Psychological Perspectives LLC
Diagnostic, Evaluation, & Treatment Center

Welcome!

Welcome to Psychological Perspectives LLC. We are glad that you and your family have chosen our services. This information will help you become familiar with your rights and responsibilities as a participant in services. If you have any questions about anything after reading this information, please ask. We will be glad to answer your questions.

ENROLLMENT AND INTAKE

To enroll in outpatient services, you will be asked to complete some preliminary paperwork. This process is called an intake assessment. This is where we get to know you and your family history to better understand your concerns and appreciate and respect your uniqueness and strengths. This information and input from you will help guide treatment. The process of getting information and completing paperwork may take some time, so we ask for your patience. It is important that we have some understanding and history of your concerns to adequately assist you in addressing your needs.

PAYMENT FOR SERVICES

- Psychological Perspectives LLC charges fees for most services and will bill either you or your insurance company.
- Co-pay fees and liability amounts are due on the day you receive the service.
- On your first appointment, you will be asked to complete billing information. Please present your current valid insurance card, social security card, Medicare, and/or Medical Assistance Cards.
- If your insurance company does not cover services and you can't afford the services, we will work with you to create a flexible payment plan or determine if there are other funding sources available.
- It is your responsibility to notify Psychological Perspectives LLC immediately if your insurance or payment information changes. Uncovered services will be billed directly to you.
- At each visit, you will be asked to sign an encounter form to verify services received.

TREATMENT CONTRACT

After the intake process is complete, we will discuss with you what you would like to see changed. You will then review the treatment plan developed at intake to work toward the changes that you identified and have agreed to address. Your treatment plan will be reviewed and updated with you every 120 days or 15 visits, whichever comes first. At that time you will need to sign the treatment plan to indicate that you have participated in the development of and agree with the treatment plan. We also need your child's signature if they are the client and age 14 or older. Services are voluntary, and you may terminate these at any time. Treatment is not an exact science, and no assurances have been made regarding the results of services. Active participation of the client/ family in working toward treatment goals will be essential to therapeutic outcomes.

INITIAL THERAPY APPOINTMENT

The first meeting will be used to provide you with further explanation of services and to work with you and your family to understand your goals for treatment and to explain treatment options and approaches. We encourage you to ask any questions that you have at that time or throughout your services.

APPOINTMENTS

- If you are late for an appointment, we cannot guarantee you a full appointment.
- If you are over 15 minutes late, the appointment may be rescheduled.

CANCELLATIONS

- 24 hours advance notice is required for cancellations. Cancellations with less than 24 hour notice will be indicated as a no show. Missing 3 appointments within a treatment period can result in termination of services, and re-entry into services may be considered after a 6-month period following discharge.
- A $50.00 out-of-pocket fee for a same day cancellation or no show may apply.
- If you reach the voicemail system, please provide your name, phone number, and the date/time of the appointment that you are canceling.

CONFIDENTIALITY

Your participation in outpatient therapy and the information you provide is considered private and strictly confidential. Strict guidelines are in place to ensure your privacy. In general, information is released only under the following conditions as permitted by law:

1. With your written consent.
2. With a court order.
3. In case of a medical emergency, including suicidal risk.
4. If information discloses that a violent crime is threatened or has been committed.
5. If there is evidence to suggest that child or elderly abuse has occurred.
6. When therapist determines that the client is in need of hospitalization.
7. When a client initiates a lawsuit against therapist.
8. If a client dies, the spouse or parent/guardian of a deceased client have a right to access their child's or spouse's records.
9. If there is admitted prenatal exposure to controlled substances that are potentially harmful.
10. If there are concerns for professional misconduct that is reported by other health care professionals, related records may be released in order to substantiate disciplinary concerns.

In addition, insurance companies and other third-party payers are given information that they request regarding services to clients. Information that may be requested includes type of services, dates/times of services, diagnosis, treatment plan, description of impairment, progress of therapy, case notes, and summaries. Further, information about clients may be disclosed in consultations with other professionals in order to provide the best possible treatment. In such cases the name of the client, or any identifying information, is not disclosed. Clinical information about the client is discussed.

