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PSYCHOTHERAPY SERVICES AND POLICIES

This document contains important information about my professional services and policies. Please read it carefully and ask me any questions that arise. When you sign this document, it represents an agreement between us.

PSYCHOLOGICAL SERVICES

Psychotherapy varies depending on the particular problems you bring as a client and the orientation and approach of the therapist. It is important to select a therapist that fits your style and goals. 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 and a general treatment plan. 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 not, I can refer you to a more appropriate therapist. Therapy involves a commitment of time, money, and energy, so you should make sure you feel comfortable working with me. If you have questions about our work together, we should discuss them whenever they arise.

We will work together to establish specific, individualized goals for therapy. We will continue to discuss your goals throughout our work together to assess and/or modify the focus of therapy according to your needs. The results of therapy cannot be guaranteed.

CONFIDENTIALITY

Your discussions with a licensed psychologist are confidential and protected by law. I may not disclose confidential information about you without your consent. There are situations, however, in which I am required to break confidentiality. These include the following circumstances: if you are in danger of harming yourself or another person; if you are unable to care for yourself; if there is suspected abuse or neglect of a child, older adult (65 or older), or dependent adult; if I am court ordered to release information as part of a legal proceeding; or as otherwise required by law.

PROFESSIONAL FEES

The fee for a 50 minute session of individual therapy is $255, discounted to $250 for payments by cash, check, or some debit. Fees for longer or shorter sessions will be prorated from this amount. You will be charged the typical session fee (prorated according to length in 10 minute increments) for calls other than calls related to scheduling and the initial phone consultation. Other services include telephone consultations, report writing, or other services you may request of me. If you become involved in legal proceedings that require my participation, you will be expected to pay for the professional time I spend preparing records or treatment summaries. You will also be expected to pay for my time spent testifying in court. There is a small increase in fees each year around January 1.

BILLING AND PAYMENTS

Payment for each session is due at the beginning of each meeting. I accept payment by check, cash, debit, or credit card. A credit card is kept on file and information destroyed at the end of treatment. Payment schedules for other professional services will be agreed to when they are requested. There is a $20 fee for returned checks. If a credit card is declined, you will be responsible for any fee incurred during the attempt to run the declined card. A $25 late fee will be added for any charges past due by 30 days, and additional charges will accrue monthly for any unpaid balances. If your account has not been paid for more than 60 days, I may use legal means to secure payment. This will involve either hiring a collection agency or going through small claims

court. If such legal action is necessary, its costs will be included in the claim. In collection situations, the only information I release regarding a client's treatment is his/her name, the nature of services provided, and the amount due.

INSURANCE REIMBURSEMENT
If you wish to receive insurance reimbursement for your sessions, it will be your responsibility to complete insurance forms and obtain reimbursement. I will provide you with receipts that contain information your insurance company may require. It is important that you find out exactly what mental health services your insurance policy covers.

CANCELLATIONS, MISSED SESSIONS, AND TARDINESS
Sessions are usually scheduled weekly for 50 minutes, although on occasion some sessions may be longer or more frequent. You will be charged for sessions you miss or cancel with less than two full business days advance notice, regardless of the reason for cancellation.

The financially responsible party (FRP) is asked to please initial here to acknowledge this two business day (48 hour) cancellation policy:

FRP Initials_____ Client (if different) Initials._____

Generally sessions will start on time. Sessions will end 50 minutes after the scheduled appointment time, even if you are late. If (on a rare occasion) I begin a session late, I will make up the missed time in some mutually agreeable fashion (e.g., by extending the session, if convenient for you).

TELEHEALTH THERAPY

If you are unable to make it into the office, I may offer a video therapy session through the platform doxy.me, a HIPAA compliant video conference service. Video therapy, or telehealth, will not be the same as a direct client/health care provider visit due to the fact that we will not be in the same room. Telehealth has potential benefits including easier access to care and the convenience of meeting from a location of your choosing. There are also potential risks to this technology, including interruptions, unauthorized access, and technical difficulties. You or I can discontinue the telehealth consult/visit if it is felt that the videoconferencing connections are not adequate for the situation.

Telehealth is NOT an Emergency Service and in the event of an emergency, you must use a phone to call 911. Neither the doxy.me platform, nor any other telehealth service, provides any medical or healthcare services or advice including, but not limited to, emergency or urgent medical services. During telehealth, I do not have access to any or all of the technical information in the doxy.me service and I cannot guarantee that such information is current, accurate or up-to-date. To maintain confidentiality, do not share your telehealth appointment link with anyone unauthorized to attend the appointment.

By initialing below, I certify:
- That I have read or had this form read and/or had this form explained to me.
- That I fully understand its contents including the risks and benefits of the procedure(s).
- That I have been given ample opportunity to ask questions and that any questions have been answered to my satisfaction.

Telehealth User Initials: _____

CONSULTATION
I sometimes consult with other professionals about treatment planning for my clients and therefore may discuss our work together with other professionals/clinicians. When I do so, I do not provide identifying information in order to protect confidentiality.

MY AVAILABILITY
You may contact me at (650) 933-3016. I am in the office Monday through Thursday. Please note that I am often not immediately available by telephone. I will make every effort to return your call on the same day you make it or by the next business day. I do not offer emergency coverage, meaning that I do not wear a pager, I am often not available for emergency sessions, and I do not provide backup coverage when I am out of town. If you have a clinical emergency, you should not wait for me to return your call. You should go immediately to the nearest emergency room (e.g., Stanford Hospital ER: 650-723-5111). If you need a therapist who provides emergency or urgent services, I will be happy to provide you with referrals.

ENDING THERAPY
You may end therapy at any time. A final session is strongly recommended for closure of our work together.

I have read and understand this document and I have had my questions answered to my satisfaction. I accept, understand, and agree to abide by the contents and terms of this agreement. I consent to participate in evaluation and/or treatment.

_____ _____
Name of client (please print) Signature of client Date

PRIVACY PRACTICES (HIPAA)
I have received a copy of Dr. Singer's Notice of Privacy Practices detailing the provisions of HIPAA and my privacy rights.

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Signature of client Date