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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.

PROFESSIONAL FEES

The fee for a 50 minute session of individual therapy is $300, discounted to $295 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 charge associated with 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.

*Please note that **I am not a Medicare provider**. If you are a beneficiary, you will not receive reimbursement for my services. You may secure Medicare reimbursed services from another qualified practitioner.

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 48 business hours (2 business days) advance notice, regardless of the reason for cancellation.

Please initial here to acknowledge this 48 business hour cancellation policy:

Client initials: _____ Parent 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: _____ Parent 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.

_____ _____

Signature of client Date Signature of parent 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.

_____ _____

Signature of client Date Signature of parent Date

ADOLESCENT CONFIDENTIALITY ADDENDUM
The process of therapy involves getting to know your perspective on difficulties or predicaments in your life, developing an understanding of the nature of the difficulties, and generating better ways to cope with or manage those difficulties. Sometimes these difficulties will include topics you do not want your parents or guardian to know about. For most people, knowing that what they say will be kept private helps with disclosing thoughts, feelings, and perceptions and to have more trust in their therapist. As a teenager, you have certain rights to privacy that are not equal to those of an adult (the legal definition of which is 18 years old), but privacy, also called confidentiality, is a critical part of effective psychotherapy. Therefore, as a general rule, information you share in therapy sessions is kept confidential, unless you give consent to disclose certain information or unless the therapist is required by law or professional guidelines to disclose certain information. Situations that would require the therapist share information typically involves your protection and the protection of others from the potential to be hurt or harmed. These situations include:

1. If you report having a plan to harm yourself, based on the evaluation of that plan, confidentiality can be broken in order to protect you from harming yourself.

2. If you report having a plan to harm someone else, based on the evaluation of that plan, confidentiality can be broken in order to protect the person you intend to harm.

3. If you are involved in activities that could cause harm to yourself or someone else, even if you do not *intend* to harm yourself or someone else, based on the evaluation of that behavior, confidentiality can be broken.

4. If you report that you are being abused - physically, emotionally or sexually – or that you have been abused in the past, the law requires that this be reported to the California Department of Social Services.

5. If you are involved in a court case and a request is made for information about your therapy, information will be disclosed with your written consent unless the court *requires* that information be provided. If this occurs, you will be informed of the proceedings, and efforts to protect your confidentiality will be taken and discussed with you.

6. If you agree that information can be shared with a specific person or entity, then we will discuss the limits of what will be shared, and how that information will be shared.

Schools and Teachers. Information will not be shared with your school, including that you are even seeing a therapist, unless you and your parents/guardians give permission. If someone from your school wants to talk about your treatment, or if it is decided that talking to someone at your school would be beneficial, then you and your parents will be asked to give their permission for that. If your parents or school want information about the treatment, and you do not want to give permission, then that will be discussed in a session.

Physicians/Doctor's Offices/Dietitians. Other healthcare providers may have been involved in referring you for therapy, may have prescribed medication for you, or may be overseeing your health in areas related to what brought you into therapy. Thus, it may be important to coordinate with your other providers regarding your progress or status, especially when medication is involved or there are other health issues. Again, your permission will be required for such a consultation to occur and it will be important to discuss in therapy what information will be disclosed, especially since some information can be disclosed to a provider that is not disclosed to your parents. The only time information can be shared with your medical provider without your permission is if you are engaged in harmful or risky behavior that creates a concern about safety.

To give permission to coordinate with your medical doctor (s) and/or dietitian, please write their name, telephone, and email address here and sign below:

Name	Telephone	Email

Parents and Guardians. Except for situations as described above, your parents/guardians will not be told of specific information you disclose in therapy. This includes activities and behavior that your parents/guardians would not approve of or be upset by, but that do not put you or others at risk for immediate harm.

It may be important to let your parents know some information that is protected by confidentiality, so you may be encouraged to share that information. Part of the therapist's job is to discuss this with

you and to decide together the best way to communicate the information. Also, parents and guardians may be able to be more helpful if they have general ideas about themes of therapy (such as autonomy, important privileges, achievement, or the status of symptoms) and the therapist may have specific suggestions for parents that do not involve breaking your privacy. These conversations will be had only with your knowledge and agreement.

AGREEMENT BY PARENTS

1. Parents are asked to respect their adolescent's rights to privacy and waive their rights to access their adolescent's treatment records.
2. Parents will be informed and confidentiality is waived if the therapist beliefs the adolescent is a serious risk or harm to his/herself or others.
3. Parents can always provide information they think is important for the therapist to know via email or voicemail.
4. Parents understand that the therapist will use informed clinical judgement about what must be shared and about the most effective method of transferring information to parents. If parents wish to provide frequent information, it will be received but does not imply that a return communication will be initiated. Communication from therapist typically involves general summaries of progress, as deemed appropriate, by email or by in-person conjoint sessions with the adolescent, with adolescent's permission.
5. Phone calls with parents outside of therapy are only offered in the case of scheduling or as deemed appropriate and necessary by therapist. This is to protect the integrity of the adolescent's therapy. If a conversation is requested by a parent and the adolescent gives permission, phone calls outside of the therapy hour will be billed at a pro-rated fee.
6. Occasionally, parent coaching sessions will be offered without the adolescent present. These can be requested by the parent or suggested by the therapist, but will always include the adolescent's informed consent. During these sessions, the focus will be exclusively on coaching parents in skills to support and understand their adolescent, and not on sharing information from their child's therapeutic work.

I have read and agree to the policies above.

Parent/Guardian Signature_____ Date_____

Parent/Guardian Signature_____ Date_____