

Outpatient Treatment Contract

with



Joseph F. Edwards, Psy.D. PLLC

Licensed Psychologist and Health Service Provider

There are several important components to a successful treatment relationship, particularly if the experience is to be helpful. A clear understanding of what is expected, ongoing communication throughout the relationship, and adherence to treatment recommendations are *essential*. It is also important for anyone in treatment to feel informed, to be involved in decision-making, and to be an *active* participant in the process of treatment. This contract represents your acknowledgment of your commitment to this approach to treatment and an opportunity for me to overview my treatment philosophy. I request that you carefully read through this treatment contract, asking questions when you have them. If you are in agreement with this approach, acknowledge your understanding and commitment to treatment by signing the last page of this contract. I ask that you keep the first three pages of this document for future reference.

As a clinical child psychologist, I provide diagnostic evaluations, individual and family psychotherapy, psychological testing, consultation, and liaison with other professionals (providing recommendations for treatment and making referrals as indicated). I also am involved in a peer consultation group that meets on a monthly basis, which is a vehicle, in which I grow professionally, for your benefit and mine. I am a solo practitioner and not in a group practice. I do the scheduling of my own patient appointments, collecting of fees for services, and billing for my services. I earned a doctorate in clinical psychology, a doctor of psychology degree, Psy.D., from Spalding University. In addition, I completed a one-year predoctoral internship program at *McLean Hospital*, an affiliate of Harvard Medical School, and completed a one-year post-doctoral fellowship in Clinical Child/Pediatric Health Psychology at the *University of Louisville School of Medicine*. I am a *licensed clinical psychologist* with a specialty in child/adolescent psychology and a *health service provider* both in the Commonwealth of Kentucky and the State of Indiana. I am listed as a registrant on the National Register of Health Service Providers in Psychology, a member of the American Psychological Association (APA) and several divisions related to clinical, child psychology and state leadership within APA, and the Kentucky Psychological Association (KPA). As a member of these organizations, I make a strong effort to adhere to the ethical standards and practice guidelines of these organizations.

Confidentiality and Informed Consent

In general, information disclosed/communicated during the course of treatment is both confidential and protected by law. However, there are a few important exceptions, including: 1) when you (or the legal guardian of a minor) has signed an appropriate consent for the release of information; 2) if a judge issues a specific order requiring my testimony (this may occur in a child custody/visitation dispute, divorce or adoption proceeding, or in a lawsuit where mental condition is felt to be an issue; 3) statute-mandated reporting of any suspected abuse (of a child, significant other, spouse, or elder); and 4) when there is a reported or perceived threat to harm self or others; potential harm to others also requires by law that steps be taken to notify the potential victim, as well as, the police. The overall message is that I have a clear *moral, ethical and legal responsibility to prevent people from being harmed when, to the best of my professional judgment, such danger appears to exist.*

I may occasionally consult with colleagues about the service that I provide for you. The most common manner in which this would occur would be through presenting your case (without identifying information) to my peer consultation group. These mental health professionals are bound by the same laws regarding confidentiality as I am. Further, I am required to keep appropriate records for clinical and legal purposes. If you utilize third party reimbursement (insurance) I will need to provide the insurer with a clinical diagnosis and summary of treatment (some of which ask questions about treatment compliance, involvement of family members, and if other family members are receiving treatment). Some insurance companies require more detailed information than other companies require. Upon your request, I will provide you with the information that your company requires. If you have concerns about the information required, please voice your concern with me so that we can determine what information will actually be released. Upon your request, I will provide you with a treatment plan form (of your specific insurance company), which used to gather information about the treatment I am providing for you (so that your insurance company can review and further authorize continued

sessions).

It is my professional belief that children and adolescents are entitled to confidentiality regarding the specific content of their therapy/treatment contact—this represents an important component in the development of trust and a therapeutic alliance. It is also important for parents to receive general information on how treatment is proceeding. If substantial concerns arise about a family member, I recommend that the concern(s) be addressed and resolved in the context of a family therapy session. If a parent (or family member) calls to provide me with information about the patient, please be aware that in the next therapy session, I will acknowledge that I received the phone call so that the patient is aware of the call. The exceptions to confidentiality previously described apply to children and adolescents as well.

It is important for both a child/adolescent and their parents to feel informed about the treatment process at every level, which includes therapy recommendations, diagnostic issues, education, medication issues, treatment goals and expectations, as well as prognosis. Part of this process includes discussing alternative approaches, the associated risks/benefits of treatment (or alternative treatments), an understanding that a desired treatment outcome is not guaranteed, and having an opportunity to ask questions. This supports positive communication, teamwork, improves treatment focus, minimizes confusion and helps avoid treatment disruption.

Treatment & Financial Issues

My approach to treatment involves considering a multidimensional nature of any psychological or behavioral distress. In other words, there rarely is one "reason" that explains mental, emotional or behavioral struggle. Given this, treatment frequently involves use of several different interventions and therapy formats (which may include: individual and family therapy, group therapy, parenting work, support groups, medication, use of community resources, and academic interventions). Focus on family, social, personal, school and interpersonal functioning is critical.

