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CONSULTATION AND PSYCHOTHERAPY AGREEMENT

This information concerns my professional practice and business policies. Please read it carefully and raise any questions you may have with me, so that we can discuss them. When you sign this document, it will represent an agreement between us.

CONSULTATION:
It is helpful to view the first 1-3 sessions as part of an initial consultation, during which we will determine together whether further work together would be beneficial. This is an opportunity for me to gather information and clarify the presenting concerns, and also a chance for you to ask any questions regarding my professional background, training, and credentials.

The Education Law and Regents Rules specify that in cases of continuous and sustained treatment of a serious mental illness (schizophrenia, schizoaffective disorder, bipolar disorder, major depressive disorder, panic disorder, obsessive-compulsive disorder, attention-deficit hyperactivity disorder, and autism), the patient shall be evaluated by a physician. The physician shall consult with me regarding the illness and advise whether any medical care is needed.

PSYCHOTHERAPY SESSIONS:
If ongoing psychotherapy is initiated, I will schedule one weekly 45-minute or 60-minute session at a mutually agreed upon time.

PROFESSIONAL FEES AND PAYMENTS:
My fee is $225-$275 for individual therapy. Fees and co-payments are expected to be paid at each session unless we agree otherwise, for example, monthly. All letters, evaluations, appeals, forms and summaries that are lengthy or time-consuming will require special payment for their preparation and transmission. There is also a charge for copying and sending copies of the chart contents.

If your account has not been paid for more than 60 days and arrangements for payment have not been agreed upon, I reserve the right to suspend or discontinue treatment with you and to seek remuneration by any means legally possible including, but not limited to, the retention of a collection agency. By signing this agreement, you agree to bear all financial responsibility for all attorney and court costs associated with collecting any unpaid debt.

INSURANCE:
If you have insurance coverage, we will have to comply with the insurance company stipulations as to the number of sessions covered, fees and co-payments, and submission of outpatient treatment reports (OTR) to

determine “medical necessity.” Privacy rights under HIPAA regulations will be followed (see Notice of Privacy Practices). If we decide to continue psychotherapy beyond what your insurance benefits cover, we can set a fee that is mutually acceptable. If I am out-of-network with your insurance company, I can provide you with the necessary receipts and other documentation you need in order to receive reimbursement through your out-of-network benefits. Most insurance plans offer out-of-network benefits for mental health treatment, but it is necessary that you contact your insurance company to determine exactly what coverage you are entitled to through your specific insurance policy including information about your deductible.

It is very important to understand that most health insurance will only pay for services considered medically necessary. This means that I am required to give a mental health diagnosis that then becomes part of your permanent medical record. Please discuss with me and questions or concerns you may have about medical necessity.

CANCELLATIONS:

Therapy works best when scheduled appointments are regularly kept. Please be aware that most insurance companies do not reimburse for missed sessions. If you do not show up for your scheduled appointment and you have not notified me **48 hours** in advance, I will try to reschedule your appointment within the week of your appointment. If we are unable to reschedule, you will be responsible for the **full fee of the session (or contracted fee if using insurance).** Extenuating circumstances are always considered. In the case of hazardous weather conditions, a telephone or video session may be conducted or we could reschedule your appointment within the week of your appointment.

CONFIDENTIALITY:

The privacy of all communications in psychotherapy is protected by law, and I cannot release any information about our work to others without your written permission. But there are a few exceptions. I am legally obligated to take action to protect others from being harmed by you, for example, to report child abuse to protect the child. This also concerns protecting safety of the patient if the patient states intent to seriously harm herself/himself, or protecting safety of another if the patient states intent to cause serious harm to a person.

COMMUNICATION AND EMERGENCIES:

Occasionally, telephone contact is needed or desired between scheduled sessions. I am often not immediately available but I monitor my voicemail messages/emails and will make every effort to return your call within 24 hours, except for weekends and holidays. If you are unable to reach me and feel that you cannot wait for my return call, you should go to your local emergency room or dial 911.

Electronic Communication and Consent for Use: Please indicate your preferred method of communication on the Psychotherapy Patient Information form, and I will honor your desire to communicate through the method you indicate. Email/texting communication should be used for scheduling and administrative purposes only. It is very important to be aware that unencrypted email and texts can be relatively easily accessed by unauthorized people and hence can compromise the privacy and confidentiality of such communication. If you communicate confidential or private information via unencrypted email or texts, I will assume that you have made an informed decision and will view it as your agreement to take the risk that such communication may be intercepted. If at any time, Sofia R. Tuchapsky, RN, LMHC or you believe that email/texting is interfering in the therapeutic process or being used ineffectively, either of us can revoke this consent verbally, refuse to respond to emails/texts, and insist upon a verbal conversation before proceeding.

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

Patient's Name: _____

Patient's Signature: _____ **Date: _____**