Patient: _____

STACEY SCHECKNER, PH.D.

PSYCHOLOGIST, LICENSE # PY 7217

South Tampa, Florida

(813) 362-3936

PATIENT INFORMATION

PATIENT NAME_____ M [ ] S [ ] D [ ] W [ ] MINOR [ ]

ADDRESS: _____Male [ ] Female [ ]

CITY: _____ STATE: _____ ZIPCODE #:_____

DOB: _____ AGE: _____SS#_____

HOME# (____)_____ - _____ WORK# (____)_____ - _____E-MAIL_____
If I am unable to reach you, do I have your permission to leave a message on your answering machine? __yes __no

[ ] EMPLOYED [ ] FULL-TIME STUDENT [ ] PART-TIME STUDENT [ ] DISABILITY

PARENTS/GUARDIAN: _____
(IF PATIENT IS MINOR)

EMERGENCY CONTACT: _____ PHONE# (____)____ - _____

Patient: _____

Stacey Scheckner, Ph.D.
Psychologist, License # PY 7217
South Tampa, Florida 33606
(813) 362-3936

OUTPATIENT SERVICES CONTRACT

Welcome to my practice. This document contains important information about my professional services and business policies. Please read it carefully and jot down any questions you might have so we can discuss these at our initial meeting. Once you sign this, it will constitute a binding agreement between us. It also contains summary information about the Health Insurance Portability and Accountability Act (HIPAA), a federal law that provides privacy protections and patient rights with regard to the use and disclosure of your Protected Health Information (PHI) used for the purpose of treatment, payment, and health care operations. HIPAA requires I provide you with a Notice of Privacy Practices (the Notice) for use and disclosure of PHI for treatment, payment and health care operations. The Notice, which is attached to this agreement, explains HIPAA and its application to your personal health information in greater detail. The law requires I obtain your signature acknowledging I have provided you with this information. Although these documents are long and sometimes complex, it is very important you read them carefully before our first session. We can discuss any questions you have about the procedures at that time. When you sign this document, it will also represent an agreement between us. You may revoke this agreement in writing at any time. That revocation will be binding on me unless I have taken action in reliance (confidence) on it (already), if you have not satisfied any financial obligations you have incurred.

PSYCHOLOGICAL SERVICES

The results of psychotherapy vary depending on the personality of both the therapist and the patient and the particular problems the patient brings. There are a number of different approaches which can be utilized to address the problems you have. It is not like visiting a medical doctor in that psychotherapy requires a very active effort on your part. In order to get the most out of our sessions, you will have to work on things we talk about both during our sessions and at home.

Psychotherapy has both benefits and risks. Risks sometimes include experiencing uncomfortable feelings such as sadness, guilt, anxiety, anger and frustration, loneliness and helplessness. Psychotherapy often requires discussing unpleasant aspects of your life. Psychotherapy has also been shown to have benefits for people who undertake it. Therapy frequently leads to a significant reduction in feelings of distress, to better relationships, and to resolutions of specific problems. But there are no guarantees about what will happen.

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 initial impressions of what our work will include and an initial treatment plan to follow. If you decide to continue, you should evaluate this information along with your own assessment of whether you feel comfortable working with me. Therapy involves a large commitment of time, money, and energy, so you should be very careful about the therapist you select. If you have questions about my procedures, we should discuss them whenever they arise. If your doubts persist, I will be happy to help you secure an appropriate consultation with another mental health professional. You may terminate services at any time by notifying me in writing. However, since a therapeutic relationship will hopefully be established between us, premature termination may result in trauma to the patient, especially a child. Thus, it is important to discuss appropriate ways to terminate therapy (ie., every other week, once a month, when needed, closing session)**.**

APPOINTMENTS

All appointments may be scheduled with me. My normal practice is to conduct an evaluation which will last from 2 to 4 sessions. During this time, we can both decide whether I am the best person to provide the services which you need in order to meet your treatment goals. If psychotherapy is initiated, I will usually schedule one 45 minute session per week at a mutually agreed time, although sometimes sessions will be more frequent. This specific block of time is reserved for you and you will be expected to pay for it unless you provide **1 week** advance notice of cancellation as someone else can use this time slot.

Patient: _____

PROFESSIONAL FEES

The initial intake session fee is $**200**. Subsequent charges are $**175** per individual session. Family and marital therapy fees are $**200** per session. In addition to weekly appointments, it is my practice to charge this amount on a prorated basis for other professional services you may require such as report writing, telephone conversations which last longer than 15 minutes, attendance at meetings or consultations with other professionals which you have authorized, preparation of records or treatment summaries, or the time required to perform any other service which you may request of me. If you become involved in litigation which requires my participation, you will be expected to pay for the professional time required even if I am compelled to testify by another party. Because of the complexity and difficulty of legal involvement, I charge $**1000** for 1/2 day or less to provide testimony at any legal proceeding. If this situation arises, I require a retainer for my services.

