



# PROFESSIONAL PSYCHOLOGICAL SERVICES, P.C.

## A Clinical and Forensic Psychology Practice Group

### Office Services and Policies and Statement of Informed Consent

Services include evaluation, psychotherapy, and evaluation for individuals, couples, and families; such therapy includes adults, adolescents, and children. Office hours are scheduled by appointment only. Appointments are scheduled during weekday and evening hours, but exceptions may be made for weekend sessions by some therapists. Services are provided either by licensed psychologists or other licensed mental health professionals. Occasionally, a therapist may be completing supervised training for professional licensure. You will be informed should your therapist be in a supervisory training relationship with the practice.

Information you share with your therapist is confidential. All professional staff and office employees are bound by these rules of confidentiality. However, there are limits to that confidentiality. Mental health professionals are required by law to notify appropriate authorities if you are believed to be a danger to yourself or others, or if you are a minor, elderly, or disabled and your therapist believes you are a victim of abuse, or if a child is suspected to have been physically or sexually abused by you. Additionally, we are required by law to report sexual abuse by another mental health professional to authorities and appropriate licensing boards. Confidential information may also be required to be made available by court order in disputed custody or other legal matters. If you are in therapy with a supervised practice associate that therapist is required to review your case with their supervisor whose name they will provide to you. Also, professionals may consult on a case with another professional from time to time, but without identification of the patient whose case is the subject of consultation. If you choose to file with a third party, e.g., health insurance company, for reimbursement of fees for therapy services, that insurance company will require basic information pertaining to identifying data, diagnosis, symptoms, general functioning, prognosis, and progress. Other than the above described situations information about you will not be released without additional written consent. Information will not be released from conjoint or family therapy files without written consent of all adult parties. When spouses or other couples are seen conjointly for therapy or in family therapy, the therapist will not testify at a future time in behalf of either spouse in the event of litigation between the spouses (e.g., civil litigation including, but not limited to, divorce or disputed custody matters). An evaluation for purposes of disputed custody matters is distinct from therapy. If an individual's purpose in seeking therapy or consultation involves issues related to child custody matters, this should be made known to the therapist immediately.

Your diagnosis and treatment goals will be discussed with you by your therapist. Therapy is a joint effort between the therapist and the patient, the results of which cannot be guaranteed as progress depends on many factors including, but not limited to, motivation, effort, and other life circumstances such as interactions with family, friends, and other associates. In undertaking therapy there are potential negative effects which include, but are not limited to, increased stress in relationships and emotional distress. Additionally, certain techniques, e.g., hypnotic techniques, may include legal and therapeutic implications for the patient. Implications or potential negative effects of a particular therapeutic technique may be discussed at any time with your therapist.

If you must reach your therapist due to an emergency or need to cancel an appointment, our office telephone system will page the therapist. However, you must directly access the therapist's personal voice mailbox for them to be paged. Leaving a message in the general office voice mail box will not result in your therapist being paged. Your therapist will respond as quickly as possible, but if you are in the midst of a life-threatening emergency and your therapist has been unable to return your call quickly, you should go to a nearby hospital emergency room or contact your community crisis hotline, e.g., Suicide & Crisis Center Hotline, 214/828-1000 or Contact Counseling & Crisis Line 972/233-2233.

While the practice group maintains a web site and has an email address, the email address is not to be used for emergencies as the message will not be delivered in a timely manner. You should also understand that messages that are delivered by way of email are not confidential as you might expect the U.S. mail to be. While unlikely, your email messages may be read by others while en route through the internet to your therapist.

Our usual and customary rate for an initial diagnostic interview is \$175.00 and individual therapy session rates which are fifty minute are \$150.00. Conjoint therapy and family therapy sessions are normally also based on a fifty minute session. Longer sessions will be charged an additional rate of \$45.00 in quarter hour increments. Insurance plans will generally not provide coverage for such extended sessions. Fees for psychological testing vary depending on the tests. While insurance may cover precertified psychological evaluations, insurance does not cover extended reports such as might be required in court-related matters. The patient is independently responsible for fees for such reports or for therapist time for review of records that might be involved in preparation of such a report. The fees are based on the standard session rate. Time out of office for a therapist to travel to a school or other location for observation or consultation is charged at the rate of \$175.00 per hour and time is calculated from the time of leaving to the time of returning to the office.

