Amy Schullery, Psy.D.
1515 West Chester Pike, C-2, West Chester, PA 19382
(610) 635-9641

PSYCHOLOGICAL SERVICES AGREEMENT

Welcome to my practice! Please review and complete these forms and bring any questions to your first appointment. When you sign this document, it will represent an agreement between us.

PSYCHOTHERAPY PROCESS

Psychotherapy varies depending on the personalities of the psychologist and client, and the particular problems you are experiencing. Psychotherapy calls 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 sometimes at home. Since therapy often involves discussing unpleasant aspects of your life, you may experience uncomfortable feelings. Benefits of psychotherapy can lead to better relationships, solutions to specific problems, and reductions in feelings of distress. But there are no guarantees of what you will experience.

I typically meet with a client for about 45-50 minutes per week, although we may agree to meet more or less frequently as needed. Our first few sessions will involve an evaluation of your needs. During this time, we can both decide if I am the best person to provide the services you need in order to meet your treatment goals. Therapy involves a large commitment of time, money, and energy from you. If you have questions or concerns, we should discuss them whenever they arise during our work together.

Your participation in therapy is voluntary and you may choose to discontinue at any time; however, I encourage clients to discuss this decision to help facilitate a plan before ending. I may choose to end treatment with a client non-voluntarily if he or she exhibits physical violence, verbal abuse, threats, carries weapons, or engages in illegal acts at the office, or if a client does not make payment or payment arrangements in a timely manner. I may also terminate therapy if a client is not making progress in therapy and/or if I believe a client's needs would be better served by another professional.

CONFIDENTIALITY

The law protects the privacy of communications between a patient and a psychologist. In most situations, I can only release information about treatment to others if the patient signs a written authorization form. Limits to confidentiality that require neither your advanced consent nor authorization are listed on my *Pennsylvania Notice of Psychologists' Policies and Practices to Protect the Privacy of Your Health Information* form. There are other situations that require only your advanced written consent. These include:

- Consultation with other health and mental health professionals.
- Disclosures required by health insurers or to collect overdue fees.

- 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.

Privacy & Email/Social Media:

Please be aware that if we are in contact via email, I cannot guarantee your confidentiality. There is a risk that the information sent via email can be read by a third party. By signing this agreement, you are acknowledging that you understand this risk. You are also granting written consent to the above situations.

I do not communicate with, or contact, any of my clients through social media platforms like Twitter and Facebook. In addition, if I discover that I have accidentally established an online relationship with you, I will cancel that relationship. This is because these types of casual social contacts can create significant security risks for you.

Privacy & Insurance:
Please also be aware that insurance companies usually require that I provide them with a clinical diagnosis. Sometimes I may be required to provide additional clinical information such as treatment plans or summaries, or copies of your record. This information will become part of the insurance company files and will probably be stored in a computer. 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. By signing this Agreement, you agree that I can provide requested information to your carrier.

Privacy of Minors
In order to consent to treatment for your child, you will need to review and sign both this document and the *PARENT/LEGAL GUARDIAN AGREEMENT for OUTPATIENT SERVICES with ADOLESCENTS.* Children between the age of 14-18 may consent to their own treatment or parents may consent for them.

LEGAL MATTERS
In any legal proceedings, I ask for your agreement that you will not ask me to testify in court, whether in person, or by affidavit. You also agree to instruct your attorneys not to subpoena me or to refer in any court filing to anything I have said or done. Note that such agreement may not prevent a judge from requiring my testimony. If I am required to testify, I am ethically bound not to give my opinion about a parent's custody or visitation suitability. If the court appoints a custody evaluator, guardian ad litem, or parenting coordinator, I will provide information as needed (if appropriate releases are signed or a court order is provided), but I will not make any recommendation about the final decision. I do not provide court-ordered therapy.

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CONTACTING ME

If you need to reach me between appointments, please call my office number. I am often not immediately available by telephone. When I am unavailable, my telephone is answered by voicemail that I monitor frequently. I will make every effort to return your call within 24 hours with the exception of weekends and holidays. If you are unable to reach me and feel that you cannot wait for me to return your call, please proceed to your nearest hospital emergency room or call 911.

