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OUTPATIENT SERVICES CONTRACT for PSYCHOTHERAPY SERVICES

Welcome to my practice. This document contains important information about my professional services and business policies. Please read it carefully and jot down any questions you might have, so that we can discuss them at our next meeting. When you sign this document, it will represent an agreement between us.

Psychotherapy Services
Psychotherapy is not easily described in general statements. **There are many different methods I may use to deal with the problems that you hope to address. Behavior therapy is not like a medical doctor visit. Instead, it 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 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. Therapy often leads to better relationships, solutions to specific problems, and significant reduction in feeling of distress. But **there are no guarantees of what you will experience.**

Our first few sessions will involve an evaluation of your needs. By the end of the evaluation, **I will be able to offer you some first impressions of what our work will include and a treatment plan to follow if you decide to continue with therapy. You should evaluate this information along with your own opinions of whether you feel comfortable working with me.** Therapy involves a commitment of time, money, and energy so we should be careful about deciding to work together. **If you have questions about my procedures, we should discuss them whenever they arise.**

Meetings
I normally conduct an evaluation that will last from 2 to 4 sessions. 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. If psychotherapy is begun I will usually schedule one 60 minute sessions per week at a time we agree on. Once an appointment hour is scheduled, you will be expected to pay for it, unless you provide 24 hour advance notice of cancellation, or unless we both agree that you were unable to attend due to circumstances beyond your control. **Therefore, a fee of $95 will be charged to you personally, if your visit is not canceled earlier than 24 hours before scheduled, unless there are exceptional circumstances.**

Billing and Payments
When you are a beneficiary of an insurance company with which I am a participating provider (BCBS Federal & PPO, TRICARE, UBH, PHCS, NCPPO/Unicare, Johns Hopkins & Medicare), **your copayment should be made at the beginning of our visit. NB: Until I receive your insurance company's explanation of benefits, the visit co-pay is $30/visit in cash or by check. If you do not have the visit fee or copayment at our first visit, we will reschedule.**

For those who prefer the privacy and confidentiality that result from paying for services without involvement of insurance companies, my fees are based on the Medicare Fee Schedule: Initial visit - $170.00; regular visit (60 minutes) - $145.00.

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, but you will usually have a deductible and/or co-payment**. I will fill out forms and submit claims for you to help you receive the benefits to which you are entitled; however, ultimately, you (not your insurance company) are responsible for full payment of my fees, if your insurance company refuses to pay for care.** Therefore, it is very important that you find out exactly what mental health services your insurance policy covers.

You should 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. I will provide you with a copy of any report I submit, if you request it.

Other Professional Fees
In addition to weekly appointments, I charge the same amount 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. Other services include report writing, telephone conversations lasting longer than 10 minutes, 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. [Because of the difficulty of legal involvement, I charge $250 per hour for preparation and attendance at any legal proceeding.]

Contacting Me
I am often not immediately available by telephone. I probably will not answer the phone when I am with a client. When I am unavailable, my telephone is answered by voice mail. I make every effort to return calls on the same day, with the exception of weekends and holidays. 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 can't wait for me to return your call, contact your family physician or the nearest emergency room and ask for the psychologist or psychiatrist on call. If I will be unavailable for an extended time, I will provide you with the name of a colleague to contact, if necessary. I do not communicate with clients via social media.

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 record, I recommend that you review them in my presence so that we can discuss the contents. Clients will be charged an appropriate fee for any professional time spent in responding to information requests.

Confidentiality
In general, law protects the privacy of all communications between a patient and a psychotherapist, and I can only release information about our work to others with your written permission. In most legal proceedings, you have the right to prevent me from providing any information about your treatment. 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 client's treatment. For example**, if I believe that a child, elderly person or disabled person is being abused, I must file a report with the appropriate agency. If I believe that a client is threatening serious bodily harm to another, I am required to take protective actions. These actions may include notifying the potential victim, contacting the police, or seeking hospitalization for the patient. If the 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**. If necessary to take action, I will make every effort to fully discuss it with you before taking 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 client. The consultant is also legally bound to keep the information confidential. If you don't object, I will not tell you about these consultations unless I feel that it is important to our work together.

It is important that we discuss any questions or concerns that you may have about this document.
Your signature below indicates that you have read and agree to abide by its terms during our professional relationship.

Name: _____

Address: _____

_____

Phone: _____

_____ _____
Signature of Client Signature of Psychotherapist

_____ _____
Date Date

Donna Kimmel, Ph.D.
10114 Parkwood Drive
Bethesda, MD 20814
240-277-4427, fax: 301-530-1250

Date: _____

Name: _____ Date of Birth _____Age:_____

Address: _____

_____

Can you be called? Home Phone: _____ Y N Cell Phone: _____ Y N
Work Phone:_____ Y N

E-mail address: _____ Marital Status: S M D W

Personal Physician: _____ What kind of work do you do? _____

Emergency contact: _____ Phone: _____ Relationship:_____

Payment Policy: Dr. Kimmel is a participating provider with BCBS Federal & PPO, Johns Hopkins, TRICARE, UBH, Medicare, PHCS, & NCPPO/Unicare. You are responsible for a visit co-payment, unless an insurance company pays the full approved visit fee.

NB: Until I receive your insurance company's explanation of benefits, the visit co-pay is $30/visit in cash or by check. If you do not have the visit fee or a copayment at our first visit, we will reschedule.

