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**LICENSED CLINICAL PSYCHOLOGIST**  
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## **CLIENT CONTRACT AND POLICY STATEMENT**

### **PRACTICE POLICIES AND PROCEDURES**

Welcome to my practice. This document contains important information about my professional services and business policies. Please read it carefully and bring any questions you may have to our next meeting so we can discuss them.

**Services & Fees:** I am available for psychotherapy, psychological testing/evaluation, consultations, and trainings. Fees for psychotherapy are \$120 per 50-minute therapy session. Cash or checks are acceptable forms of payment. Fees for psychological assessments/evaluations, consultations, and trainings are negotiated on a case-by-case basis.

**Insurance Benefits:** Dr. Smith's services generally qualify for mental health coverage by insurance companies. The nature and extent of coverage can vary even within the same company.

### **IT IS THE CLIENT'S RESPONSIBILITY TO CONTACT THEIR INSURANCE COMPANY AND LEARN EXACTLY WHAT THEIR BENEFITS COVER,**

*Clients with Blue Cross/Blue Shield Insurance:* Clients pay the full maximum reimbursement fee (set by Anthem BCBS) each session until their deductible (if any) is met. Once it is met, clients pay only the co-pay each session. Dr. Smith will then bill the insurance company directly. Note that there may be a limit on how many sessions a plan may reimburse per year. Dr. Smith will provide information to the insurance company to facilitate reimbursement, to which the client agrees by signing this document.

*Clients without Blue Cross/Blue Shield:* For clients without BC/BS, Dr. Smith will be an out-of-network provider as a Licensed Clinical Psychologist in Virginia. Your insurance company may reimburse you according to guidelines they have established for out-of-network providers. Often out-of-network benefits are considerable. You will provide statements of service that can be submitted to your insurance company for reimbursement. With your written permission, Dr. Smith will also provide information to the insurance company to facilitate reimbursement should they request it. Clients using out-of-network benefits are expected to pay Dr. Smith's full fee at the time of service (\$120).

**Billing:** Billing can be arranged in either of two ways. Insurance clients pay each session. Non-insurance clients may choose to pay for their sessions at the time of the final session of the month. Bills that are delinquent more than two months may be submitted to an independent collections agency.

**Cancellation:** Regular attendance is a critical factor for successful therapy. You are financially responsible for your appointments and/or for those of your child. Counseling sessions are generally scheduled once a week for 50 minutes, and a given hour is considered blocked for a particular client. Thus, a late cancellation results in an open hour, inconvenience, and a loss of revenue. Once an appointment hour is scheduled, you will be expected to pay for it unless you provide 24 hours advance notice of cancellation. Exceptions will be made in the case of a medical emergency. If you arrive late for a scheduled appointment, only the remainder of the 50-minute session will be available. Note that insurance companies DO NOT pay for missed appointments.

**Forensic and Litigative Services:** It is the stated philosophy of this practice that I do not participate in lawsuits of any type on a plaintiff's behalf, unless compelled to do so by subpoena or court order. If you become involved in legal proceedings that require my participation, you will be expected to pay for all of my professional time, including preparation, deposition, telephone time, transportation costs, court appearance, report writing, consultation, and supervision, even if I am called to testify by another party. Because of the complexity of legal involvement, I charge \$250 per hour for preparation and attendance at any legal proceeding.

**Confidentiality:** You have the right to confidentiality regarding any records, communications, or other information pertaining to your treatment or evaluation. Information may only be shared if you sign a release of information for that specifies who is to receive the information and the nature of the information to be shared.

I do reserve the right to consult with professional colleagues regarding treatment and evaluation. Such discussions do not include the use of names or identifying information. Exceptions to confidentiality do exist in order to protect yourself and others. A full list of such exceptions is given on my “Confidentiality of Protected Health Information” form. However, a brief summary of such exceptions follows:

***Exceptions to confidentiality***

**DANGER TO SELF OR OTHER:** The law requires that mental health professionals report information that indicates that an individual in treatment is in imminent danger of hurting himself or another person. If I believe that the client is a threat to himself/herself, I am obligated to take protective action. This action may include seeking hospitalization or contacting family members or others who can help to provide protection for the client. If I believe that a client is threatening serious bodily harm to another, I must also take protective action. This action may include notifying the potential victim, contacting the police, or seeking hospitalization for the client. In cases such as these, I will make every effort to fully discuss it with you before taking any action.

**ABUSE OF CHILDREN AND/OR ADULTS:** The law requires that all mental health providers report information believed or reasonably suspected to constitute abuse or neglect of children. The law also requires the report of suspected abuse of persons 65 or older or of other adults who may be in need of protective services due to disability.

**ORDERS OF THE COURT:** Certain records (which differ by jurisdiction) can be subpoenaed by legal process. This also applies to reports and testimony. In addition, you may give up your confidentiality if you choose to make your mental status an issue as part of a court proceeding.

**SOCIAL SERVICE REFERRALS:** If you are referred for evaluation or treatment by a Social Service Agency as part of an evaluation or intervention, there may be a requirement to share information regarding attendance, findings, recommendations and/or progress in treatment. The details of the information to be shared in such instances will be discussed with you prior to my discussion with representatives of such agencies.

**DELINQUENT ACCOUNTS:** Collection agencies or attorneys may be given identifying information only in order to pursue delinquent accounts.

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**Client Consent to Treatment**

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I, \_\_\_\_\_ (name of client or guardian as applicable), agree and consent to the policies, procedures, fees, and payment arrangements as described above.

If the patient is under the age of eighteen or unable to consent to treatment, I attest that I have legal custody of this individual and am authorized to initiate and consent for treatment and/or legally authorized to initiate and consent to treatment on behalf of this individual.

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

\_\_\_\_\_  
Print Client Name

\_\_\_\_\_  
Signature of Client or Legal Representative

\_\_\_\_\_  
Date Signed

\_\_\_\_\_  
Signature of Client or Legal Representative

\_\_\_\_\_  
Date Signed