Gonski Counseling PC

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OUTPATIENT SERVICES AGREEMENT

Welcome to the Gonski Counseling PC. This document contains important information about the professional services and business policies of this clinic. Please read it carefully and note any questions you might have so that we can discuss them at our meeting. By signing below you agree to the policies described herein. Upon the completion of our first session, I will request that you sign this document, please review it accordingly prior to the session.

PSYCHOLOGICAL SERVICES

Psychotherapy is not easily described in general statements. It does call for a very active effort on your part. In order for the therapy to be most successful, you will have to work on things we talk about both during our sessions and at home.

Psychotherapy can have benefits and risks. Since therapy often involves discussing unpleasant aspects of your life, you may experience uncomfortable feelings like sadness, guilt, anger, frustration, loneliness, and helplessness. On the other hand, psychotherapy has also been shown to have benefits for people who go through it. Therapy often leads to better relationships, solutions to specific problems, and significant reductions in feelings of distress. But there are no guarantees of what you will experience.

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 set up a meeting with another mental health professional for a second opinion.

MEETINGS

Appointments are most frequently scheduled one 50-minute session (one appointment hour of 50 minutes duration) per week at a time we agree on, although some sessions may be longer or more frequent. Once an appointment hour is scheduled, you will be expected to pay for it unless you provide 48 hours advance notice of cancellation, or unless we both agree that you were unable to attend due to circumstances beyond your control. If it is possible, I will try to find another time to reschedule the appointment.

PROFESSIONAL FEES

My hourly fee will be discussed during our initial meeting unless we have set a fee prior to that meeting, in which case that fee will apply, and is noted at the end of this agreement. The clinic's standard fee per 50-minute session for an individual therapy is $ 115.00. If we are under contract with your insurance company, our fees are governed by this contract and you are responsible for co-pays/patient responsibility as outlined by carrier. Any fees, outside of the portion covered by insurance (if being billed by us), is due at time of service.

Additionally, I charge this same amount, $115/hour, for other professional services you may need. Though I will break down the hourly cost if I work for periods of less than one hour. We will discuss areas of which I may require payment as they arise.

Other services may include, but are not limited to, report writing, attendance at meetings with other professionals you have authorized, preparation of records or treatment summaries, and the time spent performing any other service you may request of me. If you become involved in legal proceedings that require my participation, you will be expected to pay for my professional time even if I am called to testify by another party. Due to the nature and complexity of legal proceedings and my involvement thereof, my fee is $250/hour for both preparation and attendance at any legal proceeding.

INSURANCE REIMBURSEMENT

In order for us to set realistic treatment goals and priorities, it is important to evaluate what resources you have available to pay for your treatment. If you have a health insurance policy, it will usually provide some coverage for mental health treatment. Enclosed please find an insurance form that you are required to fill out and periodically update with regard to your insurance coverage. While I will do my best to help you fill out the necessary insurance forms and provide you with whatever assistance I can to help secure insurance benefits to which you are entitled; you (not your insurance company) are responsible for the full payment of my fees. Therefore, it is very important that you find out exactly what mental health services your insurance policy covers.

You should also be aware that most insurance companies require you to authorize me to provide them with a clinical diagnosis. Sometimes I have to provide additional clinical information such as treatment plans or summaries, or copies of the entire record (in rare cases). This information will become part of the insurance company files and will probably be stored in a computer. Though all insurance companies claim to keep such information confidential, I have no control over what they do with it once it is in their hands. In some cases, they may share the information with a national medical information databank. I will provide you with a copy of any report I submit, if you request it. By signing below, you agree to hold me harmless from any liability or legal responsibility that may arise from the use or disclosure of medical information to your health insurance carrier. I will do my best to keep you apprised of any requests for information from your health insurance company.

It is important to remember that you always have the right to pay for my services yourself to avoid the problems described above [unless prohibited by contract].

CONTACTING ME

I am often not immediately available by telephone. When I am unavailable, my telephone is answered by voice mail that I monitor frequently. I will make every effort to return your call on the same day you make it, with the exception of weekends and holidays. I may call late in the evening, so let me know if that is a problem. If you are difficult to reach, please inform me of some times when you will be available. If you are unable to reach me and feel that you cannot wait for me to return your call, I have a cell phone with me at all times. In the rare instance I do not respond, you may wish to place another call/text message to me. If I will be unavailable for an extended time, I will provide you with the name of a colleague to contact, if necessary.

