Outpatient Services Contract

Welcome to my practice. This document contains important information about my professional services and business policies. Please read it carefully. If you agree to each section, **INITIAL** each section and **SIGN** at the bottom. If you have questions mark the section and we will discuss it in the first session. Once you sign this contract it will constitute a binding agreement between us.

CONFIDENTIALITY

Information revealed by you during therapy will be kept strictly confidential. There are certain situations, however, where I am required by law to reveal information obtained during therapy to other persons/agencies even if you do not give permission. (Refer to the Privacy Practices HIPAA sheet for more specifics.) These are the situations: If you threaten grave bodily harm or death to another person I may inform medical or law enforcement personnel. If you report to me knowledge of physical or sexual abuse of a minor child by an adult, or of an elderly person, or of a disabled person, I am required to inform the appropriate agencies. If you report the sexual misconduct of a mental health professional, I am required to report it. If you become involved in a legal case (child custody, civil suit, etc.) I may be required to produce records or testify. ____

INITIAL EVALUATION

The first 2 to 3 sessions are part of an initial evaluation. During this evaluation we both determine if I am the best person to provide the services you need. ___

SESSIONS

If we agree to work together I will usually schedule one session per week at a mutually agreed upon time. Longer sessions may be requested. We may meet more frequently if that is necessary. ___

CANCELLATIONS

If a scheduled appointment needs to be changed, or cancelled, please give me at least 24 hours advance notice. You may cancel appointments by calling 512-329-0989 at anytime. I CHARGE THE FULL SESSION FEE (not just the copay) for cancellations made without 24 hours notice. *(Emergencies are exempted*.) Insurance companies do not pay for any part of missed appointments.___

FEES

The fee for the 65-minute Initial Evaluation session is **$175.00**
The fee for Individuals is **$160.00 (45 minutes); $165.00 (60 minutes) Your insurance company policies determine the length of the session.**
The fee for Family or Couples **$165.00 (60 minutes)**
The fee for a two hour session is **$330.00.**
If you become involved in a litigation that involves my participation you will be expected to pay for my professional time even if I am compelled to testify by the another party.___

PAYMENT

Payment is due at the beginning of the session. If payment is more than 60 days in arrears and no suitable payment plan has been made, I have the option of using a collection agency or other legal means to obtain payment.___

INSURANCE

I recommend that you consult with your plan administrator to know what your plan covers. I have an Insurance Coverage Inquiry form that outlines all the questions you need to ask. Let me know if you need it. You are ultimately responsible for full payment,. Thus, if a problem arises with your insurance I will ask you to call and resolve the problem with your insurance company. If you wish to keep your information absolutely private (no diagnosis, no clinical information to insurance companies) you have the right to pay for my services yourself.___

MINORS (Skip if this does not apply to you)
The law may provide parents with the right to examine a minor's treatment records. It is my policy to request an agreement from parents to consent to give up access to the minor's records.. I will, however, provide the parents with general information about therapy. If I believe that there is a high risk that the minor will seriously harm self or another, I will notify the parents of my concern. If possible, I will always discuss with the minor what I will reveal to the parents and will do my best to resolve with the minor any objections he/she may have about what I am prepared to discuss._____
Parent(s) consent to give up access._____

CONTACTING ME
Usually I am not immediately available by telephone. I will make every effort to return your call on the same day you make it with the exception of Fridays, weekends, and holidays. Always leave me your telephone number (slowly and clearly) and times when you are available.____

EMERGENCIES
In case of emergencies, try to reach me by voice mail during business hours. If you are in a crisis after hours or on weekends, please call the **24-hour Hot Line at 472-4357** at the Austin State Hospital, or **St. David's Pavilion Psychiatric Hospital at 867-5800**. My practice is not geared for crisis intervention , but arrangements may be made for more immediate telephone contact if your situation warrants.___

TERMINATION OF THERAPY
You have the right to end therapy with me at any time. If it appears to me that you do not seem to be benefiting from your work with me, I may refer you to another professional. I will assist you in finding another professional that may better fit your needs. I also have the right to terminate treatment if you fail to pay for services.

ACKNOWLEDGMENT OF HIPAA PRIVACY PRACTICES
I acknowledge that I have received a copy of Dr. de la Sota's HIPAA Privacy Practices. I understand that I may contact Dr. de la Sota or the Health and Human Services (202) 619-0257 if I have any questions about how my psychological records are protected. I understand that the HIPAA notice outlines several situations in which confidentially may be released.___

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 **Date**

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