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Outpatient Services Contract

Welcome to my therapy practice. I look forward to working with you. This document contains information about my professional services and practice policies. Please review the following information carefully and do not hesitate to ask questions if any of the following information appears to be unclear. After signing this document, it will represent a professional agreement between us.

Psychological Services: Psychotherapy is a difficult process to describe in general terms. The process of psychotherapy typically focuses on change, which will hopefully result in improvements in one or more areas of your life. Although you can receive many benefits from therapy, this process can sometimes be frustrating and challenging. Since therapy often involves discussing unpleasant aspects of your life, the process of therapy may cause you to experience strong and often difficult emotions (e.g., anger, sadness, loneliness). On the other hand, the potential benefits of participating in therapy might include improved relationships with others, reduced negative emotional states in your day to day life, an increased ability to manage stress and other life problems, and discovering new ways of thinking about yourself, others, and the environment. Therapy often involves a large commitment of time, money, and energy. In order for therapy to be most successful, it requires a commitment from you to work on the goals/objectives that we talk about both during our sessions and at home.

Meetings: During our first session, we will complete an intake assessment. This process typically involves me obtaining information from you about your history and background. The goal of this assessment is for me to gain a better understanding of you so that I can provide the best treatment possible. During this session, we will also establish your goals for therapy and assess the likelihood of you achieving these goals through our therapy sessions. If you decide that you could benefit from therapy with me, I will typically schedule one 45-minute session (one appointment hour of 45 minutes duration) per week at a mutually agreed upon time, although some sessions might be longer or occur more frequently. Once an appointment time is scheduled, you will be expected to pay for it unless you cancel 24 hours in advance (note: there is an exception to this policy if we both agree that the reason for the missed appointment was because of circumstances that were beyond your control).

Professional Fees: My hourly fee is $150. In addition to weekly appointments, I charge this amount for other professional services that you may need, although I will break down the hourly cost if I work for periods of less than one hour. Other services may include, report writing, preparation of records or treatment summaries, and time spent on performing any other service that you request of me.

Billing and Payment: Payment is due at the time services are rendered unless other arrangements have been made (e.g., if you are using health insurance coverage for payment). If you are using health insurance to cover payment for our sessions, it is expected that your copayments will be made at the time services are rendered. Payment schedules for other

professional services will be agreed to when they are requested. In circumstances of unusual financial hardship, I am available to discuss payment arrangements. In cases when an account has been neglected by you and there has been no sign of good faith despite my repeated attempts toward resolution, I reserve the right to use legal means to secure the payment (e.g., hire a collection agency or go through small claims court). In most collection situations, the only information that I would release regarding your treatment would be your name, the nature of services provided, and the amount due. Finally, there is a charge for all returned checks.

Missed Appointments: As previously mentioned, I reserve the right to charge you (i.e., not your insurance carrier) for any missed appointments or any appointment that is cancelled within less than 24 hours of your scheduled appointment. Again, the charge for a missed session will be waived if there is agreement between us regarding your inability to attend the session because of circumstances beyond your control.

Insurance Coverage: Please be advised that you are financially responsible for your visits at my office. My practice will submit charges for treatment to your insurance carrier. If your insurance company requires an authorization number prior to the start of therapy, you are responsible for contacting them in advance of our first therapy session. Please be advised that it is my custom to inform all new patients about their responsibility to contact their insurance company prior to starting therapy. Although I accept insurance reimbursements, **payment for services is ultimately your responsibility.**

Contacting Me: I am often not immediately available by telephone and it may take some time before I am able to return your call. If I am unavailable, my telephone is answered by voice mail that I monitor frequently. If there is a matter that you think cannot wait until our next scheduled appointment, leave a message and I will return your call as soon as possible. I will make every effort to return your call on the same day that you called, except for weekends and holidays. If you have an emergency and cannot reach me quickly enough, please go to the nearest hospital emergency room. On occasions when I plan to be unavailable for an extended period of time (e.g., away on vacation), I will provide you with the name and phone number of a colleague to contact.

Contacting You: If you are 15 minutes late for a scheduled session, I will typically call you to learn if you are still planning to come to my office. If you do not wish for me to call you, please let me know and/or provide a more discrete (e.g., cell phone) number. In addition, there may be instances when you will receive a mailing from my office (e.g., a statement or some other communication). My mailing envelopes display my practice's name and address. If receiving mail from my office is a concern for you, please let me know.

Professional Records: The law and standards of my profession require that I maintain treatment records. You are entitled to receive a copy of the records or, I can prepare a summary of the records instead. Because these are professional records, they can be misinterpreted or upsetting by someone who is not a mental health professional. If you wish to see your records, I recommend that you review these records in my presence so that we can discuss the information contained in the records.

Legal Cases: If you are involved in a legal case in which your mental status is being questioned and the services that you have requested are NOT for expert opinion or testimony, then please be

advised that your therapist, in order to avoid a potential conflict of interest and to preserve the patient-therapist relationship, cannot serve as an independent expert at a later date. If you need an expert opinion or evaluation for legal purposes, please let me know BEFORE the start of services so that I may refer you to a professional who can help in this area.

Confidentiality: Following the New Jersey state law and the American Psychological Association (APA) code of ethics, the therapist-patient relationship is privileged and confidential. In most cases, I can only release information regarding our work together with your permission. However, there are several limitations to confidentiality depending on your particular circumstances. If your health insurance carrier falls under the federal ERISA act, this carrier is entitled to and may request information about your treatment. In most legal proceedings, you have the right to prevent me from sharing information regarding your treatment. However, in some cases, a judge may order my testimony if he or she finds this action to be necessary. If I believe that a child is being abused or neglected, I must report this suspected abuse to the appropriate state agency. If I believe that you are an imminent danger to yourself or others, I am required to take protective actions (e.g., call the police, warn a potential victim, or seek emergency psychiatric care for you). These situations do not occur frequently and I will make every effort to discuss these issues with you before taking action.

Therapy Contract

By signing below, I verify that I have read and understand the therapeutic contract and give my consent for treatment:

Signature: ________________________________ Date:_______________

Notice of Privacy Practices

By signing below, I verify that I have received and reviewed the Notice of Privacy Practices. I understand that Dr. Rockwood is committed to protecting my privacy and confidentiality as described in the Notice of Privacy Practices.

Signature: _____________________________Printed Name: _____________________________

Signature: _____________________________Printed Name: _____________________________
Parent (for Minor)