Lansing Psychological Associates
234 Michigan Ave.
East Lansing, MI 48823
(517) 337-6545 FAX (517) 337-3010

TREATMENT AGREEMENT

Welcome to our clinic. This document contains important information about our professional services and business policies. Please read it carefully and jot down any questions that you might have so that we can discuss them at our next meeting. Once you sign this, it will constitute a binding agreement between you and Lansing Psychological Associates, P.C.

I acknowledge that I am voluntarily authorizing treatment for myself or for my dependent, _____ _____, at Lansing Psychological Associates, P.C. (LPA). Further, it is understood:

That treatment will be rendered by appropriate licensed or certified professional personnel:

The primary therapist will be _____.

That I may contact the clinic or the primary therapist as the need arises at (517) 337-6545. If the primary therapist is unavailable, the clinic will arrange for contact as soon as possible by the primary therapist or another professional staff member or direct me to Ingham Community Mental Health Emergency Services telephone number. Further, that the primary therapist may acknowledge in writing a professional referral.

The after hours emergency phone number to speak to someone at LPA is (877) 481-5032.

Psychological Services

Psychotherapy is not easily described in general statements. It varies depending on the personality of both the therapist and the client and the particular problems which the patient brings. There are a number of different approaches which can be utilized to address your problems. It is not like visiting a family doctor, in that it requires a very active effort on your part. In order to be most successful, you will have to work both during our sessions and at home.

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

Hours

That the services offered by LPA are Mondays through Thursdays from 8:00 a.m. to 9:00 p.m., and Fridays from 8:00 a.m. to 5:00 p.m. Appointments at times other than standard office hours may be scheduled with the agreement of the primary therapist.

Cancellations

That LPA requires 24 hours notice for canceling appointments with your therapist, and 48 hours notice for canceling appointments with the psychiatrist. If you fail to give the clinic the proper notice, or simply do not appear for a scheduled appointment, you will be billed personally for this session ($75.00). **Insurance companies will not cover missed appointments.** LPA does recognize that there are reasonable exceptions to this policy. These will be handled on an individual basis. You may discuss any aspect of LPA's payment policy with your therapist.

Rights

That I have certain rights, including:

a. All civil rights guaranteed by state and federal law;
b. I will be treated with respect and dignity;
c. I may obtain a summary of my record;
d. I may make a request in writing if I need special confidential handling of my account regarding billing or messages being left on my recorder in the event that an appointment must be changed due to illness or emergency;
e. I am assured of freedom from financial and other exploitation and retaliation.
f. I am entitled to information on legal services, self-help, and advocacy support service entities.
g. I am assured that if I file a complaint, grievance, or appeal a decision made by LPA, that I will not be retaliated against or presented with barriers to services.
h. I will report ethical code violations – see copy of Code of Ethics in waiting room – or complaints about treatment or interactions at LPA to the Chief Executive Officer (CEO) at (517) 337-6545 or in writing within one (1) week of awareness of such violation. The CEO will have four (4) weeks to investigate and respond to the complainant. There will be no reprisal for such reporting.
i. When a staff member appears to be impaired in functioning due to licit or illicit medication, it needs to be reported to the CEO.
j. I may refuse services and be informed of the consequences;
k. I may contact the Chief Executive Officer at (517) 337-6545 if I have reason to believe that my rights have been violated or if I wish to register a complaint.
l. I have a right to request a copy of the Transition/Discharge Summary at the end of treatment.

Confidentiality

Information discussed in the therapy setting is held confidential and will not be shared without permission except under the following conditions:

a. The client threatens harm to another person(s).
b. The therapist suspects child abuse or neglect. State law mandates that mental health professionals need to report these situations to the appropriate persons and/or agencies.

In general, the confidentiality of all communications between a client and a therapist is protected by law, and we can only release information about our work to others with your written permission.

However, there are exceptions. In most judicial proceedings, you have the right to prevent us from providing any information about your treatment. However, in some circumstances, such as child custody proceedings and proceedings in which your emotional condition is an important element, a judge may require testimony.

If we believe that a client is threatening serious bodily harm to another, we are required to take protective actions, which include notifying the potential victim, notifying the police, or seeking appropriate hospitalization. If a client threatens to harm him/herself, we may deem it necessary to seek hospitalization for the client, or to contact family members or others who can help provide protection. These situations have rarely arisen in our practice. Should such a situation occur, we will make every effort to fully discuss it with you before taking any action. We have an on-call service and the on-call person will communicate with your primary therapist concerning such contact.

While these exceptions to confidentiality should prove helpful in informing you about potential problems, it is important that we discuss any questions or concerns which you may have during the course of your treatment.

Responsibilities

That I also have certain responsibilities, which include the following:

1. The responsibility (when it is in my best interest) to sign forms for release of information, since the staff cannot give out this information without my permission, except in the case of emergency;
2. The responsibility to help develop a plan for treatment;
3. The responsibility to suggest changes for improvement of my services, when appropriate;
4. The responsibility to comply with the provisions of this Treatment Agreement and to carry out to the greatest extent possible the provisions of the treatment plan.

That, according to state law, certain communicable diseases must be reported to the Michigan Department of Community Health; if it is discovered that I have such a communicable disease, I consent to such disclosure.

Orientation

LPA is a barrier free facility, non-smoking, comfortable environment with accessible restrooms. LPA does not use seclusion or restraint. LPA does not allow illicit drugs to be brought into the office. LPA does not allow any weapons to be brought into the office.

