Psychology Associates of La Mesa
5360 Jackson Drive, Ste, 104
La Mesa, CA 91942

Your name: _____ Date_____ Dr_____

AGREEMENT FOR PSYCHOLOGICAL SERVICES

This form explains how we will work together. If there is anything you do not understand, please ask me. I will answer your questions.

SERVICES

I provide both therapy and testing. I work with adults and children.

Who are you seeking services for? Check all that apply.

(__) Myself
(__) My spouse or partner
(__) My child or children
(Please list names of children)

Child's Name _____ Age _____ Grade _____

_____

_____

_____

_____

_____

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_____

If services are for a child, are you the:

(Check only one)

( ) Parent, still married to child's other parent.
( ) Parent, divorced from child's other parent
( ) Parent, was not ever married to child's other parent
( ) Step-Parent, married to child's biological parent
( ) Adoptive Parent
( ) Legal Guardian
( ) Foster Parent
( ) Caregiver, but not parent of child (ie, grandmother, relative, friend of family)

Does <u>anybody</u> living in your home have a social worker with CPS? __ Yes __ No

PERMISSION TO PROVIDE SERVICES FOR CHILDREN

I need written consent to care for children under 18 years old. If there are two parents, usually both must give permission, even if they do not live together. When you sign this form, you give me consent to treat the children listed on the first page.

✓ I have read and understand the above. Initials_____ Date_____

PARTICIPATION IN SERVICES IS VOLUNTARY

Seeing me is voluntary. If you wish to change providers, I will help you find another therapist who will see you.

Even the court or a social worker has said you must get therapy, you can still ask to change therapists. If you are not clear about your rights, ask your attorney for advice.

You can ask questions at any point in our work together

✓ I have read and understand the above. Initials_____ Date_____

LIMITS OF SERVICES

I do not guarantee results. I will do my best, but treatment results may not be what you hope for.

There are some risks in family or couples therapy. For example, you may come for services to fix a relationship, but one party may decide to end it. This can be partly as a result of therapy. I have no ability to foresee or prevent such possible outcomes.

I am not a physician. I do not write prescriptions or tell you about how to take medications your doctor has prescribed.

I work alone and am not part of a group. A machine often answers my telephone. I check my messages frequently, and strive to return calls quickly. If you cannot reach me in an emergency situation, please call 911 or go to the nearest emergency room.

If you have questions about the benefits and possible risks of psychological services, please ask them.

✓ I have read and understand the above. Initials_____ Date_____

Notice of Privacy Practices – Brief Version

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. YOU WILL ALSO BE OFFERED AN EXTENDED NOTICE OF PRIVACY PRACTICES AT THE TIME OF YOUR FIRST SESSION.

Our commitment to your privacy

Our practice is dedicated to maintaining the privacy of your personal health information as part of providing professional care. We also are required by law to keep your information private. These laws are complicated, but we must give you this important information. This pamphlet is a shorter version of the full, legally required NPP which you received along with this so refer to it for more information. However, we can't cover all possible situations so please talk to our Privacy Officer (see the end of this pamphlet) about any questions or problems.

We will use the information about your health which we get from you or from others mainly to provide you with **treatment**, to arrange **payment** for our services, and for some other business activities which are called, in the law, health care **operations.** After you have read this NPP we will ask you to sign a **Consent Form** to let us use and share your information. If you do not consent and sign this form, we cannot treat you.

If we or you want to use or disclose (send, share, release) your information for any other purposes we will discuss this with you and ask you to sign an Authorization form to allow this.

Of course we will keep your health information private but there are some times when the laws require us to use or share it. For example:

1. When there is a serious threat to your health and safety or the health and safety of another individual or the public. We will only share information with a person or organization who is able to help prevent or reduce the threat.

2. Some lawsuits and legal or court proceedings.

3. If a law enforcement official requires to do so.

4. For Workers Compensation and similar benefit programs.

There are some other situations like these but which don't happen very often. They are described in the longer version of the NPP.

Your rights regarding your health information

1. You can ask us to communicate with you about your health and related issues in a particular way or at a certain place which is more private for you. For example, you can ask us to call you at home, and not at work to schedule or cancel an appointment. We will try our best to do as you ask.
2. You have the right to ask us to limit what we tell people involved in your care or the payment for your care, such as family members and friends. While we don't have to agree to your

request, if we do agree, we will keep our agreement except if it is against the law, or in an emergency, or when the information is necessary to treat you.