BILLING AND PAYMENTS

You will be expected to pay for each session at the time it is held, unless we agree otherwise. Payment for other professional services such as psychological testing will be agreed to at the time these services are requested. I do not "carry" cases for long-term payment arrangements as I do not have the personnel or capability of providing loans or keeping up with such arrangements. If payment is a problem, you will need to make arrangements with a bank, credit union, or family members who can assist you. In circumstances of unusual temporary financial hardship, I may be willing to negotiate a fee adjustment or installment payment plan. I make a practice of providing a limited number of "pro bono" services (meaning for the public good) for a minimal fee in assisting some individuals. The decision to provide pro bono services fluctuates and is made on a case-to-case basis.

If your account is more than 30 days in arrears and suitable arrangements for payment have not been agreed to, I have the option of using legal means to secure payment, including charging a late fee, retaining collection agencies or suing in small claims court which will require me to disclose otherwise confidential information. In most cases, the only information, which I release, about a client's treatment would be the client's name, the nature of the services provided and the amount due. If such legal action is necessary, the costs of bringing that proceeding will be included in the claim.

TELEPHONE CALLS AND APPROPRIATE COMMUNICATION

Therapy takes time and crisis may occur between sessions. Depending upon the severity of distress, please follow these guidelines in order to best facilitate progress.

If you have an emergency between sessions, please call 911 or The Crisis Center of Tampa Bay, Inc. @ 211 as they are both 24-hour hotlines. If you are not put through immediately, please call 813.234.1234. You can also call your family physician or the emergency room at the nearest hospital and ask for the psychologist or psychiatrist on call. You may reach me at the above listed phone and leave a confidential voice message **IF** you will not be with your child at his/her appointment and feel I need to know something before the session. I am the only one who has access to my voice mail. If I am unavailable for an extended time, I will provide you with the name of a trusted colleague whom you can contact if necessary.

SUPPORT-GUIDELINES

In the interim, please buy a journal for both parents and adolescent patients. PLEASE use your journals to express specific weekly concerns you would like to discuss during session. I will speak with parents the first or last fifteen minutes of each session depending upon what is clinically indicated. If you would like me to document specific weekly concerns, please hand them to me to file at session.

CONFIDENTIALITY

In general, the confidentiality of all communication between a client and a psychologist is protected by law and I can only release information about your treatment to others if you sign a written authorization form that meets certain legal requirements imposed by state law and/or HIPAA. But, there are some situations where I am permitted or required to disclose information without either your consent or Authorization:

- I may occasionally find it helpful to consult other health and mental health professionals about a case. During a consultation, I make every effort to avoid revealing the identity of my patient. The other professionals are also legally bound to keep the information confidential. If you do not object, I will not tell you about these consultations unless I feel that it is important to our work together. I will note all consultations in your Clinical Record (which is called "PHI" in my Notice of Psychologist's Policies and Practices to Protect the Privacy of Your Health Information).

- Disclosures required to collect overdue fees are discussed elsewhere in this Agreement.

- If a patient threatens to harm himself/herself, I may be obligated to seek hospitalization for him/her, or to contact family members or others who can help provide protection.

- If you are involved in a court proceeding and a request is made for information about the professional services I have provided you and/or the records thereof, such information is protected by psychologist-patient privilege law. I cannot provide any information without your (or your legally-appointed representative's) written authorization, a court order, or discovery request from another party to the court proceeding where that party has given you proper notice (when required) and has stated valid legal grounds for obtaining PHI, and I do not have grounds for objecting under state law (or you have instructed me not to object). If you are involved in or contemplating litigation, you should consult with your attorney to determine whether a court would be likely to order me to disclose information.

- If a government agency is requesting the information for health oversight activities pursuant to their legal authority, I may be required to provide it to them.

- If a patient files a complaint or lawsuit against me, I may disclose relevant information regarding that patient in order to defend myself.

- If a patient files a worker's compensation claim, I must, upon appropriate request, disclose information relevant to the claimant's condition to the worker's compensation insurer.

There are some situations in which I am legally obligated to take actions, which I believe are necessary to attempt to protect others from harm and I may have to reveal some information about a patient's treatment. These situations are unusual in my practice.

- If I have knowledge of a child under 18 or I reasonably suspect a child under 18 that I have observed has been the victim of child abuse or neglect, the law requires that I file a report with the appropriate governmental agency, usually the county welfare department. I also may make a report if I know or reasonably suspect that mental suffering has been inflicted upon a child or that his or her emotional well-being is endangered in any other way (other than physical or sexual abuse, or neglect). Once such a report is filed, I may be required to provide additional information.

