

Psychotherapy Services Contract

Welcome to my therapy practice. I look forward to working with you. This document contains information about my professional services and practice policies.

Please review the following pages carefully and do not hesitate to ask questions if any of the information appears unclear. Once signed, this document will represent a professional agreement between us.

Psychological Services:

The process of Cognitive Behavioral Therapy typically focuses on modifying thoughts, feelings and behavior. Hopefully these changes will result in improvements in one or more areas of your life.

The potential benefits of participating in therapy may include improving interpersonal relationships, contending with difficult emotions, increasing your ability to manage stress and other life problems, as well your discovering new ways of thinking about yourself, others, and your surroundings.

Although you can receive many benefits from therapy, this process can sometimes be frustrating and challenging. Since therapy often involves discussing unpleasant or painful aspects of your life, the process may cause you to experience strong and difficult emotions (e.g., anger, sadness, loneliness).

Therapy also often involves an investment of time, money and energy. For therapy to be most successful, it requires a commitment from you to work both during our sessions and at home on the goals and objectives that we identify together. Most often CBT requires you to do “homework” such as completing “thought records” or performing other behavioral exercises, either at home or with my help during your sessions.

Meetings:

Prior to our first meeting, you will be asked to complete an initial assessment form. This questionnaire requests information from you about your history and background. The goal of using this form is to gain a better understanding of you so that I can provide the best treatment possible.

During the first session, we will also work together to establish your goals for therapy and to determine the likelihood of your achieving these goals through our therapy sessions.

If you decide that you could benefit from therapy with me, I will usually schedule one 50-minute session (one appointment is 50 minutes duration) per week at a mutually agreed upon time, although some sessions might be longer or occur more or less frequently. Once an appointment time is scheduled, you will be expected to pay for it unless you cancel 24* hours in advance. *Monday appointments require cancellation by Friday, 5:00 P.M.

Professional Fees:

Our initial evaluation fee is \$250. The fee for a 50 minute session is \$195. In addition to weekly meetings, we charge this amount for other professional services that you may need, although we will break down the cost into 10 minute segments if we work for periods of less than 50 minutes.

These services may include telephone consultations of more than 10 minutes, report writing, preparation of records or treatment summaries, and time spent on performing any other services that you request of us.

Billing and Payment:

Payment for service is due at the time of each visit.

If a check is returned, a fee based on our bank's current fee schedule will be added to your bill. In cases when a bill has been neglected by you, there will be an administrative fee of 1% per month imposed on any outstanding unpaid balance of more than 30 days past due from date of visit.

Insurance

As specified in our financial agreement, Dr. Schonberg is an "out of network" provider for all commercial insurance plans. We will provide an insurance receipt which you can submit to your insurance company for direct reimbursement. Please be aware that your insurance is an arrangement between you and your company and we are not a party to this contract. Naturally, we will assist you with required authorizations when you ask or provide us with copies of these requests.

Dr. Schonberg is a non participant in either Medicare or Medicaid. As such, her fees are not reimbursable by Medicare or Medicaid. If you are a Medicare beneficiary or Medicare eligible and you wish to be treated by Dr. Schonberg, you will be asked to sign an agreement indicating both your willingness to pay her usual rate and your understanding that the bill cannot be submitted to Medicare.

Non-Payment:

If, after repeated notification, a balance due is not met with payment, we reserve the right to use legal means to obtain the payment (e.g., hire an attorney, collection agency or resort to small claims court.) In most collection situations, the only information that would be released regarding your personal information would be your name, the nature of services provided, and the amount due.

Appointment Cancellation or "Missed Appointments":

Your appointment time is reserved for you and only you, usually more than a week in advance. **If you cannot use the time, 24 hours advance telephone notice is needed for you to avoid session charges for this unused time and so that the time can be made available to another client. Appointments cancelled with less than *24 hours' notice from your scheduled appointment time will be billed for the full session charge. Appointments scheduled for *Monday must be cancelled by Friday 5:00 P.M. to avoid full session charges.**

Please ask questions if this statement is unclear to you.

