WellSpring Child and Family Psychology, PC

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Phone: (540) 693-0096

Welcome to WellSpring Child and Family Psychology. This document contains important information about our business practices and services. Please read it carefully and note any questions you may have so we can discuss them at our first meeting. When you sign this document, it will represent an agreement between us.

PSYCHOLOGICAL SERVICES: Psychotherapy can have benefits and risks. Since 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, but there are no guarantees of what you will experience. Satisfaction with the sessions will be increased by your commitment to the process, including a willingness to persevere through difficult or uncomfortable feelings and to participate fully and honestly.

Psychotherapy services vary depending on the personalities of the therapist and patient, and the particular problems you bring forward. There are many different methods we may use to deal with the problems that you hope to address. Psychotherapy is not like a medical doctor visit. Instead, it calls for an active effort on your part. In order for the therapy to be more successful, you will have to work on things we talk about both during our sessions and at home.

EVALUATION: Our first few sessions will include an evaluation of your needs, which typically lasts from one to three sessions. This evaluation should afford us the opportunity to decide if your therapist is the best person to provide the services you need in order to meet your treatment goals. By the end of the evaluation, we will be able to offer you our working impression of the problem, some first impressions of what our work will/might include, and possible treatment outcomes if we decide to continue working together. You should evaluate this information along with your own sense of whether you feel comfortable working with us.

At the same time, we will assess whether we can help you. If at any point during the initial assessment or during therapy we assess that we cannot be effective in helping you, we will discuss this with you and, if appropriate, end treatment. In such a case, we will give you referrals to other qualified professionals. If you request it and authorize it in writing, we will talk to the therapist of your choice in order to help with the transition. If you have questions about our procedures, their possible risks, our expertise in employing them or about the treatment plan, we should discuss them whenever they arise. You also have the right to ask about other treatments for your condition and their risks and benefits.

APPOINTMENTS: Appointments are 45-50 minutes long, and the time scheduled for your appointment is assigned to you and you alone. If you need to cancel or reschedule a session, we ask that you provide 48-hours' notice. If you miss a session without canceling or cancel with less than 48-hours' notice, a $50 fee will apply the first time, a $75 fee will apply the second time, and the full session fee will apply thereafter and you may lose your spot in the schedule. Please note that insurance companies will not cover this fee. If you are more 20 minutes late to your appointment, we will have to reschedule your appointment. After one late arrival, we will charge in the same manner as described above for late cancel or no-shows.

PROFESSIONAL FEES: The current standard fee for the initial intake is $160.00 and each subsequent session is $135.00. You are responsible for paying at the time of your session. Payment can be made by check or cash. Credit cards are accepted, although a $3 convenience fee applies for each transaction. Any checks returned to our office are subject to an additional fee of $35.00 to cover the bank fee that we incur. If you refuse to pay your debt, we reserve the right to use an attorney or collection agency to secure payment or to charge your on-file credit card (per credit card agreement).

Other services, such as phone calls (over 10 minutes), paperwork, completing forms, report-writing, attendance at meetings, or any other service you request of us will be billed at a pro-rated basis. If you anticipate becoming involved in a court case, we recommend that you discuss this with us fully before you waive your right to confidentiality. If your case requires our participation, you will be expected to pay for all of the professional time required even if another party compels us to testify. Our fee for legal and court-related activity is $300 an hour, including time in court, travel time, and administrative preparation time. You will also be responsible for any legal fees we incur as a result of your court case.

INSURANCE: If you choose to use insurance to help pay for services, our billing service and/or we will assist you in filing claims and ascertaining information about coverage, but you are responsible for knowing your coverage and informing us of any changes.

Authorization from the insurance company may be required before they will cover therapy fees. If you did not obtain authorization and it is required, you may be responsible for full payment of the fee. You must disclose if you have any secondary insurance policies. Many policies leave a percentage of the fee (which is called co-insurance) or a flat dollar amount (referred to as a co-payment) to be covered by the patient. Either amount is to be paid at the time of the visit. In addition, some insurance companies also have a deductible, which is an out-of-pocket amount that must be paid by the patient before the insurance companies are willing to begin paying any amount for services. This will typically mean that you will be responsible to pay for initial sessions with us until your deductible has been met; the deductible amount may also need to be met at the start of each calendar year. Once we have all of the information about your insurance coverage, we will discuss what we can reasonably expect to accomplish with the benefits that are

available and what will happen if coverage ends before you feel ready to end your sessions. It is important to remember that you always have the right to pay for our services yourself to avoid the problems described above, unless prohibited by our provider contract.