- If I observe or have knowledge of an incident that reasonably appears to be physical abuse, abandonment, abduction, isolation, financial abuse or neglect of an elder or dependent adult, or if an elder or dependent adult credibly reports that he or she has experienced behavior including an act or omission constituting physical abuse, abandonment, abduction, isolation, financial abuse, or neglect, or I reasonably suspect that abuse, the law requires that I report to the appropriate government agency. Once such a report is filed, I may be required to provide additional information.

- If a patient communicates a serious threat of physical violence against an identifiable victim, I must take protective actions, including notifying the potential victim and contacting the police. I may also seek hospitalization of the patient, or contact others who can assist in protecting the victim.

- If I have reasonable cause to believe the patient is in such mental or emotional condition as to be dangerous to him or herself, I may be obligated to take protective action, including seeking hospitalization or contacting family members or others who can help provide protection.

If such a situation arises, I will make every effort to fully discuss it with you before taking any action and I will limit my disclosure to what is necessary. While this written summary of exceptions to confidentiality should prove helpful in informing you about potential problems, it is important that we discuss any questions or concerns that you may have now or in the future. The laws governing confidentiality can be quite complex, and I am not an attorney. In situations where specific advice is required, formal legal advice may be needed.

PATIENT RIGHTS

HIPAA provides you with several rights with regard to your Clinical Records and disclosures of protected health information. These rights include requesting that I amend your record; requesting restrictions on what information from your Clinical Records is disclosed to others; requesting an accounting of most disclosures of protected health information that you have neither consented to nor authorized; determining the location to which protected information disclosures are sent; having any complaints you make about my policies and procedures recorded in your records; and the right to a paper copy of this Agreement, the attached Notice form, and my privacy policies and procedures. I am happy to discuss any of these rights with you.

Patient: _____

MINORS/FAMILY

There are some special considerations in the treatment of minors that need further explanation. Patients under 18 years of age who are not emancipated can consent to psychological services subject to the involvement of their parents or guardian unless the psychologist determines that their involvement would be inappropriate. A patient over age 12 may consent to psychological services if he or she is mature enough to participate intelligently in such services, and the minor patient either would present a danger of serious physical or mental harm to him or herself or others, or is the alleged victim of incest or child abuse. In addition, patients over age 12 may consent to alcohol and drug treatment in some circumstances. However, unemancipated patients under 18 years of age and their parents should be aware that the law may allow parents to examine their child's treatment records unless I determine that access would have a detrimental effect on my professional relationship with the patient, or to his/her physical safety or psychological well-being. Because privacy in psychotherapy is often crucial to successful progress, particularly with teenagers, and parental involvement is also essential, it is usually my policy to request an agreement with minors [over age 12] and their parents about access to information. This agreement provides that during treatment, I will provide parents only with general information about the progress of the treatment, and the patient's attendance at scheduled sessions. I will also provide parents with a summary of their child's treatment when it is complete. Any other communication will require the child's authorization, unless I feel that the child is in danger or is a danger to someone else, in which case I will notify the parents of my concern. Before giving parents any information, I will discuss the matter with the child, if possible, and do my best to handle any objections he/she may have.

When the primary patient is a minor (under 18 years of age), his/her parent/guardian must give his/her consent to psychological services. The involvement of both parents is strongly recommended. If parents are divorced and there is joint custody, both parents must sign a consent to treat form. You should also know that noncustodial parents usually have the right to obtain healthcare information about the minor even though they do not have any decision-making authority. Treatment for the child may include individual psychotherapy (including play therapy), family therapy, and parental consults. When the treatment of choice is family therapy, information is shared during the family therapy session.

I frequently see minors whose parents are divorced or divorcing to help them adjust to the changes that are occurring, and will consult with both parents as to what is considered to be in the best interests of the child. However, no formal recommendations regarding custody or visitation will be made verbally or in writing. A custody evaluation is a specialized evaluation. These are performed by a court ordered psychologist with forensic training rather than a treating psychologist. I will be happy to refer you to a psychologist who is qualified to conduct such an evaluation. For helpful treatment, the minor needs to be reassured that what he says during the therapy session will not be used in court against one parent or the other. Consequently, it is my practice to only disclose confidential information in a custody hearing under a judge's order. If it appears that the therapeutic relationship with the child has been jeopardized by the disclosure or appearance in Court, termination of treatment will be considered and a referral to another child therapist will be offered if necessary.

OFFICE SPACE

I share office space with other independent mental health professionals. While we share office space, I want you to know I am completely independent in providing you with clinical services and I alone am fully responsible for those services. My professional records are separately maintained. I am the only one who has access to them without your specific written permission.

I welcome any questions you may have about any aspect of my professional services or business arrangements. Your signature below indicates you have read the information in this document and agree to abide by its terms during our professional relationship. It also serves as an acknowledgement you have received the HIPAA notice form described above. You may receive a copy of this agreement upon request. You have the right to revoke your consent to treatment in writing at any time.

_____

Patient Name

_____ _____

Patient/Guardian Signature Date