Contacting Me:

During the day I may not immediately be available by telephone because I am with clients. If I am unavailable, my telephone is answered by voice mail that I monitor frequently. If there is a matter that you think cannot wait until our next scheduled appointment, please leave a message and I will return your call as soon as possible. I will make every effort to return your call on the same day or within 24 hours of your message, except for weekends and holidays.

If you have an emergency and cannot reach me, please call the Morristown Medical Center Hotline at (973) 540-0100 or go to the nearest hospital emergency room. On occasions when I plan to be unavailable for an extended period of time (e.g., away on vacation or at a conference,) I will provide you with the name and phone number of a colleague to contact.

Contacting You:

If you are 15 minutes late for a scheduled session, I will typically call you to determine if you are still planning to come to our appointment.

If you do not wish for me to call you, please let me know and/or provide a private phone number on which you are comfortable being contacted.

In addition, there may be instances when you will receive a mailing from my office (e.g., a statement or some other communication).

My mailing envelopes display my practice's name and address. If receiving mail from my office is a concern for you, please let me know.

E- Mail:

Many of my clients elect to request or confirm appointments by e-mail. Please be aware that if you use e-mail your communication is not secure and you acknowledge your permission for me to reply in an unsecured manner.

Collaborating with other Professionals Involved in your Care:

Many of my clients are referred by their personal physicians or other treating professionals. Collaborating with other treating professionals often benefits the client and enhances treatment effectiveness. Please sign and complete the Consent Form found on the "FORMS" page of this site for the relevant professionals involved in your care.

Professional Records:

The law and standards of my profession require that I maintain treatment records. You are entitled to receive a copy of the records or, I can prepare a summary of the records instead. Because these are professional records, they can be misinterpreted or upsetting by someone who is not a mental health professional. If you wish to see your records, I recommend that you review these records in my presence so that we can discuss the information contained in the records.

Legal Cases:

If you are involved in a legal case in which your mental status is being questioned and the services that you have requested are NOT for expert opinion or testimony, then please be advised that your therapist, in order to avoid a potential conflict of interest and to preserve the patient-therapist relationship, cannot serve as an independent expert at a later date.

If you need an expert opinion or evaluation for legal purposes, please let me know BEFORE the start of services so that I may refer you to a professional who can help in this area.

Confidentiality:

Following the New Jersey state law and the American Psychological Association (APA) code of ethics, the therapist-patient relationship is privileged and confidential. In most cases, I can only release information regarding our work together with your permission. However, there are several limitations to confidentiality depending on your particular circumstances.

- If your health insurance carrier falls under the federal ERISA act, this carrier is entitled to and may request information about your treatment.
- In most legal proceedings, you have the right to prevent me from sharing information regarding your treatment. However, in some cases, a judge may order my testimony if he or she finds this action to be necessary.
- If I believe that a child is being abused or neglected, I must report this suspected abuse to the appropriate state agency.

If I believe that you are an imminent danger to yourself or others, I am required to take protective actions (e.g., call the police, warn a potential victim, or seek emergency psychiatric care for you).

These situations do not occur frequently and I will make every effort to discuss these issues with you before taking action.

Please print and sign the next page, and bring it to your first visit.

Therapy Contract

By signing below, I verify that I have read and understand the therapeutic contract and give my consent for treatment:

Signature: _____ Date: _____

Or

Signature: _____ Print Name: _____
Parent (for Minor):

Notice of Privacy Practices

By signing below, I verify that I have received and reviewed the Notice of Privacy Practices. I understand that Dr. Schonberg and Dr. DiDomenico are committed to protecting my privacy and confidentiality as described in the Notice of Privacy Practices.

Date: _____

Signature: _____ Print Name: _____

Date: _____

Signature: _____ Print Name: _____
Parent (for Minor):