3. You have the right to look at the health information we have about you such as your medical and billing records, and your psychotherapy notes. You can even get a copy of these records but we may charge you. Contact our Privacy Officer to arrange how to see your records. See below.

4. If you believe the information in your records is incorrect or missing important information, you can ask us to make some kinds of changes (called amending) to your health information. You have to make this request in writing and send it to our Privacy Officer. You must tell us the reasons you want to make the changes.

5. You have the right to a copy of this notice. If we change this NPP we will post the new version in our waiting area and you can always get a copy of the NPP from the Privacy Officer.

6. You have the right to file a complaint if you believe your privacy rights have been violated. You can file a complaint with our Privacy Officer and with the Secretary of the Department of Health and Human Services. All complaints must be in writing. Filing a complaint will not change the health care we provide to you in any way.

If you have any questions regarding this notice or our health information privacy policies, please contact our Privacy Officer who is **Linda Schrenk, Ph.D.** and can be reached by phone at **(619) 698-9525** or by email at drls@att.net.

The effective date of this notice is April 14, 2003

✓ I have read and understand the above Notice of Privacy Practices.

Initials_____ Date_____

PARENT'S RIGHTS TO CHILDREN'S RECORDS

(If no children are to be receiving services, skip to next page.)

In general, parents have the right to information about the services their children receive. I will tell you whether or not the child is participating and making progress. I will not show you my records. I will not discuss what the child says in private.

> At times I may refuse to provide parents, or any third parties acting on the request or authorization of parents, with information and records pertaining to a child's mental health evaluation or treatment, if it is my opinion that such disclosure would negatively impact the child or the child's evaluation or treatment. Your initials below and your signature on this form constitute a release from any and all liability from my good-faith refusal to disclose your child's information or records.

If you have any questions, please ask them before initialing this section.

✓ I have read and understand the above. Initials_____ Date_____

APPOINTMENTS

Sessions usually last 50 minutes. If you miss too many sessions, I will stop working with you.

✓ I have read and understand the above. Initials_____ Date_____

FINANCIAL AGREEMENT

My usual fee is **$125 per 50-minute session** for therapy services performed in the office, and **$125 per hour** other services. **As a rule, you should expect to pay at the end of each session.** Any change in this fee policy must be negotiated in advance

Your insurance may pay for all or part of the fee. If you are planning to use your insurance, let me know, so we can discuss specifics. Your co-payment is due the day I see you. In case your insurance company does not pay, the fee remains your responsibility.

Some government programs, such as Medi-Cal, pay the entire cost of treatment. If you are covered by such a plan, claims will be sent directly to the program, not to you.

Monthly statements or insurance claims will be sent to you, or to your insurance carrier. Insurance claims include information about your diagnosis and treatment services. You must give permission to release that information to your insurance carrier before I can submit a claim.

You should feel free to discuss any questions regarding fee policy. If there is a problem, let me know, so we can arrange a payment plan.

Should financial situations change or fees be changed with fair notice, this form may be changed with accompanying initials.

Finally, if we agree to a payment plan and you do not pay your bill, legal steps may be taken. The only information that will be given to the court, a collection agency or an attorney will be your name, address, the dates of your appointments, and the amount due.

✓ I have read and understand the above. Initials_____ Date_____

SPECIAL FEE ARRANGEMENT:

[To be filled out only after discussion with Dr. Schrenk.]

Special fee agreement

✓ Client's initials _____Date_____

✓ Dr. Schrenk's initials _____Date_____

AUTHORIZATION TO RELEASE INFORMATION TO INSURANCE COMPANY:

I authorize the release of any medical or other information necessary to process insurance claims related to this care. I also request payment of government benefits either to myself or to the party who accepts assignment below.

✓ I have read and understand the above. Initials_____ Date_____

Please sign below when you have read and understood all of the agreement.

I have read and understood this Agreement for Services. I have had a chance to ask questions and my questions have been answered. I understand this agreement fully, and voluntarily sign:

_____

( ) Patient ( ) Parent ( ) Other_____Date

_____

( ) Patient ( ) Parent ( ) Other_____Date