MANDATED REPORTING

Mental health staff are considered mandated reporters of child abuse.

Pennsylvania's Child Protective Services Law defines an abused child as any person under the age of 18 who shows evidence of one of the following: Non-accidental serious physical injury, non-accidental serious mental injury, serious physical neglect, or sexual abuse. The injury, neglect, or abuse must be caused by a perpetrator or acts of omission of a perpetrator. We are required to report any knowledge or suspicion or claim of abuse to CHILDLINE 1-800-932-0313. In the event that we are obligated to report some concern about your family, whether it was to CHILDLINE or to Children, Youth, and Family Services, we want you and your family to be fully aware of our position. We do not make the determination that any act is "abuse." Our job is to report any suspicions or acts that fall within the guidelines above.

PROFESSIONAL RECORDS

The laws and standards of psychology and professional counseling require that treatment records be kept. You are entitled to review your therapy health records, or your clinician can prepare a summary for you instead. However, you may not photocopy any psychotherapy notes or other documents in the mental health file. Because these are professional records, they can be misinterpreted and/ or upsetting to untrained readers. If you wish to see your records, it is recommended that we review them together so that the contents may be discussed. Confidentiality cannot be maintained via email correspondence, and will be limited to scheduling purposes. Clients will be charged an appropriate fee for any professional time spent in responding to information requests.

We routinely request authorizations for school, medical, and other records for clients entering into services. It is important to know how other factors may be impacting the reason for seeking treatment. These records cannot be released or requested without a signed authorization. Please ask if you have questions regarding requests for records.

MINORS

If you are under 18 years of age, please be aware that laws may provide your parent/guardian the right to examine your treatment records. If your parent/guardian agrees to give up rights to access your records, the clinician will provide them

only with general information about our treatment, unless there is concern with high risk that you will seriously harm yourself or someone else. In this case, your clinician is required by law to release information to them and possibly to protection agencies. Before giving your parent/guardian any information, we will discuss the matter with you, if possible, and do our best to handle any objections that you may have. It is also noted that PA State Law allows minors 14 years and older the right to consent for mental health treatment.

CRITERIA FOR DISCHARGE

- Successful completion of treatment (attainment of treatment goals)
- Client voluntarily leaves treatment
- Treatment has been determined to be ineffective and the client is referred to another provider or level of care
- Client threatens to harm or harms another client or staff person
- Client's needs and behaviors are not within the scope of services
- Irregular or nonattendance
- Inability to reach the client/ lack of contact with the provider
- Client/parent/guardian refuses to follow treatment recommendations or agree to participate in the treatment plan
- Continued participation of the parent/guardian in activities/behaviors that put the child at risk

From the time of admission, it is always a goal to work with you to meet your treatment goals. During the course of treatment, regular treatment plan updates will be done with you to assess treatment progress and formulate an aftercare plan for when services end. The aftercare plan will assist you and your family with identifying and planning for any services that you or your family may need following discharge.

PROFESSIONAL FEES

The fees for services will vary depending on the type of session. In general, the hourly out-of-pocket fee is $160 for an initial intake appointment and $135 per therapy session after that. Following intake, psychological testing is also billed at $135 per hour. If we are contracted with your behavioral insurance provider, we will agree to accept the contracted reimbursement amount specified by your insurance provider if less than the above stated amount. You will be expected to pay for each session, or co-pay/ deductible/ co-insurance, determined by your insurance provider at the time it is held. This is so unless we agree otherwise or unless you have insurance coverage, which requires another arrangement. Payment schedules for other professional services will be agreed to when they are requested. In circumstances of unusual financial hardship, we may be willing to negotiate a fee adjustment or payment installment plan. There will be an additional fee of $35 for each returned check.

If you go more than two appointments without making payments, you will have to contact the office to arrange scheduling of any future appointments, as there will no longer be a standing appointment for you. If your account has not been paid for more than 60 days and arrangements for payment have not been agreed upon, the company has the option of using legal means to secure the payment. This may involve hiring a collection agency or going through small claims court. If such legal action is necessary, its costs will be included in the claim. In most collection situations, the information released includes the patient's name, the nature of services provided, and the amount due. All payments can be made by cash or check in the name of "Psychological Perspectives LLC."

