The Self Empowerment Center

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INFORMED CONSENT

PSYCHOLOGIST-CLIENT SERVICE AGREEMENT

PSYCHOLOGICAL SERVICES

Therapy is a relationship between people that works in part because of clearly defined rights and responsibilities held by each person. Psychotherapy has both benefits and risks. Risks may include experiencing uncomfortable feelings, such as sadness, guilt, anxiety, anger, frustration, loneliness and helplessness, because the process of psychotherapy often requires discussing the unpleasant aspects of your life. However, psychotherapy has been shown to have benefits for individuals who undertake it. Therapy often leads to a significant reduction in feelings of distress, increased satisfaction in interpersonal relationships, greater personal awareness and insight, increased skills for managing stress and resolutions to specific problems. But, there are no guarantees about what will happen. Psychotherapy requires a very active effort on your part. In order to be most successful, you will have to work on things we discuss outside of sessions. The first sessions will involve a comprehensive evaluation of your needs. By the end of the evaluation, I will be able to offer you some initial impressions of what our work might include. At that point, we will discuss your treatment goals and create an initial treatment plan.

APPOINTMENTS

Appointments will ordinarily be about 50 minutes in duration, typically once per week. If you need to cancel or reschedule a session, I ask that you provide me with 24 hours notice. If you miss a session without canceling, or cancel with less than 24 hour notice, my policy is to collect $ 50 cancelation charge. Please note that insurance companies do not reimburse for cancelled sessions.

PROFESSIONAL FEES

The standard fee for the initial intake is $200 and each subsequent session is $160.00. You are responsible for paying at the time of your session. Any bounced checks are subject to an additional fee of up to $35.00 to cover the bank fee that I incur. If you refuse to pay your debt, I reserve the right to use an attorney or collection agency to secure payment.

In addition to weekly appointments, it is my practice to charge for other professional services that you may require such as report writing, telephone conversations that last longer than 15 minutes, attendance at meetings or consultations. In case you become involved in a court case, I recommend that we discuss this fully before you waive your right to confidentiality. If your case requires my participation, you will be expected to pay for the professional time required even if another party compels me to testify.

INSURANCE

If you have a health insurance policy, it will usually provide some coverage for mental health treatment. Any services not covered by insurance will be your responsibility; including deductible, co-insurance and copayments. Copayments are due at the time of service. You are responsible for letting me know if/when your coverage changes. In case your insurance company cannot cover for my services, I will do my best to help you find another provider.

Most insurance companies ask me to provide them a clinical diagnosis. Sometimes I have to provide additional clinical information such as treatment plans or summaries. Though all insurance companies claim to keep such information confidential, I have 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. By signing this Agreement, you agree that I can provide requested information to your carrier.

If I am not a participating provider for your insurance plan, I will supply you with a receipt of payment for services, which you can submit to your insurance company for reimbursement. Please note that not all insurance companies reimburse for out-of-network providers. If you prefer to use a participating provider, I will refer you to a colleague.

PROFESSIONAL RECORDS

I maintain records of the psychological services that I provide in a secure location in the office. You have the right to a copy of your file, available to you upon request.

CONFIDENTIALITY

My policies about confidentiality and your privacy rights, are fully described in a separate document entitled Notice of Privacy Practices. Please remember that there are exceptions to confidentiality if I believe that yours or someone else's safety is jeopardized. .

PARENTS & MINORS

It is my policy not to provide treatment to a child under age 12 unless s/he agrees that I can share whatever information I consider necessary with a parent. For children over 12 years, all other communication will require the child's agreement, unless I feel there is a safety concern.

CONTACTING ME

You can reach me by phone and if you leave a message on my confidential voice mail, your call will be returned within 24 hours unless there is an emergency. If, for any number of unseen reasons, you do not hear from me or I am unable to reach you, and you feel unsafe, 1.) go to your Local Hospital Emergency Room, or 2.) call 911 and ask to speak to the mental health worker on call. I will make every attempt to inform you in advance of planned absences, and provide you with the name and phone number of the mental health professional covering my practice.

Email, Skype, SMS, U.S. Mail, and other forms of communication often have a potential for breaches of security and confidentiality. It is your responsibility to password protect, delete or otherwise secure your communications.

I give consent to communicate with Dr. Khan using the following methods, and by providing email, user names and numbers I consent to using these methods of communication, despite knowing my responsibility to ensure the security of these communications on the receiving end:

Email address: _____

SMS/Cell phone: _____

Other methods (User Name): _____

OTHER RIGHTS

If you are unhappy with what is happening in therapy, I hope you will talk with me so that I can respond to your concerns. You may also request that I refer you to another therapist and are free to end therapy at any time.

CONSENT TO PSYCHOTHERAPY

Your signature below indicates that you have read this Agreement and the Notice of Privacy Practices and agree to their terms.

_____

Signature of Patient or Personal Representative

_____

Printed Name of Patient or Personal Representative

Date ___/___/ _____