Pete Morones, Ph.D.
Licensed Psychologist

CONSENT TO TREATMENT & OFFICE POLICIES

Psychological Services: Welcome to my practice. I am an independent licensed psychologist in private practice. Psychotherapy or *"talk therapy"* is a collaborative process that varies depending on the particular problems you are experiencing and the personalities of the psychologist and client. Therapy calls for an active effort on your part during and in between sessions in order for treatment to be most beneficial. Our first few sessions will involve a review of what led you to seek therapy, learning about your symptoms and your background. You are also welcome to ask me questions. All of this information is helpful in getting to know you and to help us both determine if we are well suited to work together.

Psychotherapy can have benefits and risks. Therapy may provide relief and benefits such as reduction in feelings of distress, alleviation, or improvement of certain problems, and increased confidence and self-esteem. Because therapy often involves addressing difficult aspects of your life, you may experience uncomfortable feelings such as sadness, guilt, anger, anxiety, frustration, loneliness, and changes in relationships or other areas of your life. Emotions and difficulties may intensify at times as a normal part of the therapy process. Although, there is no guarantee of what you will experience in therapy, or of the treatment outcome, please be assured that you will be treated with respect and that I will work to foster a supportive, safe, and trusting environment as we work together to address your concerns and goals.

Therapy involves a commitment of time, energy, and financial resources. Therefore, you are encouraged to carefully evaluate the information above, along with your own impressions and feelings of me to determine if you believe that we can work together. If at any time you have questions or concerns about your therapy, please feel free to discuss them with me. I will check with you periodically to see how you are feeling about the therapy process so that we can make changes that support your goals. Also, if you have questions about my practice, policies, procedures, or qualifications, please do not hesitate to ask. Please know that I will be happy to suggest referrals to other mental health professionals if either one of us determines that therapy is not progressing.

Fees: Psychotherapy sessions are by appointment only. The fee for the initial evaluation is $270.00; and the fee for subsequent therapy appointments is $180.00 per 40-minute sessions; and $240.00 for 55-minute sessions . If you are a returning client that I have not seen within the past twelve months, this is usually considered a new evaluation. Additional professional activities on your behalf outside of regularly scheduled appointments are billed at $240.00 per hour, prorated to the nearest ¼ hour. Such activities may include, but are not limited to: telephone or other forms of consultation or communication either with you or on your behalf; letter or report writing, document review, and processing of requests for information (e.g. review of records, disability claims). Legal and/or court related proceedings/requests, including but not limited to document review, preparation, processing, depositions or testimony, consultation, travel and wait time; and other case related activities or expenses are billed at $300.00 per hour. *Please note that insurance <u>does not</u> cover these activities and payment is your responsibility.*

Insurance: There are important considerations if you chose to utilize insurance. Utilizing insurance often makes sense and has financial advantages in terms of what your particular policy may cover. However, insurance companies only cover certain diagnoses and aspects of treatment for what they deem to be "medically necessary" treatment. At a minimum, I will be required to provide your insurance company information about your diagnosis, appointments, and treatment. I may also be required to furnish more detailed information such as your history, treatment plans, medication, drug and alcohol, psychiatric and psychological information, etc. Insurance companies can also request to audit your entire chart or clinical

record. Information provided to your insurance company will become part of their company records. I do not have control of your records or information after it has been released to your insurance company or a third party.

You have the right to pay for your own treatment without the use of insurance. Paying out of pocket will allow you the freedom to see the provider of your choosing, and to have fewer restrictions in terms of your reasons for seeking therapy, frequency, or length of therapy. It will also allow you to preserve a higher degree of privacy in terms of your personal information.

If requested and permitted*, I will bill your primary insurance as a courtesy; however, you are responsible for determining coverage, co-payment/co-insurance and any deductibles that may apply. You are also responsible for verifying and maintaining a valid and current authorization for treatment, when required by your insurance. Please contact your insurance company if you have any questions or concerns regarding your coverage. *You are ultimately responsible for any fees that are not reimbursed by your insurance.*

**Please note that I am not a Medicare provider and that I am not permitted to bill Medicare, nor would you be able to submit a claim to Medicare for my services.*

Payment: Payment is expected at time of service, unless alternative arrangements have been made. Payments are to be made directly to Dr. Pete Morones. Payments can be made by check, cash, and credit or debit card. A valid credit or debit card authorizing payment for outstanding balances is required. A late fee surcharge of $20.00 will be added for each month in which there is an outstanding balance. There is a $25.00 fee, and any fees imposed by the bank, for payments that do not clear (i.e., insufficient funds/returned checks). Unless otherwise negotiated, delinquent payments beyond 90 days may be referred to a collection agency.