If a therapist is subpoenaed to court to testify regarding your treatment, you are responsible for the therapists fees for time out of office for travel and court proceedings. This also applies if the therapist is required to provide testimony by deposition. You are responsible for these fees even if you are not the person that sought the testimony. Fees for time out of office for time and travel are based on a rate of \$200.00 per hour with a minimum fee of \$800.00. If the therapist is required to be available into the afternoon for either court testimony or deposition a full day fee of \$1,800.00 is required. A deposit of \$1,800.00 is required a week prior to the scheduled testimony. If only a half day is required the balance of \$800.00 will be refunded to you or charged back to your credit card.

Telephone consultation time will be charged to the patient in increments of fifteen minutes at the rate of \$45.00 per unit. You will be responsible

**(See Other Side of Page)**

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Effective 10/15/2009

for the fee as it will not be reimbursed by your insurance. Telephone consultation will be considered as any conversation with a therapist other than conversation pertaining to scheduling. Generally, scheduling problems can be worked out by the office secretary. All fees are subject to periodic adjustment.

**Appointments not canceled 24 hours prior to the scheduled session will be charged to the individual.** (Insurance will not pay for missed sessions.) If a patient misses two consecutive scheduled sessions, the patient will be considered to have given notice of termination of therapy. Additionally, a patient who does not reschedule for a period during sixty days following their last therapy session will be considered to have terminated therapy. Patient's returning for therapy following termination of therapy will be considered to be opening a new case for purpose of therapy.

Fees for professional services are customarily paid at time services are provided. In order that your session and office procedures may flow most smoothly, please have your check made out prior to your session. **All therapists and counselors are associated with Professional Psychological Services, P.C. and all checks should be made payable to "Professional Psychological Services" or "PPS."** Various bank cards may be accepted as means of payment. Returned checks are subject to a \$20.00 service charge.

If your account in this office is delinquent for a period of greater than sixty days your therapist may refer you to a community agency or program to continue needed services. A delinquent account may also be turned over to an agency for collection. The agency will be given only your name, identifying information, and amount owed, but will not be provided other information about your case. In such a case, the collection agency may contact you in seeking payment for services delivered to you by your therapist.

Health insurance frequently reimburses for mental health benefits. Most of our group members are affiliated with a number of managed health care groups and preferred provider groups. Your co-payment with these therapists will be lower than if you choose to see a therapist who is not affiliated with the preferred provider network. If you have any questions about your insurance coverage, please ask our office personnel.

Professional Psychological Services, P.C. will accept assignment of insurance benefits only if coverage can be verified. **Verification of benefits by our office is not, however, a guarantee of payment by your insurance company as the insurance company verifying benefits will not guarantee payment even when verifying that an individual is covered for services.** The financial liability for services of patients who are members of managed care plans may be limited to deductibles and copayments for services to the extent that the insurance reimburses according to contractual rates with PPS.

You have the right to ask an office staff member or therapist about any questions you have regarding these policies. Your signature below means that you have read and acknowledge the above office policies and agree to comply with those policies as described. Your signature also means that you agree you have had the opportunity to have answered any questions you may have about these policies and that you are giving your informed consent to participate in counseling or therapy with a treatment provider from this practice group

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature

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## Conjoint Therapy

If individuals are being seen for conjoint therapy each must sign below confirming that they understand and agree to comply with office policies pertaining to therapy of couples and/or families as well as other office policies.

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature

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## Therapy or Counseling for Minors

If a child is being seen for therapy each parent with legal rights and responsibilities pertaining to the child must sign below. Your signature represents your informed acknowledgment of Office Services and Policies and informed consent for the provision of therapy and/or counseling services to your minor child.

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature