SSQ PSYCHIATRY LLC
TREATMENT CONSENT FORM

Please read carefully, initial on each page, sign, and date on the last page

SERVICES OFFERED

PSYCHOTHERAPY

Psychotherapy, or talk-therapy, is a powerful treatment for many mental complaints. It offers benefits of improved interpersonal relationships, stress reduction, and a deeper insight into one's own life, values, goals, and development. It requires a great deal of motivation, discipline, and work from both parties for a therapeutic relationship to be an effective one. Clients will have varying success depending on the severity of their complaints, their capacity for introspection, and their motivation to apply what is learned outside of sessions. Clients should be aware that the process of psychotherapy may bring about unpleasant memories, feelings, and sensations such as guilt, anxiety, anger, or sadness. It is not uncommon for these feelings to have an impact on current relationships you may have. If this occurs, it is very important to address these issues in session. Usually these unpleasant sensations are short lived.

At your initial visit, I will conduct a thorough review of your current complaints and of your background. By the end of the initial visit I will offer my preliminary impressions, and we will discuss your treatment options. Sometimes, psychotherapy alone will suffice. Often times, however, a combination of psychotherapy and medication management is optimal (see below). One of the most important curative aspects of a therapeutic relationship is the goodness-of-fit between therapist and client, so the initial visit is also your opportunity to determine for yourself if I am the right therapist for you. If you feel that I am not well matched to your needs, I would be happy to provide you referrals to other mental health professionals.

MEDICATION

Medications may be indicated when your mental symptoms are not responsive to psychotherapy alone. When a mental illness markedly impacts your ability to work, maintain interpersonal relationships, or properly care for your basic needs, medication may offer much needed relief. If it is agreed that medications are indicated, I will discuss with you all the medication options that are available to treat your current condition. I will make an effort to present this information in language that you can understand. You will learn how the medication works, its dosage, and frequency, its expected benefits, possible side effects, drug interactions, and any withdrawal effects you may experience if you stop taking the medication abruptly. By the end of the discussion you will have all the information you need to make a rational decision as to which medication is right for you.

You may already be receiving psychotherapy from another therapist, and are referred to me for medication management. In this case I will make a strong effort to coordinate care with your therapist (with your consent). I believe communication between mental health professionals is key to providing effective care. Not everyone is a good candidate for medication therapy. Such therapy requires strict adherence to dosage, frequency, close follow-up, and sometimes regular blood tests. Your ability to adhere to medication treatment will be taken into consideration in making the decision to start such therapy.

Initials ____

FREQUENCY AND DURATION OF VISITS

At your initial ____ minute visit, we will decide together the structure of your therapy. If medications are prescribed, or changed, I prefer to conduct a ___ minute follow-up visit in approximately two weeks. This is necessary to ensure proper administration, and minimize any side effects you may experience. If your symptoms improve, follow-up visits can be spaced out at monthly intervals. For clients on maintenance therapy, follow-up visits can be held at three-month intervals. If you are to undertake psychotherapy, weekly __ minute sessions will provide the best results. We may discuss an alternate treatment structure depending on your circumstances.

FEES

For a __ minute initial evaluation, my fee is $____.00. Follow up psychotherapy or combination (psychotherapy and med management) visits will last ___-minutes, and will cost $____.00. The fee for a ___ minute med management visit is $___.00. Other miscellaneous services such as filling forms, telephone correspondence, prior authorizations, court hearings, etc. requiring more than ten minutes of time, will cost $___.00 per ten minute interval. Fees may be subject to change. If my fees are to increase, I will provide you with a thirty (30) day notice to alert you to the change.

CANCELLATIONS AND NO-SHOWS

If you must cancel or reschedule an appointment, I require at least 24-hour notice (weekends not included). If your appointment is on a Monday, the cancellation must be made by the same hour on the preceding Friday. Cancellations that occur with less than 24-hour notice or failure to show to an appointment will be charged the full fee for the session.

PAYMENTS

I will expect payment at the beginning of each session, unless we have agreed on other arrangements. I accept cash or personal check, and major credit cards. Checks should be made payable to "_____." If payment is sixty (60) days past due, I reserve the right to utilize legal resources such as collection agencies or small claims court in order to obtain payment for my services.

