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## **ADULT OUTPATIENT SERVICES CONTRACT**

Welcome to my practice. This document contains important information about my professional services and business policies. Please read it carefully and jot down any questions you might have so that we can discuss them at this or any future meeting. When you sign this document, it will represent an agreement between us.

### **PSYCHOLOGICAL SERVICES**

Psychotherapy is not easily described in general statements. It varies depending on the personalities of the psychologist and patient, and the particular problems you bring forward. There are many different methods I may use to deal with the problems that you hope to address. Psychotherapy is not like a 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 on things we talk about both during our sessions and at home.

Psychotherapy can have benefits and risks. Since therapy often involves discussing unpleasant aspects of your life, you may experience uncomfortable feelings such as 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.

I consider our first few sessions an assessment period for both of us. This is the time for you to assess if you feel you will be able to develop a good working relationship with me as your therapist. This is also the time that I will be assessing your needs. During this process, we will decide together if we can effectively work together. Therapy involves a large commitment of time, money, and energy, so you should be very careful about the therapist you select. If you have questions about my procedures, we should discuss them whenever they arise. If you ever decide that you want to change providers/therapist *for any reason*, you are always welcome to do so, although I hope you would be able to discuss this with me first. If you decide you would like a referral to another, please feel free to ask, but if you are not comfortable asking, often the back of your insurance card will provide a number to call so that you may obtain names of other local providers that take your insurance.

### **MEETINGS**

I normally conduct an evaluation that can last from 2 to 6 sessions. During this time, we can both decide if I am the best person to provide the services you need in order to meet your treatment goals. If you decide to start psychotherapy, I will usually schedule one 45-60-minute session once a week or every other week, at a time we both agree, although rarely, some sessions may be longer or more frequent. Once an appointment is scheduled, you will be expected to pay for it unless you provide twenty four (24) hours advance notice of cancellation. If it is possible, I will try to find another time to reschedule the appointment.

### **PROFESSIONAL FEES**

I have a fee schedule for the different services I provide. In addition to weekly appointments, I charge this amount for other professional services you may need, though I will break down the hourly cost if I work for periods of less than one hour. Other services include report writing, telephone conversations lasting longer than ten (10) minutes, attendance at meetings with other professionals you have authorized, preparation of records or treatment summaries, and the time spent performing any other service you may request of me.

### **LEGAL FEES**

My practice is not a forensic (legal) practice. In this practice my emphasis is on the healing of mental and behavioral issues, and I therefore do not participate in legal matters. I need your agreement that my involvement with you will be strictly

limited to the therapeutic process. This means, among other things, that you and I will both treat anything that is said in session as confidential and you will instruct your attorneys not to subpoena me or to refer in any court filing. I am aware that this agreement may not prevent a judge from requiring my testimony, although I will likely work to prevent such an event from occurring.

If I am required to testify, I want you to realize that our treatment is not designed to assist you in the legal sense, but to assist your mental and behavioral health. I do not conduct court ordered treatment, or disability or forensic evaluation. If I am required to appear as a witness, the party responsible for my participation agrees to reimburse me at the rate of \$250 per hour for time spent traveling, preparing reports, testifying, being in attendance, and any other case-related costs.

### **BILLING AND PAYMENTS**

You will be expected to pay for each session (or the session co-pay) at the time it is held, unless we agree otherwise or unless you have insurance coverage which requires another arrangement. Payment schedules for other professional services will be agreed to when they are requested.

If your account has not been paid for more than sixty (60) days, and arrangements for payment have not been agreed upon, I have the option of using legal means to secure the payment. This may involve hiring a collection agency or going through small claims court. For most collection situations, the only information I release regarding a patient's treatment is his/her name, the nature of services provided, and the amount due.

### **INSURANCE REIMBURSEMENT**

In order for us to set realistic treatment goals and priorities, it is important to evaluate what resources you have available to pay for your treatment. If you have a health insurance policy, it will usually provide some coverage for mental health treatment. I will file for insurance reimbursement, however, you (not your insurance company) are responsible for full payment of my fees. It is very important that you find out exactly what mental health services your insurance policy covers.

You should carefully read the section in your insurance coverage that describes mental health services. If you have questions about the coverage, please call your plan administrator. I will try to provide you with whatever information I can based on my experience and will be happy to help you in understanding the information you receive from your insurance company.

Due to the rising costs of health care, insurance benefits have increasingly become more complex. It is sometimes difficult to determine exactly how much mental health coverage is available. "Managed Health Care" plans such as may require authorization before they provide reimbursement for mental health services. You should also be aware that most insurance companies require you to authorize me to provide them with a clinical diagnosis. This information will become part of the insurance company files and will probably be stored electronically on a computer. Insurance companies are required to keep information confidential, but I have no control over what they do with it once it is in their hands. It is important to remember that you always have the right to pay for my services yourself.