Cancellation & No-Show Policy: The scheduling of an appointment involves the reservation of time exclusively for you. If you are not able to keep your appointment, 24-hour notice is required to avoid a late cancellation charge. You will be charged 50.00 for the first missed appointment or late cancellation, and up to the full session fee for subsequent missed appointments or not providing more than 24-hour notice. You will not be charged for cancellations due to illness, weather or health related emergencies. Insurance does not cover late cancellations or no-shows, and you will be responsible for payment. These fees may be charged to your credit card on file. If you need to cancel your appointment, you can leave a message any time and any day at (503)236-4665.

I have read and agree with Dr. Morones' cancellation, no-show, and billing policies: _____

Please initial

Emergencies: Should you need to contact me between appointments, please call (503) 236-4665, and leave a message, if I am not available. I typically return calls within 24 hours Monday-Thursday. If you have an emergency that requires immediate attention, please leave me a message, and then call the 24-hour Crisis Line at: (503)988-4888. You can also call 911 or go to your nearest emergency room.

Privacy & Confidentiality: Your work in therapy is private, confidential, and protected by state and federal laws. No identifying information will be released to other parties without your consent, except as necessary, required or permitted by law under the following circumstances:

- If you chose to use insurance, I will need to share/receive information with your insurance company or their representatives. Such information usually includes diagnostic and treatment information. Additional information as outlined above (Insurance Section) may also be provided to your insurance company or their representatives. I will do my best to answer your questions regarding insurance, however please keep in mind that I do not work for the insurance companies and I do not know the particulars of various plans or policies.

You are advised to check with your insurance regarding questions and concerns about your information and policy.

- Harm or risk of harm to yourself and/or others. Examples include abuse of a minor, older adult, disabled person; imminent risk of hurting yourself, another identified person, or intended acts of violence that may jeopardize the welfare of others or society (i.e. acts of terrorism). Crimes, threats, or violence directed at my property or me.
- Information necessary as part of standard business operations. Examples include sharing necessary, but minimal, information with office managers, bookkeepers, billing services, professional consultants, and/or collection agencies. I may also need to share information with other mental health professionals providing coverage in my absence.
- Court order/Subpoena. If you are involved or associated in legal proceedings, or the subject of an investigation, and a request is made for information regarding your therapy. Such requests may include information regarding your diagnosis, history, disclosures made by you, my impressions/observations, health, medications, and use of substances. Such information is protected by psychologist-patient privilege law and professional codes of conduct unless you or your representative waives your rights to confidentiality; or if there is an enforceable subpoena or court order.
- Worker's Compensation, disability, life/health insurance or similar claims. If you file such a claim or application, requests are often made for parts or all of your medical records, including psychotherapy records. When you file or apply for such claims you may be asked to waive part or all of your rights of confidentiality. *
- If you file a complaint against me, I may disclose the necessary information about you and our work together to comply with an investigation and/or to defend my actions.
- Medical emergencies or accidents.
- If you grant me explicit permission to share information regarding your treatment with another party.

If, or when, I receive a request to disclose information about you and/or your treatment, I will attempt to contact you and respect your wishes. Such requests may occur during or after therapy, including several years later. It is strongly advised that you consult with an attorney regarding how such disclosures, waiving of rights, or a request that I do not share your information, may affect you and your case.

In order to provide you with a high quality of care, I may discuss or exchange information with other professionals to promote your care and well-being. This might include past or present health care providers. Please know that before speaking with such professionals, I will seek your permission first and explain my reasoning. If you are comfortable with this, together we will decide what information may or may not be shared. In addition, to provide a high degree of care, I may occasionally consult with other healthcare professionals regarding your treatment; however, this will be done without disclosing your name or identifying information unless I have your explicit permission to do so. Please do not hesitate to ask question or discuss your concerns regarding confidentiality.

HIPAA: Included with these forms is information on the Health Portability and Accountability Act (HIPAA). This is a federal law that provides protections and rights with regard to health care information for the propose of treatment, payment, and health care operations. HIPAA requires that I offer you a form titled: *Notice of Privacy Practices* and that I obtain your signature acknowledging that you were offered this information. Please take time to carefully review this separate document.

YOUR SIGNATURE BELOW INDICATES THAT YOUR HAVE REVIEWED THIS AGREEMENT AND AGREE TO THE TERMS. Your signature also serves as an acknowledgment that you received the document ***NOTICE OF PRIVACY PRACTICES (HIPAA)*** document.

_____ _____

Client Signature Date

01/22

_____

Printed Name