

Perry Guthrie, Ph.D.

Disclosure Statement and Agreement for Services

Introduction

This document is intended to provide important information to you regarding your treatment. Please read the entire document carefully and be sure to ask your therapist any questions that you may have regarding its contents.

Information about your Therapist

At an appropriate time, your therapist will discuss his professional background with you and provide you with information regarding his experience, education, special interests, and professional orientation.

Your therapist is a Licensed Clinical Psychologist practicing as an independent therapist at Aspen Psychological and Psychiatric Services.

Perry Guthrie, Ph.D., Licensed Clinical Psychologist, PSY 7347

Fees and Insurance

- The fee for service for authorized EAP service is waived. There are no co-pays. **Initial here:** _____
- The fee for service for HMO approved individual, couples and/or a family therapy session is the amount of the contracted co-pay. **Initial here:** _____
- The fee for service for PPO individual, couples and/or family therapy sessions is the amount of the co-pay. Many PPO plans have a “deductible.” If the deductible has not been met, you may have to pay a higher contracted fee until the deductible has been met. Please call your insurance plan to determine the amount you are to pay. I will help you determine the amount as well. **Initial here:** _____
- It is important to note if authorization is not covered, you will be responsible for the cost of the therapy session of \$125.00. **Initial here:** _____
- For cash paying clients, I charge \$125.00 per therapy hour. **Initial here:** _____

Please inform your therapist if you wish to utilize health insurance to pay for services. If your therapist/provider is a contracted provider for your insurance company, your therapist/provider will discuss the procedures for billing your insurance. The amount of reimbursement and the amount of any co-payments or deductible depends on the requirements of your specific insurance plan. You should be aware that insurance plans generally limit coverage to certain diagnosable mental conditions. You should also be aware that you are responsible for verifying and understanding the limits of your insurance coverage. Although your therapist/provider is happy to assist your efforts to seek insurance reimbursement, we are unable to guarantee whether your insurance will provide payment for the services provided to you. Please discuss any questions or concerns that you may have about this with your therapist. **Initial here** _____

Individual sessions and conjoint (marital/family) sessions are approximately 45 to 50 minutes in length. Fees are payable at the time that services are rendered. **Initial here:** _____

If for some reason you find that you are unable to continue paying for your therapy, you should inform your therapist. Your therapist will help you consider any options that may be available to you at that time.

Confidentiality

All communications between you and your therapist will be held in strict confidence unless you provide written permission to release information about your treatment. If you participate in marital or family therapy, your therapist will not disclose confidential information about your treatment unless all person(s) who participated in the treatment with you provide their written authorization to release. However, it is important that you know that your therapist utilizes a “no secrets” policy when conducting family or marital/couples therapy. This means that if you participate in family, and/or marital/couples therapy, your therapist is permitted to use information obtained in an individual session that you may have had with his when working with other members of your family. Please feel free to ask your therapist about his “no secrets” policy and how it may apply to you. **Initial here:** _____

There are exceptions to confidentiality. For example, therapists are required to report instances of suspected child or elder abuse. Therapists may be required or permitted to break confidentiality when they have determined that a patient presents a serious danger of physical violence to another person or when a patient is dangerous to him or herself. In addition, a federal law known as The Patriot Act 2001 requires therapist (and others) in certain circumstances, to provide FBI agents with books, records, papers and documents and other items and prohibits the therapist from disclosing to the patient that the FBI sought or obtained the items under the Act.

Initial here: _____

Minors and Confidentiality

Communications between therapists and patients who are minors (under the age of 18) are confidential.

However, parents and other guardians who provide authorization for their child’s treatment are often involved in their treatment. Consequently, your therapist, in the exercise of his professional judgment, may discuss the treatment progress of a minor patient with the parent or caretaker.

Patients who are minors and their parents are urged to discuss any questions or concerns that they have on this topic with their therapist. **Initial here:** _____

Appointment Scheduling and Cancellation Policies

Sessions are typically scheduled to occur one time per week at the same time and day if possible. Your therapist may suggest a different amount of therapy depending on the nature and severity of your concerns. Your consistent attendance greatly contributes to a successful outcome. In order to cancel or reschedule an appointment, you are expected to notify your therapist at least 24 hours in advance of your appointment. If you do not provide your therapist with at least 24 hours notice in advance, you are responsible for payment of \$45.00 for the missed session. Please understand

that your insurance company will not pay for missed or cancelled sessions. **Initial here:**

Therapist Availability/Emergencies

Telephone consultations between office visits are welcome. However, your therapist will attempt to keep those contacts brief due to his belief that important issues are better addressed within regularly scheduled sessions.

You may leave a message for your therapist at any time on his confidential voicemail. If you wish your therapist to return your call, please be sure to leave your name and phone number(s), including area code, along with a brief message concerning the nature of your call. Non-urgent phone calls are returned during normal workdays (Monday through Friday) within 24 hours. If you have an urgent need to speak with your therapist, please indicate that fact in your message and follow any instructions that are provided by your therapist's voicemail. In the event of a medical emergency or an emergency involving a threat to your safety or the safety of others, please call 911 to request emergency assistance.

Therapist Communications

Your therapist may need to communicate with you by telephone, mail, or other means. Please indicate your preference by checking one of the choices listed below. Please be sure to inform your therapist if you do not wish to be contacted at a particular time or place, or by a particular means.

_____ My therapist may call me at home. My home phone number is () _____

_____ My therapist may call me on my cell phone. My cell phone number is () _____

_____ My therapist may call me at work. My work phone number is () _____

_____ My therapist may send mail to me at my home address

_____ My therapist may send mail to me at my work address

About the Therapy Process

It is your therapist's intention to provide services that will assist you in reaching your goals. Based upon the information that you provide to your therapist and the specifics of your situation, your therapist will provide recommendations to you regarding your treatment. He believes that therapist and patients are partners in the therapeutic process. You have the right to agree or disagree with your therapist's recommendations. Your therapist will also periodically provide feedback to you regarding your progress and will invite your participation in the discussion.

Due to the varying nature and severity of problems and the individuality of each patient, your therapist is unable to predict the length of your therapy or to guarantee a specific outcome or result.

Termination of Therapy

The length of your treatment and the timing of the eventual termination of your treatment depend on the specifics of your treatment plan and the progress you achieve. It is a good idea to plan for your termination, in collaboration with your therapist. Your therapist will discuss a plan for termination with you as you approach the completion of your treatment goals.

You may discontinue therapy at any time. If you or your therapist determines that you are not benefiting from treatment, either of you may elect to initiate a discussion of your treatment alternatives. Treatment alternatives may include, among other possibilities, referrals, changing your treatment plan, or terminating your therapy.

General Consent for Child or Dependent Treatment

I am the legal guardian or legal representative of the patient and on the patient’s behalf legally authorize the practitioner/group to deliver mental health care services to the patient. I also understand that all policies described in this statement apply to the patient I represent.

_____	_____
Patient Name	Patient Social Security #
_____	_____
Signature of Legal Guardian/Legal Representative	Date
_____	_____
Relationship to Patient	Benefit Plan Subscriber Name

Mental Health Benefit Plan	

Your signature indicates that you have read this agreement for services carefully and understand its contents.

Please ask your therapist to address any questions or concerns that you have about this information before you sign!

Name of Patient

Date: ____ / ____ / ____