

COGNITIVE BEHAVIORAL THERAPY CENTER OF THE TRIANGLE
OUTPATIENT SERVICES CONTRACT

Effective January 1, 2019

Welcome to the Cognitive Behavioral Therapy Center of the Triangle. This document contains important information about our professional services and business policies. Please read it carefully so that we can discuss any questions that you might have. When you sign this document, it will represent an agreement between us.

PSYCHOLOGICAL SERVICES

Psychotherapy is not easily described in general statements. It varies depending on the personalities of the psychologist and patient, and the particular problems one hopes to address. There are many different methods I may use to deal with those problems. Psychotherapy is not like a medical doctor visit. Instead, it calls for a very active effort on your part. In order for the therapy to be most successful, you will have to work on things we talk about both during our sessions and at home.

Psychotherapy can have benefits and risks. Because therapy often involves discussing unpleasant aspects of your life, you may experience uncomfortable feelings like sadness, guilt, anger, frustration, loneliness, and helplessness. On the other hand, psychotherapy has also been shown to have benefits for people who go through it. Therapy often leads to better relationships, solutions to specific problems, and significant reductions in feelings of distress.

Our first few sessions will involve an evaluation of your needs. By the end of the evaluation, I will be able to offer you some first impressions of what our work will include and some ideas regarding a plan to follow. You should evaluate this information along with your own opinions about whether you feel comfortable working with me. At the end of the evaluation period, I will notify you if I believe that I am not the right therapist for you and, if so, I will give you referrals to other practitioners whom I believe are better suited to help you.

Therapy involves a large commitment of time, money, and energy, so you should be very careful about the therapist you select. If you have questions about my procedures, we should discuss them whenever they arise.

MEETINGS

Our first appointment will be a 90-minute intake session. This session and the subsequent 1-3 sessions are an evaluation period during which we can both decide if I am the best person to provide the services you need in order to meet your treatment goals. If we agree to begin psychotherapy, I will usually schedule one 45-minute session per week, at a time we agree on, although some sessions may be longer or more frequent. **Once an appointment hour is scheduled, you will be expected to pay for it unless you provide 24 hours advance notice of cancellation.**

PROFESSIONAL FEES

My professional fees are as follows:

Standard therapy session, 45 minutes (45-50 minutes): \$160

Extended therapy session, 60 minutes (60-75 minutes): \$240

Intake session, 90 minutes: \$275

Group therapy session, 90 minutes: \$80

For other professional services, I charge an hourly rate of \$160, though I will prorate the hourly cost if I work for periods of less than one hour. Other professional services include report writing, telephone conversations lasting longer than 15 minutes, attendance at meetings with other professionals you have authorized, preparation of treatment summaries, and the time spent performing any other service you may request of me. If you become involved in legal proceedings that require my participation, you will be expected to pay for any professional time I spend on your legal matter, even if the request comes from another party.

PAYMENT AND INSURANCE REIMBURSEMENT

In order for us to set realistic treatment goals and priorities, it is important to evaluate what resources you have available to pay for your treatment. The CBT Center is not in-network with any insurance panels. You will be expected to pay for each session at the time it is held.

If you have a health insurance policy, it will often provide some reimbursement for out-of-network mental health treatment; however, you (not your insurance company) are responsible for full payment of my fees. I recommend that you consult your insurance company to understand what mental health services your insurance policy covers. If you have questions about the coverage, call your plan administrator.

Once a month, or upon request, I will provide you with an account statement that you can submit to your insurance company to claim your out-of-network benefits. This statement will include codes that signify your diagnosis and the treatment procedure (individual therapy, group therapy, etc.). Sometimes, insurance companies ask for additional clinical information. Upon your request, we will provide this information and it will become part of the insurance company files.

Please inform us if you are enrolled in Medicare. All providers at the CBT Center have opted out of Medicare, and an additional consent form is required of those clients who are enrolled.

Once we have all of the information about your insurance coverage, we will discuss what we can expect to accomplish with the benefits that are available and what will happen if they run out before you feel ready to end our sessions. It is important to remember that you always have the right to pay for my services yourself.

CONTACTING ME

I am often not immediately available by telephone. Though I am usually in my office between 9 AM and 5 PM, I probably will not answer the phone when I am with a client. When I am unavailable, my telephone is answered by voice mail that I monitor frequently. I will make every

effort to return your call on the same day you make it, with the exception of weekends and holidays. If you are difficult to reach, please inform me of some times when you will be available. If you are unable to reach me and feel that you cannot wait for me to return your call, contact your family physician or the nearest emergency room and ask for the psychiatrist on call. If I will be unavailable for an extended time, I will provide you with the name of a colleague to contact, if necessary.

CONFIDENTIALITY

In general, the privacy of all communications between a patient and a psychologist is protected by law, and psychologists can only release information about our work to others with your written permission. But there are a few exceptions.

In most legal proceedings, you have the right to prevent your psychologist from providing any information about your treatment. In some proceedings involving child custody and those in which your emotional condition is an important issue, a judge may order a psychologist to testify if he/she determines that the issues demand it.

There are some situations in which I am legally obligated to take action to protect others from harm, even if I have to reveal some information about a patient’s treatment. For example, if I believe that a child, elderly person, or disabled person is being abused, I must file a report with the appropriate state agency.

If I believe that a patient is threatening serious bodily harm to another, I am required to take protective actions. These actions may include notifying the potential victim, contacting the police, or seeking hospitalization for the patient. If the patient threatens to harm himself/herself, I may be obligated to seek hospitalization for him/her or to contact family members or others who can help provide protection. If a situation occurs, I will make every effort to fully discuss it with you before taking any action.

I may occasionally find it helpful to consult other professionals about a case. During case consultation, I make every effort to avoid revealing the identity of a patient. As licensed professionals themselves, consultants are also legally bound to keep the information confidential. If you don’t object, I will not tell you about these consultations unless I feel that it is important to our work together.

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

Client Signature _____ Date _____

Provider Signature _____ Date _____