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

_____ _____

Name (printed) Signature

_____

Date

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FEES, BILLING & PAYMENTS

FEES

My fee is $175 for an intake session and $150 for each session of therapy thereafter, except for couples sessions which are $175 for each session. This fee may vary depending on your individual circumstances. In addition to weekly appointments, I charge this amount for other professional services like report writing, phone conversations, 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, though I will break down the hourly cost if I work for periods of less than one hour. All fees are subject to change each year.

INITIAL:_____

BILLING & PAYMENTS

You will be expected to pay for each session at the beginning of the session. Payment schedules for other professional services will be agreed to when they are requested. If your account has not been paid for more than 60 days, I have the option of using legal means to secure the payment, such as a collection agency or small claims court. If such legal action is necessary, its costs will be included in the claim. I will charge a $25 fee for any returned checks and add a late fee of $15 per month for any overdue account for which payment arrangements have not been made.

INITIAL:_____

CANCELLATION POLICY

Once an appointment hour is scheduled, you will be expected to pay for it unless you provide at least **48 hours advance notice of cancellation**. **Please notify me by phone if you need to cancel or change an appointment.** Please note that insurance companies do not reimburse for missed sessions. Therefore, you will be responsible for my full fee of **$150**. INITIAL:_____

INSURANCE

You (not your insurance company) are responsible for full payment of my fees. I do not typically submit claims on your behalf if I am not in network with your insurance company. It is very important that you find out exactly what mental health services your insurance policy covers.

You agree to forward any payments made to you by insurance that are owed to me for services provided. You also agree to pay for services that have been provided, when your insurance denies claims and will not pay for whatever reason.

INITIAL: ____

LEGAL COSTS

If you become involved in legal proceedings that require my participation, you will be expected to pay for my professional time, including preparation and transportation costs,

being in attendance, and any other case-related costs, even if I am called to testify by another party. Because of the difficulty of legal involvement, I charge $275 per hour for preparation and attendance at any legal proceeding.

INITIAL:_____

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

_____ _____

Name (printed) Signature

_____

Date

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Pennsylvania Notice of Psychologists' Policies and Practices to Protect the Privacy of Your Health Information Signature Form

I acknowledge that I have received the Pennsylvania Notice of Psychologists' Policies and Practices to Protect the Privacy of Your Health Information form that describes how psychological and medical information about me may be used and disclosed, and how I can get access to this information.

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_____ _____

Name (printed) Signature

_____

Date

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Authorization for Credit Card Payment for Outstanding Balance

Please provide credit card information below. This is requested to keep on file and will not be used except to pay an outstanding balance on your account. Please note that I have a 24 hour cancellation policy with the exception of emergencies or when we otherwise agree that charges will not apply for a cancellation with less than 24 hours advanced notice. Otherwise, the full session fee ($150.00) will be charged to your account. If payment is not received for a balance on your account in a timely fashion, your credit card will be charged. Also, please note that I charge a $25 fee for any returned checks and a monthly late fee of $15 to any overdue account where payment arrangements have not been made. Thank you.

I, _____, authorize Amy Schullery, Psy.D. to charge the credit card below for any outstanding balance on my account, and agree to the conditions set forth above.

Signature_____ Date_____

Credit Card Type (Visa, Mastercard, etc.):_____

Credit Card Number:_____

Expiration Date: ___/___/___

Security Code (from back of card):_____

Billing Address Zip Code: _____

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Consent to Email

Email exchanges with my office should be limited to things like setting and changing appointments, billing matters and other related issues since email is not secure and security of sensitive health information can not be guaranteed. If you need to discuss a clinical matter with me, it is best to call me so we can discuss it on the phone or wait so we can discuss it during your therapy session. The telephone or face-to-face context simply is much more secure as a mode of communication.

Please sign acknowledging receiving this notification and indicate if you consent to exchanging emails. Thank you.

I consent to email exchange: Yes_ No_

Email address: _____

Signature:
_____

Date:
_____