PROFESSIONAL RECORDS

The laws and standards of my profession require that I keep treatment records. You are entitled to receive a copy of your records, or I can prepare a summary for you instead. Because these are professional records, they can be misinterpreted and/or upsetting to untrained readers. If you wish to see your records, I recommend that you review them in my presence so that we can discuss the contents. Patients will be charged an appropriate fee for any professional time spent in responding to information requests or reviewing the contents of a patient's file with that patient.

CONFIDENTIALITY

In general, the privacy of all communications between a patient and a therapist is protected by law, and I can only release information about our work, or my work with your child, to others with your written permission. In the case of minors, those over 12 years of age must sign the release in addition to a parent/guardian (see below). However, there are a few exceptions.

In most legal proceedings, you have the right to prevent me from providing any information about your treatment. The courts very much support therapist/patient confidentiality. However, in some proceedings involving child custody and those in which your emotional condition is an important issue, a judge may order my testimony if he/she determines that the issues demand it.

There are some situations in which I am legally obligated to take action to protect others from harm, even if I have to reveal some information about a patient's treatment. The Illinois Mental Health and Developmental Disabilities Confidentiality Act (MHDDCA) mandates a psychologist to "warn" any intended victim, as well as the responsible authorities, where a patient discloses in session that he or she intends to cause physical harm to a specifically identifiable victim. It is then the psychologist's responsibility to take steps to notify the victim and/or local authorities and provide enough information with which the authorities and/or the victim might prevent the harm from occurring. Therefore, if a patient discloses intent to harm a specific person, I must either contact that person and the authorities, or attempt to secure the hospitalization of the patient. These disclosures are also protected by an immunity clause in the statute.

Additionally, if I believe that a child, elderly person or disabled person is being abused, I must file a report with the appropriate state agency. Pursuant to the Abused and Neglected Children's Reporting Act (ANCRA) in Illinois, "mandated reporters" are required to disclose any *suspected* instances of abuse or neglect of minors to the Illinois Department of Children and Family Services (DCFS). As a mental health provider, I am a mandated reporter. If a call is placed, DCFS may investigate the situation. If such a report is to be made, it is my policy to, when possible, first advise the patient/guardian that DCFS will be contacted.

Subsequent to a “mandated” report, the patient, and possibly others, will be contacted by a follow up investigator from DCFS. If these investigators confirm the presence of abuse or neglect, a letter so indicating will be issued, and possible court hearings could result. If the DCFS investigators conclude that no abuse or neglect has occurred, a letter will be issued indicating that the claim is “unfounded.” The statute also provides the therapist with absolute immunity from any criminal or civil liability in the event that such a report is made, **even without the consent of the patient.**

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. The above situations have rarely occurred in this practice. If a similar situation occurs, I will make every effort to fully discuss it with you before taking any action.

I may occasionally find it helpful to consult other professionals about a case. During a consultation, I make every effort to avoid revealing the identity of my patient. The consultant is also legally bound to keep the information confidential. By signing below, you agree that I am not obligated to inform you about these consultations unless I feel that it is important to our work together.

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. I will be happy to discuss these issues with you if you need specific advice, but formal legal advice may be needed because the laws governing confidentiality are quite complex, and I am not an attorney.

Patients under the age of 18 years

If you are under 18 years of age, please be aware that the law provides your parents the right to examine your treatment records. Additionally, if you are 12 years or older, I am required to seek your signature before I am able to release records to your parents, unless I feel that is not a compelling reason to deny access to those records. If your parents agree, I will provide them only with general information about our work together. However, disclosure of information may be necessary and/or mandated if I feel there is a high risk that you are being harmed, will seriously harm yourself, or may harm someone else. In those instances, I will notify your parents of my concern, and will have to provide other notifications to designated agencies as mandated by IMHDDCA and/or ANCRA. I will also provide your parents with a summary of your treatment when it is complete. Before giving them any information, I will discuss the matter with you, if possible, and do my best to handle any objections you may have with what I am prepared to discuss.

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

_____ _____
Signature of Patient (12 years or older) Date

_____ _____
Signature of Parent (if Patient is under 18) Date

_____ _____
Signature of Witness Date