INSURANCE POLICIES

I do not currently accept insurance policies. If you are on a PPO plan, I will be considered "out of network." If you wish to be reimbursed for your sessions, you will need to consult your insurance company to determine their policies regarding mental health benefits for out-of-network providers. I will provide you a paper "super bill" that you can submit to your insurance company for reimbursement. Most PPO plans will reimburse between 20%-60% of the fee. Many insurance companies have limitations on the number and frequency of visits, and types of medications that will be covered. Occasionally, certain forms of treatment, or large number of sessions require a prior authorization. If this is the case, I may need to provide information about your diagnosis, history, and treatment plan to your insurance company. Once this information is provided, it will be subject to the privacy policies of the insurance provider.

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MEDICAL RECORDS

I am required by law to keep complete medical records. Most medical records will be electronic, encrypted, and under strict security. Any written records including the initial consent forms, letters, outside medical records, will be kept secure. You are entitled to review your medical record at any time, unless I feel that by viewing your records, your emotional or physical well-being will be jeopardized. If you wish to view your records, I recommend that we review them together to minimize any confusion or misinterpretation of medical terms. Time spent collecting, printing, copying, and summarizing the medical record will be charged the appropriate fee.

CONFIDENTIALITY

The security of your sensitive information is of the utmost importance, and I am bound by law to protect your confidentiality. Any disclosure of your treatment to others will require your explicit written consent. As described above, basic information about your treatment may be disclosed to your insurance company for purposes of prior authorization if necessary. There are exceptions to this confidentiality, where disclosure is mandatory. These may include, but are not limited to the following:

- If there is a threat to the safety of others I may be required by law to take protective measures including reporting the threat to the potential victim, notifying police, and seeking hospitalization.
- When there is a threat of harm to yourself, I am required to seek immediate hospitalization, and will likely seek the aid of family members or friends to ensure your safety.
- In legal hearings, you do have the right to refuse my involvement in the hearing. There are rare circumstances, however, in which I will be required by a judge to testify on your emotional, or cognitive condition.
- In situations where a dementing illness, epilepsy, or other cognitive dysfunction prevent you from operating a motor vehicle in a safe manner, I will be required to report this to the DMV.
- If a mental illness prevents you from providing for your own basic needs such as food, water, shelter, I will be required to disclose information to seek hospitalization.
- These situations rarely occur in an outpatient setting. If they do arise, I will do my best to discuss the situation with you before taking action. In rare circumstances I may find it helpful to consult with other professionals specialized in such situations (without disclosing your identity to them).

MY PRACTICE

No person operating in my office suite will have access to your records without your written consent. I am fully responsible for the services I provide you. If I refer you to another community therapist/physician, we may find it helpful to collaborate and coordinate your care, and this will require your written consent. Any clinician to whom I refer you will be responsible for the care they provide to you.

You agree to follow all rules and requirements for the safe and legal use of controlled or prescribed medications, as prescribed by myself or another physician. You also agree to follow all rules of the practice regarding behavior and safety. If your behavior is deemed to be inappropriate, aggressive, or outside the scope of a professional physician-patient relationship, I reserve the right to terminate your treatment and refer you to an appropriate therapist or hospital for further treatment. In such an event, I will provide you with appropriate notice and make your medical records reasonably available to you as described herein.

Initials ____

CONTACT INFORMATION

My voice mail at _____ is the best way to contact me outside the office. I do carry a cell phone with me at all times, and check my voicemail regularly. When you leave a message, please state your name clearly, your phone number(s) (even if you think I have it), reason for calling, and let me know when the best time is to contact you. When a message is left, I will be paged immediately. Please note that I may be with a client, but will make every effort to address your issue as soon as possible. For non-urgent matters, please allow 24 business hours for a response. Messages left late in the day, on weekends or holidays, may not be returned until the next business day.

If you or someone close to you is in immediate danger, please call 9-1-1 or proceed to the nearest emergency room. If you choose to contact me via e-mail, please be aware that e-mail is not a secure means of communicating sensitive mental health information. I do not check my e-mail regularly, so it is not an appropriate way of contacting me in an emergency.

TREATMENT CONSENT

By signing below, you certify that you have read and understand the terms stated in the Treatment Consent Form. You indicate that you understand the scope of my services, session structure, fees, cancellation/no-show policies, payment policy, insurance reimbursement, confidentiality, the nature of my practice, and my contact information, and that you agree to abide by the terms stated above during the course of our therapeutic relationship.

Client name (please print): _____ Date: _____

Client's signature: _____

Psychiatrist signature _____ Date: _____

Initials ____