Your commitment to the treatment process is an essential part of good treatment and involves:

- 1) attending scheduled appointments consistently;
- 2) notifying the office in a timely fashion if you unavoidably must cancel an appointment;
- 3) communicating with me (and the other healthcare providers who work with you) regarding:
 - any suicidal/homicidal threats or gestures, evidence of hallucinations or changes in thought processing, aggressive or self-abusive behavior, substance abuse concerns, the development of concerning *risk-taking* behavior (e.g., run away behavior), concern about possible abuse, non-adherence to treatment recommendations, misuse of medication, school suspensions, legal difficulties, or runaway behavior, a major decline in home, school, occupational, or personal functioning, a substantial change within the family (or family stressor);
- 4) communication about billing and insurance information, and the making of regular payments on your account as you have agreed; I reserve the right to utilize a collection agency when a balance occurs and you do not adhere to the payment plan that you agreed to;
- 5) inform me as quickly as possible if and when there are changes in insurance coverage (otherwise, in this day and age of managed care, sessions which go *unauthorized* will be unlikely to be reimbursed to you by your insurance company); it is the members responsibility to know if their plan requires pre-authorization and obtain such from the insurance company;
- 6) if you are a member of an insurance company for which I am NOT a participating provider, I ask that you reimburse me for the services I render and that you ask your health insurance company to reimburse you. As a courtesy, an initial claim will be filed on your behalf, and the insurance company instructed to send any reimbursement directly to you. If there is a problem with an insurance claim, I can provide you with a copy of the HCFA form so you can re-file a claim;
- 7) if you are a Humana/Lifesynch member, you will be expected to make your Humana specialist co-payment at the time of service. If you have a high deductible plan, you will be expected to pay the full negotiated Humana rate at the time of service. All necessary claims will be filed on your behalf with Humana;

- 8) if you bring a child for treatment and sign the financial responsibility form, you are ultimately responsible for paying the charges in a timely manner (even if you are divorced and the court has mandated that your ex-spouse be responsible for the full, or a portion, of medical bills---you will need to pay for the service(s) and, then pursue reimbursement from your former spouse);
- 9) monitoring and/or utilizing medication as prescribed by a physician and keeping me up to date on prescription changes;
- 10) actively participating in the treatment involves completing homework assignments, applying new skills and insights gained through therapy sessions, openly discussing any "complications" that affect treatment, as well as, any unforeseen side-effects of treatment.

Attendance at scheduled appointments is extremely important, not only for successful treatment outcome, but also in terms of consideration of others who may have the desire to schedule appointments. Because of this, I ask that you call to reschedule appointments with as much in advance as possible. *Appointments canceled with less than 48 hours notice* will be charged (\$65) which is one-half the regular hourly fee. Appointments missed *without notification* will be charged **full fee** (\$130). After two canceled or missed appointments, discussion about this pattern will be part of the next therapy session; a pattern of such incidents will result in a review of these treatment contract expectations, and may lead to a termination of treatment, due to non-compliance. I will, however, provide you with information pertaining to other treatment options/referrals, and in the interim, should you experience a crisis, will be available to offer emergency care.

Special Fees

It is expected that payment for the session be made at the time of each session, unless special arrangements have been made in advance. If a balance accumulates, it is expected that the regular payments be made. If you encounter some special financial limitations, it is your responsibility to inform me, or my office manager, promptly so that a payment plan can be developed (this will avoid the utilization of collection procedures including an attorney and/or a collection agency). Please refer to the Fee Schedule of a listing of all my professional fees. Please be aware there is a special fee of \$20 per occurrence associated with a "bad check" (to help offset additional expenses such as bank fees). Further, if a patient requests that clinical records be mailed (upon signing the appropriate release of information form) there is a 25-cent per page charge (if 15 pages or more are requested). Special fees are charged for attending school meetings or observations (\$130 per hour), and for preparing for and giving legal depositions, as well as preparation for, travel time and testimony time in legal proceedings (\$400/hr). From time to time, a parent will ask that I write a special letter for an attorney, daycare, etc., there are special charges for letters of \$110/letter. I do not charge for writing routine letters to pediatricians or family physicians or other doctors involved in providing care to the patient. Further, while I do not charge for routine phone calls, I do bill at my therapy rate for extended phone calls and you would be informed of such a charge and there would be mutual agreement for such a consultation.

Doctor/Patient Contact

Another important aspect of any treatment relationship is your ability to make contact with your psychologist, either in the form of scheduling initial or follow-up appointments, or through phone contact if the need arises. I am available to see appointments on a scheduled basis. I schedule my own appointments, and if I am not available you may leave me a message on my answering machine with your contact information and I will return your call to schedule an appointment. My office has an answering machine available to receive phone calls *24 hours a day, seven day's a week*. Messages may be left on the answering machine at any hour. There is emergency contact information available as an option on the answering machine. There will be occasions when I am not personally available. In such circumstances, a covering mental health professional would be available to address emergency concerns. My cell phone number currently is 502.541.2764, which you may call and I have voice mail should I not be available to immediate answer your call. **As a patient you have specific *rights and responsibilities*. A list of these basic rights and responsibilities is available at the waiting room.**

TREATMENT CONTRACT
with



Joseph F. Edwards, Psy.D. PLLC
Licensed Psychologist

I have read and understand this treatment contract. I acknowledge receiving my personal copy of the first three pages of this contract. I have had an opportunity to ask questions, understand the information, and accept the guidelines/expectations that were presented.

Name of child (or adolescent) in whose name the treatment is being conducted

Signature of Parent/Guardian (or Adult patient)

Date

Signature of the adolescent (age 14 or older)

Date

Witness

Date

JFE 10/01/2013

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