If we are not participating providers for your insurance plan, we 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. We will provide assistance in identifying a provider in your network.

Most insurance companies require you to authorize us to provide them with a clinical diagnosis. Sometimes we have to provide additional clinical information such as treatment plans or summaries or copies of the entire record (in rare cases). This information will become part of the insurance company files. By signing this Agreement, you agree that we can provide requested information to your carrier if you plan to pay with insurance.

PROFESSIONAL RECORDS: We are required by law and the standards of our profession to keep treatment records. We currently keep electronic health records with TherapyNotes. Any additional paper records are maintained in a secure location in the office. I keep brief records noting that you were here, your reasons for seeking therapy, the goals and progress we set for treatment, your diagnosis, topics we discussed, your medical, social, and treatment history, records I receive from other providers, copies of records I send to others, and your billing records. Except in unusual circumstances that involve danger to yourself, you have the right to a copy of your file. Because these are professional records, they may be misinterpreted and/or upsetting to untrained readers. For this reason, we recommend that you initially review them with us or have them forwarded to another mental health professional to discuss the contents. If we refuse your request for access to your records, you have a right to have our decision reviewed by another mental health professional, which we will discuss with you upon your request. You also have the right to request that a copy of your file be made available to any other health care provider at your written request.

CONFIDENTIALITY: Our policies about confidentiality, as well as other information about your privacy rights, are fully described in a separate document entitled Notice of Privacy Practices. You have been provided with a copy of that document and we have discussed those issues. Please remember that you may reopen the conversation at any time during our work together.

PARENTS & MINORS: While privacy in therapy is crucial to successful progress, parental involvement can also be essential. It is our policy not to provide treatment to a child under age 13 unless s/he agrees that we can share whatever information we consider necessary with a parent. For children 14 and older, we request an agreement between the client and the parents allowing us to share general information about treatment progress and attendance, as well as a treatment summary upon completion of therapy. All other communication will require the child's

agreement, unless we feel there is a safety concern (see also above section on Confidentiality for exceptions), in which case we will make every effort to notify the child of our intention to disclose information ahead of time and make every effort to handle any objections that are raised.

CONTACTING US: The best way to reach us is by calling our telephone number 540-693-0096 and leaving a voicemail, which we monitor regularly during business hours. However, we are often not immediately available by telephone since we do not answer the phone when we are with clients or otherwise unavailable. At these times, you may leave a non-urgent message on our confidential voicemail and your call will be returned as soon as possible when the provider you left a message with is in the office.

In some circumstances, we can also be reached by email. Do not use email to communicate any personal information, including information about a crisis or emergency, as this method of communication is not confidential nor regularly monitored.

We are an outpatient clinic. We are not available on the weekends or evenings and are only available by appointment during office hours. On occasion, we will cancel a session due to vacation, professional development, emergency, or illness. We will make every effort to notify you as early as possible and to reschedule with you in a timely and convenient a way for you as possible.

If for any number of unseen reasons, you feel you cannot wait for your next appointment, a return call, and/or if you feel unable to keep yourself safe, 1) contact the Rapphannock Area Community Services Board/Emergency Services at 540-373-6876, 2) go to your Local Hospital Emergency Room, or 3) call 911 and ask to speak to the mental health worker on call.

OTHER RIGHTS: If at any point you are unhappy with services here, we hope you will talk with us so that we can respond to your concerns. Such comments will be taken seriously and handled with care and respect. You may also request that we refer you to another therapist and are free to end therapy at any time. You have the right to considerate, safe, and respectful care, without discrimination as to race, ethnicity, color, gender, sexual orientation, age, religion, national origin, or source of payment. You have the right to ask questions about any aspects of therapy and about our specific training and experience.

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

I hereby authorize the "Release of Medical Information" for insurance purposes by WellSpring Child and Family, P.C. The required "Assignment of Benefits" is hereby noted and I direct you to make payment directly to the provider as listed for treatment received by any dependents or myself. I acknowledge that payment is due at the time of treatment and I accept full financial responsibility for all charges not covered by this "Assignment of Benefits."

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Signature of Patient or Personal Representative

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Printed Name of Patient or Personal Representative

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Date

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Description of Personal Representative's Authority

(Revised 12/2016)