On occasion cases become involved in the court system. Examples include divorce, custody, and personal injury cases, but there are many others. In signing this form, I acknowledge that I **will not** be seeking my provider's testimony in court. I also agree not to use any treatment records in court. As otherwise applicable, fees for court-related services are billed at a per diem fee of $2,500 to the requesting party. This includes any additional consultation with my attorney, preparation for deposition, actual deposition, or court testimony (including travel and wait time). All fees for court-related services are to be paid in advance.

There may be some circumstances in which the client requests that we complete forms on their behalf. Some examples of these might include Disability Claim forms, Workers Compensation Claim forms, Health or Life Insurance Application forms, or requests for additional sessions from my managed care companies. I understand that I will be charged $25 for the completion of these forms if they are completed outside of our session time or there will be no charge if they are completed during our regular session time. Fees will not be charged for corresponding with another health care professional about a client's care.

INSURANCE REIMBURSEMENT

By signing this form, I am acknowledging my responsibility for payment of any services not covered by the funding source. Funding sources may include, but are not limited to, Medical Assistance, private/commercial insurance, county funding,

and/or assigned managed care company. I am aware that it is my responsibility to maintain enrollment in funding sources. In the event there is a change in my funding source, it is my responsibility to notify Psychological Perspectives LLC. I acknowledge that failure to notify Psychological Perspectives LLC of changes may result in uncovered services and that I may be liable for services not paid by my funding source. I acknowledge that it is my responsibility to contact my funding source to determine what my responsibilities are and what the responsibilities are of this provider. In the event that insurance payments are paid out to me directly, it is my responsibility to forward these payments to Psychological Perspectives LLC. My signature on this form gives permission for Psychological Perspectives LLC to bill my funding source on file, as well as authorizes the release of information to my funding source to secure payment for services provided.

When applicable, it is the responsibility of Psychological Perspectives LLC to obtain authorizations and/or authorization updates from my funding sources. This process may include releasing the diagnoses as well as additional clinical information, such as treatment plans or summaries, or copies of the entire record in some cases. This information will become part of the insurance company files and will probably be stored in a computer. Though all insurance companies claim to keep such information confidential, Psychological Perspectives LLC has no control over what they do with it once it is in their hands. In some cases, they may share the information with a national medical information databank. Upon request, we will provide you with a copy of any report we submit. For services not covered by your insurance, we will discuss and sign additional consent for agreement of out-of-pocket expenses.

CONSENT TO EMERGENCY TREATMENT

I/ the client ____ do/ ____ do not give my consent to receive emergency and/ or first aid care by Psychological Perspectives LLC, local doctor(s), ambulance service, or hospital emergency department in the event that such emergency medical treatment is appropriate. This includes diagnostic procedures. I further allow Psychological Perspectives LLC to have me transported to a medical facility if the situation is determined to warrant such care.

CONTACTING US

You may call the main office number at (412) 294-7399. We may not be immediately available by telephone, although telephone messages are checked regularly Monday through Friday between 9 AM to 5 PM. We will make every effort to return your call on the same day you make it, with the exception of weekends and holidays, although this cannot be guaranteed. If you are difficult to reach, please inform us of some times when you will be available. If you are unable to reach us and feel that you cannot wait for a return phone call, contact your primary care physician or the nearest emergency room and ask for the psychiatrist on call. You can also call re:solve, a 24-hour mental health crisis line, at 1-888-7-YOU CAN (1-888-796-8226). Please specify below how we should respect your confidentiality when phoning you:

_____ Initial here if you would like us to maintain your confidentiality when leaving voicemails by stating only our names and call back number.

_____ Initial here if we may state our names, call back number, nature, and purpose of the call.

Your signature below indicates that you have read the information in this document and agree to abide by its terms during our professional relationship.

My signature indicates that I (client and parent/guardian) have reviewed and understand the above information, including confidentiality and consent for treatment.

Client Printed Name _____ Date_____

Client Signature _____ Date_____

Parent/ Guardian Signature (Minors) _____ Date _____

Provider's Signature (Witness) _____ Date _____