Primary Insurance:_____ Member number:_____
If the policy is in someone else's name, what is that person's name and relationship to you?
Name:_____ Relationship:_____
Address, if not yours:_____

Secondary Insurance: _____Number:_____

Some insurance companies require *pre-authorization* in order to pay for services. You are responsible for obtaining *pre-authorization*. Does your insurance require *pre-authorization*? Y N Do you have it? Y N
I understand I'm responsible for visit fees whether or not my insurance carrier authorizes/pays for services.

There is a $95 charge (to you) if a visit is not cancelled 24 hours before scheduled, except when emergency or illness cause the untimely cancellation or absence.

Accounts go to collection after three written attempts to collect a balance.

I understand and agree to the policies described above. I authorize Dr. Kimmel to release administrative, diagnosis, and treatment information to my insurance company in order to process my insurance claims. I authorize Dr. Kimmel to receive assigned benefits. I may revoke this authorization at any time in writing.

Signature:_____ Date: _____

I authorize Dr. Kimmel to collaborate on my care with Drs. _____.

Signature _____**Date**_____

Name:_____Date:_____Last primary care visit:_____

Suicide: Thoughts Plan Attempt None
Self-injurious behavior: Present Absent
Drugs: Street Prescribed Over the counter

Homicide: Thoughts Plan Attempt None
Alcohol: How much? How often?
Do you smoke cigarettes? Y N

Have you observed, experienced or learned of an extremely traumatic event? Y N

Do you now, or, have you ever, experienced anyone kicking or hitting you or forcing you to do things you didn't want to do? Y N

Do you…

1. Often fail to give close attention to details or make careless mistakes in schoolwork, at work, or during other activities? Y N
2. Often have difficulty sustaining attention in tasks or play activities? Y N
3. Often not seem to listen when spoken to directly? Y N
4. Often show poor follow through on instructions or fail to finish daily tasks or duties in the workplace? Y N
5. Often have difficulty organizing tasks and activities? Y N
6. Often avoid, dislike, or feel reluctant to engage in tasks that require sustained mental effort? Y N
7. Often lose things necessary for tasks or activities? Y N
8. Often become easily distracted by extraneous stimuli? Y N
9. Often forget returning calls, paying bills, keeping appointments? Y N
10. Often fidget with or tap your hands or feet or squirm in your seat? Y N
11. Often leave your seat in situations when remaining seated is expected? Y N
12. Often feel restless? Y N
13. Often find yourself unable to play or engage in leisure activities quietly? Y N
14. Often feel "on the go," or as if "driven by a motor?" Y N
15. Often talk excessively? Y N
16. Often complete other people's sentences and have difficulty waiting your turn in conversation? Y N
17. Often have difficulty waiting your turn? Y N
18. Often interrupt or intrude on others? Y N

Have there been times lasing at least a few days when you felt the opposite of depressed, that is, when you were very cheerful and high, and this felt different than your normal self? Y N

Have there been times lasting at least a few days when you were unusually irritable, and quick to argue or fight? Y N

Do you worry that you might do or say something that would embarrass you in front of others? Y N

Please circle any condition(s) for which you have been treated:

Angina - Bleeding - Bronchitis - Cancer - Chronic Pain - Circulatory issues - Diabetes - Digestive issues - Emphysema - Headaches - Hearing problems - Heart attack - High Blood Pressure - IBS – Insomnia - Kidney problems – Seizures – Stroke/paralysis – Surgery – Thyroid disease – Ulcers – Vision problems
ADHD - Alcoholism - Anxiety - Bipolar disorder - Depression - Eating disorder - Hospitalization for mental health problem – PTSD – Schizophrenia – Suicide Attempt

Height: _____ Weight: _____

Please list your medications: _____

Name _____ Date _____

Over the past two weeks, have you been distressed because of:

1. Depressed mood most of the day, feeling sad, empty, hopeless; Y N
2. Diminished interest or pleasure in most activities, most of the day; Y N
3. Significant weight loss or gain without intending to; Y N
4. Trouble sleeping or needing too much sleep; Y N
5. Being hyper-active or sluggish; Y N
6. Fatigue, or loss of energy; Y N
7. Feelings of worthlessness or guilt; Y N
8. Diminished ability to think or concentrate, or being indecisive; Y N
9. Recurrent thoughts of death, or thinking about dying (without an actual plan), or a suicide attempt or plan. Y N

Over the past six months, have you experienced distressful:

1. Excessive anxiety and worry about a number of events or activities; Y N
2. Difficulty in controlling worry; Y N
3. Restlessness, or feeling keyed up or on edge; Y N
4. Being easily fatigued; Y N
5. Difficulty concentrating or your mind going blank; Y N
6. Irritability; Y N
7. Muscle tension; Y N
8. Sleep disturbance. Y N

I enjoy being with lots of people most of the time. Y N
or
I prefer to be alone or with only a few people at one time. Y N

I enjoy dealing with facts, the here and now, and I am quite practical. Y N
or
I enjoy thinking about what things mean and imagining what is "really" there. Y N

I usually make reasoned, logical decisions based on laws and overall principles. Y N
or
I usually make decisions based on the heart-felt needs of individuals. Y N

I am sensitive to the passage of time and feel strongly about organizing what appears to be chaotic. Y N or
I am relaxed about the passage of time and I am satisfied to let things take their own course, most of the time. Y N

Could you be the color orange? Y N

WHAT DO YOU HOPE ACHIEVE FROM COUNSELING WITH ME?