

## **AGREEMENT FOR PSYCHOLOGICAL SERVICES**

Welcome. This Agreement contains important information about my professional services and business policies. Please read and sign. You may ask questions about anything covered in this agreement at any time.

### **PSYCHOTHERAPY**

Psychotherapy is not easily described in general statements. It varies depending on the personalities of the psychologist and patient, and the particular problems you are experiencing. There are different methods I may use to help address different problems. Psychotherapy is not like a typical 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 in and outside of our sessions.

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, or helplessness. On the other hand, psychotherapy has also been shown to have many benefits. Therapy often leads to improved relationships, solutions to specific problems, and significant reductions in feelings of distress. But there are no guarantees of what you will experience.

### **MEETINGS**

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 if you decide to continue with therapy. You should evaluate this information along with your own opinions of whether you feel comfortable working with me. Therapy involves a large commitment of time, money, and energy, so you should be very careful about the therapist you select. If you have any questions, please feel free to ask them as they arise.

If psychotherapy is begun, I will usually schedule one 50-minute session (one appointment hour of 50 minutes duration) per week at a time we agree on, although this may vary. **Once an appointment hour is scheduled, you will be expected to pay for it unless you provide 24 hours advance notice of cancellation (unless due to significant illness or emergency).** It is important to note that insurance companies do not provide reimbursement for unused sessions.

### **PROFESSIONAL FEES**

Currently, my general hourly fee is \$150 (the initial appointment is \$280, couples therapy is \$180, and group therapy is \$60, all per hour). In addition to appointments, I charge the hourly rate for other professional services. Examples of other services include report writing, frequent or lengthy telephone conversations or email, consulting with other professionals, and preparation of records or treatment summaries.

If you become involved in legal proceedings that require my participation, you will be expected to pay for my professional time, including preparation and transportation costs, even if I am called to testify by another party. I will not agree to court appearance unless we have discussed the matter thoroughly and both agree that such appearance will not interfere with our therapy relationship and that I will be able to participate in the legal proceedings without unreasonable bias. Because of the complexity and difficulty of legal involvement, my fee, in advance, is \$200 per hour for involvement in any legal work.

These fees will change from time to time. Current fees can be found within the latest revision of this agreement, available on <http://www.strisik.com>.

### **CONTACTING ME**

Due to the nature of my work, I am often not immediately available by telephone. While I am usually in my office during regular business hours, I probably will not answer the phone when I am in an appointment.

When I am unavailable, my telephone is answered by confidential voice mail that I monitor frequently. I will make every effort to return your call on the same day, with the exception of weekends, holidays, and vacations. Nighttime calls will usually be returned the next day. If you find yourself in an urgent situation, make a judgment about the prudence of waiting for my call versus calling your primary care physician, 911, or the Anchorage Community Mental Health Center's 24-hour crisis line (563-3200). If I am away for extended periods, my voice mail message will indicate that and state when I will return.

Email is a convenient method of communication, though it is best used for administrative matters such as scheduling and insurance issues. Please note that information transmitted by email is not entirely secure. Please use your judgment and your own level of comfort when transmitting personal information using this medium.

### **LIMITS ON CONFIDENTIALITY**

The law protects the privacy of all communications between a patient and a psychologist. In most situations, I can only release information about your treatment to others if you sign a written authorization form. There are some situations where I am permitted or required to disclose information without either your consent or Authorization. Please see the attached "Notice of Policies and Practices to Protect the Privacy of Your Health Information" for more information. A summary is provided below:

- I may occasionally find it helpful to consult other health and mental health professionals about a case. During a consultation, I make every effort to avoid revealing the identity of my patient.
- If a 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 you are involved in a court proceeding and a request is made for information concerning your diagnosis and treatment, such information is protected by the psychologist-patient privilege law. I cannot provide any information without your (or your legal representative's) written authorization, or a court order. If you are involved or contemplating litigation, you should consult with your attorney to determine whether a court would be likely to order me to disclose information.
- I am required to comply if a government agency requests information for health oversight activities.
- If a patient files a complaint or lawsuit against me, I may disclose relevant information regarding that patient in order to defend myself.

I am legally obligated to take action, such as making a report to a protective agency or warning a potential victim, which I believe is necessary to protect others from harm, and thereby revealing information about a patient's treatment. These situations are unusual in my practice.

- If I have reasonable cause to suspect a child has suffered harm as a result of child abuse or neglect.
- If I have reasonable cause to believe a vulnerable adult suffers from abandonment, exploitation, abuse, neglect, or self-neglect; or a disabled person has been abused.
- If a patient communicates an immediate threat of serious harm to an identifiable victim, I may be required to notify the potential victim, contact the police, and/or seek hospitalization for the patient.

If any such situation arises, I will make every effort to discuss it with you fully before taking any action, and I will try to limit my disclosure to what is necessary.

While this written summary of exceptions to confidentiality should prove helpful in informing you about potential problems, it is important that we discuss any questions or concerns that you may have now or in the future. The laws governing confidentiality can be quite complex, and I am not an attorney. In situations where specific advice is required, formal legal advice may be needed.

### **PROFESSIONAL RECORDS**

The laws and standards of my profession require that I keep Protected Health Information about you in your Clinical Record. If you provide a written request, you have the right to examine and/or receive a copy of

your records. Because these are professional records, they can sometimes be misinterpreted and/or upsetting to untrained readers. For this reason, I recommend that you initially review them in my presence or have them forwarded to another mental health professional to review with you. There may be a charge for reproducing records or for the time required to review them with you.

**BILLING, INSURANCE, AND PAYMENT**

Payment can be with Check, Cash, or Mastercard/Visa. You will be expected to pay for each session at the time it is held, unless we agree otherwise. In most cases, as a courtesy, I will be glad to file your insurance. In that case, you would only pay your deductible, co-payments, and amounts not covered by insurance. As the insured, you are ultimately responsible for determining what services are covered and to what degree. The situation may vary if I am a participating practitioner with your insurance company. Unless I am participating with your insurance company, I usually will not complete treatment reviews by companies who manage your benefits. This is for clinical reasons that I will be glad to discuss with you. As this may affect your level of benefits, please understand how your insurance works with regard to mental health benefits when initiating services. I suggest that you call to verify your mental health coverage and any requirements your insurance company imposes to insure coverage.

If your account has not been paid for 90 days or more and arrangements for payment have not been agreed upon, late payment fees of 1.5% per month will be charged, and I have the option of using legal means to secure payment. This may involve hiring a collection agency (in which case, a 30% delinquency fee will be added to your balance) or going through small claims court (in which case, legal costs will be included in the claim). These situations are rare, and require disclosure of otherwise confidential information (usually just name, the nature of services provided, and amount due). Please do not let this happen; I would much rather communicate and find some solution to overdue accounts.

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My signature below indicates that I have read this agreement, agree to its terms, and I have received the HIPAA notice form titled "Notice of Policies and Practices to Protect the Privacy of Your Health Information." Signing also authorizes Dr. Strisik to supply my insurance company(s) with the information necessary to authorize services and to process insurance claims for me and/or my dependants and authorizes payment of medical benefits directly to Dr. Strisik for the services provided.

\_\_\_\_\_  
Signature of Patient or Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Name of Patient (if different)

\_\_\_\_\_  
If signed by patient's personal representative, a description of the authority to act for the patient must be provided (e.g., parent, legal guardian, etc.).