The treatment begins with initial paperwork prior to an initial appointment with a therapist. I will discuss my reasons for seeking treatment and my therapist will help me develop a plan to work on

my concern. I will help write my Treatment Plan and sign it. LPA will not place any restrictions on me during my treatment. I will help review my progress every three months. I will work on the plan with assistance from my therapist until I am functioning reasonably well again and I will transition my treatment with concurrence from my therapist to other less restrictive services or none at all. If I need emergency help, I agree to have 911 called on my behalf.

Termination

That successful termination of treatment is determined when my therapist and I agree that the treatment goals have been substantially completed. I understand that I may be discharged from the clinic by my therapist for the following reasons:

1. I have successfully completed the treatment program to which I initially agreed, implying that I have made significant progress toward meeting treatment goals;
2. I choose to terminate treatment;
3. I need to withdraw due to medical, financial, or legal problems, geographic relocation, lack of parental consent, or other financial demands;
4. My lack of attendance and/or motivation prevents further progress toward goal achievement. (If I have not appeared for face-to-face contact for ninety (90) days, I will be automatically terminated);
5. I demonstrate inappropriate behavior relative to self, staff, or other clients which is disruptive to the therapeutic process (i.e., threatening and/or intimidating behavior);
6. I refuse to make appropriate financial arrangements to pay for therapeutic services (when I have the financial ability to do so, and this is seen as a treatment issue);
7. I fail to comply with the provision of this Treatment Agreement.

I have been informed of the proposed treatment, the services which may be provided, and any attendant benefits, risks, and/or consequences. I give my consent to treatment, understanding that I maintain the option to terminate the consent at my discretion. I give my permission to be contacted for follow-up studies.

Insurance and Payment Policies

In order for us to set realistic treatment goals and priorities, it is important to evaluate what resources are available to pay for your treatment. If you have a health benefits policy, it may provide some coverage for mental health treatment. Please be aware that most insurance agreements require the therapist to provide a clinical diagnosis and sometimes additional clinical information such as a treatment plan or summary or, in rare cases, a copy of the entire record. This information will become part of the insurance company records, as allowed by HIPAA guidelines.

I voluntarily give my permission for LPA to provide information to my insurance company to collect for professional services performed by my therapist. I also realize that the filing of insurance claims is a courtesy that is extended to LPA clients; **however, I am ultimately responsible, and not my insurance company, for full payment of the fee to which we have agreed. Therefore, it is very important that you find out exactly what mental health services your insurance policy covers. This includes services not covered by insurance, such as deductibles and co-payments. Your insurance company requires LPA to collect co-payments at the time of service; however, if you do accrue a balance, you will receive an itemized statement at the beginning of each month, payable upon receipt.** LPA has several allowable forms of payment: cash, check, money order,

Visa, or MasterCard. If your balance is carried past 30 days, there will be a service charge applied to your account. If payment is not made within 30 days of the second bill, LPA reserves the right to use whatever legal means necessary to collect this balance.

Once we have all of the information about your insurance coverage, we will discuss what we can expect to accomplish with the benefits that are available and what will happen if the insurance benefits run out before you feel ready to end our sessions. It is important to remember that you always have the right to pay for our services yourself.

The parent/guardian who authorizes treatment for an individual may be financially responsible. Any change in name, address, phone number, or insurance information is the responsibility of the client or parent/ guardian to inform this office.

Professional Fees

Our hourly rate is Two Hundred Twenty ($220) Dollars per session for individual psychotherapy. Our initial assessment fee is Two Hundred Fifty ($250) Dollars. Our conjoint/family fee is One Hundred Eighty-Five ($185) Dollars per session. Usually our contracts require that we accept their rates as payment in full. In addition to regular appointments, it is our practice to charge for other professional services which you may require such as report writing, telephone conversations, attendance at meetings, consultations with other professionals which you have authorized, preparation of records, treatment summaries, or the time required to perform any other service which you may request of us. Your therapist will be more than happy to discuss any of these details with you as you request.

Professional Records

The standards of our profession require that we keep appropriate treatment records. If you wish to see your records, it is recommended that you review them in our presence so that we can discuss what they contain.

Client or Guardian Checklist

Please initial all the items below which have been covered with you:

____ A 24 hour therapy and 48 hour psychiatry notice is needed to cancel an appointment to avoid a $75 charge.

____ I have reviewed and been offered a copy of this Treatment Agreement.

____ I have reviewed and been offered a copy of LPA's Code of Ethics.

____ I recognize LPA does not use seclusion or restraint.

____ I recognize LPA does not allow tobacco use in the offices.

____ I recognize LPA does not allow licit or illicit drugs or weapons (e.g. guns, knives, etc.) to be brought into the office. I understand that if I bring such items into the office, I will be asked to remove the item from the clinic and my session may need to be rescheduled.

____ I understand that if I (we) fail to follow the stated guidelines, that services at LPA may be either suspended or terminated until such time that we are in compliance.

____ I understand that it is my responsibility to monitor and manage any prescription medications that I bring into the offices.

____ I have reviewed my role in developing a treatment plan and transition guidelines.

____ I have had the opportunity to review the HIPAA (Health Insurance Portability and Accountability Act) guidelines made available to me.

____ I agree to have mental health care coordinated with my primary care physician and/or other prescribing providers as applicable.

____ I have been advised of emergency procedures regarding fire, tornado, and other possible natural occurrences.

Do you have an advanced directive? Yes ___ No ___

Comment: _____

_____ _____
Signature of Client or Guardian Date Witness Date

_____ _____
Signature of Client or Guardian Date Witness Date

I agree to accept 100% financial responsibility for this account.

_____ _____
Signature of Client or Guardian Date Witness Date

_____ _____
Print Name Date of Birth

_____ _____
Relationship to Patient Social Security Number

_____ _____
Mailing Street Address City State ZIP

Effective Date Range: From _____ to _____

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