

With the exception of certain specific exceptions (described below), everything you and/or your child tell your therapist is confidential. This means that nothing will be revealed without your consent. If we need to talk with or write to you or your child's school or with other professionals who work with you or your child, we will ask you to sign a consent to release and exchange information.

If your child is receiving services, your child and their therapist may do some individual work together. For children over the age of 12 years, I will keep what your child says confidential (between the therapist and your child), unless I feel that certain information is important for you to know. In these cases, we will discuss with your child how we will talk to you about the issue of concern. If your child is an adolescent, it is possible that he/she will reveal sensitive information regarding sexual contact, alcohol and drug use, or other potentially problematic behaviors. Sometimes these behaviors are within the range of normal adolescent experimentation, but at other times they may require parental intervention. If I ever believe that your child is at serious risk of harming him/herself or another, I will inform you.

There are some exceptions to confidentiality. If you plan to pay for all or part of you or your

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child's treatment with insurance, the insurance carrier has a right to know certain basic information, such as a diagnosis and the dates of your sessions. Some managed care companies require more information on an ongoing basis in order to conduct utilization review. Other exceptions to confidentiality are child abuse and neglect, dangerous behavior directed toward other people and potential suicide. Please see the Notice of Policies and Practices to Protect the Privacy of Your Health Information (provided to you) for more information about the exceptions to confidentiality.

HIPPA Communication Requirements

Due to HIPPA regulations and standards, it is vital that we make every effort to protect your health information, and with email and text this cannot be ensured. Email and text will be limited to scheduling updates and exchanging password-protected documentation. Session content will be communicated either face to face or over the phone during a scheduled conversation. For urgent matters, email is not an appropriate form in which to reach me.

Psychotherapy Sessions

Each psychotherapy session lasts for 55 minutes. I make every effort to start and end sessions on time. If a parent or guardian must leave the premises during the appointment, please plan to return at a quarter till the hour in case a session debrief is indicated.

Fee and Payments

For self-pay clients, the fee is \$175 per session (sliding scale fees available). Off-site sessions (lasting 60 minutes or longer) including consultation meetings, school observations, IEP meetings, and in-home appointments can be provided. The fee for these sessions is \$200 per hour. Off-site sessions and/or consultations with other providers, employers, and/or school staff are not covered by insurance. You are financially responsible for the bill. I ask that you pay at each session. In addition to self-pay, I am in-network for Blue Cross Blue Shield PPO. Please consult your BCBSIL PPO insurance agent to clarify your coverage for mental health outpatient services. Co-insurance payments are due within 14 days of service and/or prior to next scheduled appointment, whichever is sooner. You may wish to contact your insurance to clarify coverage for an "out of network provider" if you have other insurance coverage. You will be provided with a monthly invoice that includes all information needed to file for insurance reimbursement and income tax purposes. If you have difficulty paying for therapy under the conditions outlined, I would be happy to discuss alternative plans. I do offer sliding scale fees for self-pay clients.

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Phone Consultation Policy

Due to the often complex nature of both familial and social systems, we understand that some between session problem-solving will be indicated from time to time. In an effort to maintain high quality services offered both in and out of session, I offer 30- minute phone-based appointments. These 30-minute sessions can be scheduled simply by calling or emailing at: 773-681-2480 and dr.sophiduffy@gmail.com. These phone sessions will be billed at a rate of \$45 per appointment. When 30 minutes simply is not enough, a face-to-face session can be scheduled in an effort to meet you and your family's unique needs. Phone-based sessions should not be scheduled or used for emergencies or other urgent matters. Phone-based sessions should not be the primary form of service provision.

Outside Provider Consultation

At Know. Grow. Heal., Inc., I am happy to collaborate with outside service providers given a signed release of information form has been obtained. Phone-based consultation with other health professionals, employers, teachers, physicians, tutors, nannies, childcare providers, etc. will be billed at a rate of \$25 per 15 minutes. This is a different service than off-site meetings and consultations, which are in person meetings lasting an hour or longer.

Legal Involvement

The therapist's role with you and/or your child is limited to providing treatment. In this role, I will not provide recommendations concerning custody or custody arrangements (e.g., visitation) and will not become involved in any legal dispute. If, for any reason, a therapist is required to appear as a witness, the party responsible for their participation agrees to reimburse them at the rate of \$375 per hour for time spent traveling, preparing reports, testifying, being in attendance, and any other case-related costs.

Missed Sessions

If you need to cancel a session for a reason other than illness or emergency, I ask that you give at least 24-hours notice. If a session is missed or canceled without 24-hour notice, you are responsible for paying for a missed session fee of \$75. If you are late to a session, you are responsible for the full session fee. Insurance cannot be used to cover missed session fees.

Availability and Emergencies

I may not be immediately available by telephone or email. In the case of an emergency, always call 911 and/or proceed to your nearest emergency room. You are welcome to leave a voicemail and I will return your call as soon as I am able, typically within 24 hours. Voicemail messages and email are not appropriate for communicating emergencies. If I am unavailable

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for an extended period of time, I will have another therapist cover; I will let you know who that person is and how you can reach them.

Professional Records

The laws and standards of our profession require that we keep treatment records. You and your child (if age 12 years or older) have the right to inspect and copy your records. Please see the Notice of Policies and Practices to Protect the Privacy of Your Health Information (provided to you) for more information about my professional records.

Late Payment

A \$25 late payment fee will be added to all invoices where payment has not been received within 14 days of the invoice date.

Other Rights

You have a right to ask questions about any aspect of therapy and about my specific training and experience. If you are unhappy with what is happening in therapy, I encourage you to talk with me so that I can respond to your concerns.

You have the right to considerate, safe, and respectful care, without discrimination as to race, ethnicity, color, gender, sex, sexual orientation, age, religion, national origin, or source of payment. Both client and therapist have the right to terminate services at any point during treatment.

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Agreement

Your signature below indicates that you have read the service agreement and agree to its terms. Your signature also acknowledges that you received a copy of our Notice of Policies and Practices to Protect the Privacy of Your Health Information (HIPAA).

_____ Adult Client Name (please print)	_____ Adult Client Signature	_____ Date
_____ Child Client Name (please print)	_____ Child Client Signature (if 12 and older)	_____ Date
_____ Parent/Guardian Name (please print)	_____ Parent/Guardian Signature	_____ Date
_____ Therapist Signature	_____ Date	

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