### **CONTACTING ME**

I am often not immediately available by telephone and I do not answer the phone when I am with a patient. When I am unavailable, my telephone is answered by voice mail (that I monitor frequently). I will make every effort to return your call within forty eight (48) hours, with the exception of weekends and holidays. If you are difficult to reach, please inform me of some times when you will be available. If you are unable to reach me and feel that you can't wait for me to return your call, contact your family physician or the nearest emergency room and ask for the mental health specialist on call. If I will be unavailable for an extended time, I will provide you with information of who to contact, if necessary.

### **PROFESSIONAL RECORDS**

The laws and standards of my profession require that I keep treatment records. You are entitled to receive a copy of your records, or I can prepare a summary for you instead. Because these are professional records, they can be misinterpreted and/or upsetting to untrained readers. If you wish to see your records, I recommend that you review them in my presence so that we can discuss the contents.

### **MINORS**

If you are under eighteen years of age, please be aware that the law may provide your parents the right to examine your treatment records. It is my policy to discuss with the minor and parent/guardian the limits to confidentiality and come to an agreement that makes therapy for the minor as confidential as possible. I generally don't discuss session content held with minors with parent/guardian unless in the presence of the client. If the minor/client wants me to discuss session content, I will review this with the client, unless I feel there is a high risk that the client will seriously harm themselves or someone else. In this case, I will notify them of my concern.

## **CONFIDENTIALITY**

In general, the privacy of all communications between a patient and a psychologist is protected by law, and I can only release information about our work to others with your written permission. But there are a few exceptions. In most legal proceedings, you have the right to prevent me from providing any information about your treatment. In some proceedings involving child custody and those in which your emotional condition is an important issue, a judge may order my testimony if he/she determines that the issues demand it.

There are some situations in which I am legally obligated to take action to protect others from harm, even if I have to reveal some information about a patient's treatment. For example, if I believe that a child, elderly person, or disabled person is being abused, I must file a report with the appropriate state agency. If I believe that a patient is threatening serious bodily harm to another, I am required to take protective actions. These actions may include notifying the potential victim, contacting the police, or seeking hospitalization for the patient. If the patient threatens to harm themselves, I may be obligated to seek hospitalization for him/her or to contact family members or others who can help provide protection. These situations have rarely occurred in my practice. If a similar situation occurs, I will make every effort to fully discuss it with you before taking any action.

I may occasionally find it helpful to consult other professionals about a case. During a consultation, I make every effort to avoid revealing the identity of my patient. The consultant is also legally bound to keep the information confidential. If you don't object, I will not tell you about these consultations unless I feel that it is important to our work together.

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 at our next meeting. I will be happy to discuss these issues with you if you need specific advice, but formal legal advice may be needed because the laws governing confidentiality are quite complex, and I am not an attorney. (If you request, I will provide you with relevant portions or summaries of the state laws regarding these issues.)

## **Your Rights and Responsibilities**

As a client in my care, you have certain rights, but also responsibilities. The statements below are intended to serve as guidelines to help you as the client (or parent/guardian of the client), the provider/therapist and all others involved in the treatment process to work cooperatively and effectively.

### ***As the client you have the following rights:***

- To be treated with respect and dignity.
- To expect that all issues that affect you will be handled in a confidential manner.
- To select a behavioral health provider of your choice. If you are dissatisfied for any reason, you have the right to choose another network provider.
- To know the identity and professional status of the provider. To participate with your provider in the decision making process regarding your care.
- To review communications and other records pertaining to your care, including the source of payment for treatment.
- To receive information about your care in a way you understand.

### ***As the client or parent/caregiver of a client, you are responsible for:***

- Carrying your medical insurance card.
- Providing, to the best of your knowledge, accurate and complete information about your concerns and any information relevant to your child's mental/behavioral health.
- Verbalizing that you do or do not understand the treatment process and what is expected.
- Participating, to the degree possible, in understanding your behavioral health problems and developing mutually agreed-

upon treatment goals and following the plan of care to the best of your ability.

- Keep all scheduled appointments. If you are unable to do so, for any reason, notifying my office in advance.

If appointments are not kept, a charge of the full fee may be incurred that insurance will not cover. Services will be stopped if there are three (3) late cancel/no-show appointments within 1 year .

- Paying applicable co-payments and fees.

**Abbreviated Contract**

- Once an appointment hour is scheduled, you will be expected to pay for it unless you provide twenty four (24) hours advance notice of cancellation.
- If you decide to terminate treatment, please allow at least one closing session to properly end the treatment relationship.
- At the end of treatment, if requested, I will provide you with a summary that includes a general description of goals, progress made, and potential areas that may require intervention in the future.
- If necessary for safety of you or another person, I may need to disclose information without consent. You agree that my role is limited to providing treatment and that you will not involve me in any legal disputes, especially a dispute concerning custody or custody arrangements (visitation, etc.).
- You also agree to instruct your attorneys not to subpoena me or to refer in any court filing.
- If, for any reason, I am required to appear as a witness, the party responsible for my participation agrees to reimburse me at the rate of \$250 per hour for time spent traveling, preparing reports, testifying, being in attendance, and any other case-related costs.

Your signature below indicates that you have read the information in this document and agree to abide by its terms during our professional relationship.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date