Joni E. Prince, Ph.D.
Psychotherapy Services Agreement

PSYCHOLOGICAL SERVICES

Psychotherapy is not easily described in general statements. It varies depending on the personalities of the psychologist and patient, and the particular problems you are experiencing. There are many different methods I may use to deal with the problems that you hope to address. Psychotherapy 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 been shown to have many benefits. Therapy often leads to better relationships, solutions to specific problems, and significant reductions in feelings 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. You should evaluate this information along with your own opinions of whether you feel comfortable working with me. Therapy involves a large commitment of time, money, and energy, so you should be very careful about the therapist you select. If you have questions about my approach, feel free to discuss them with me as they arise.

SESSIONS

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 45-minute session (one appointment hour of 45 minutes duration) per week at a time we agree on, although some sessions may be longer or more frequent. **Once an appointment hour is scheduled, you will be expected to pay for it unless you provide 24 hours advance notice of cancellation. It is important to note that insurance companies do not provide reimbursement for cancelled sessions, so the full $160.00 fee will be your responsibility.**

The following information pertains to my financial policy. I hope this will answer any questions you may have, but if you do have any questions or special concerns please do not hesitate to discuss them with me **at the first session.** Please acknowledge your understanding of this policy by signing at the end of this form. If you would like a copy of this form for your records I will be happy to provide one for you.

- My fee is $160.00 per therapy hour and $170.00 for couples or family sessions, **payable at the end of each session**. The usual therapy hour consists of 45 minutes. The fee for the initial diagnostic session is $195.00. Charges for consultations outside the usual therapy hour (i.e., school observations, hospital visits, depositions, etc.) will be determined on an individual basis. 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, transportation, and waiting costs, even if I am called to testify by another party. [Because of the difficulty of legal involvement, I charge $185.00 per hour for preparation and $350.00 per hour for attendance at any legal proceeding.]

- Payment is expected at the end of each session. **Please discuss exceptional circumstances with me at the first session**. Visa and MasterCard are accepted for your convenience. An insurance receipt is available for your convenience in submitting your insurance claims. Collection of insurance benefits or any other arrangement regarding third party payment is your responsibility. If you are a member of a managed care company in which I participate, I will file insurance for you. After the office manager verifies your insurance eligibility and level of benefits, I will gladly accept only the co-payment. Until that time, please plan on paying the full contracted amount.

  ** The amount we collect is based on information we receive from your insurance company. However, we do not always receive accurate information. Therefore, please be aware that you may receive a bill for services after a session because there is often a delay from when we submit an insurance claim and when it is paid. Statements are sent after insurance has paid for a date of service.

- Since your appointment time is reserved for you, please notify me as soon as possible if you find that you must cancel an appointment. Appointments not canceled with at least **24 hours notice** will be billed at the usual fee of $160.00 or $170.00. **Missed appointments cannot be billed to the insurance company.** You may leave a message with my answering service after hours and on weekends if you need to cancel an appointment.

CONTACTING ME

Due to my work schedule, I am often not immediately available by telephone. When I am unavailable, my telephone is answered by either my assistant who knows where to reach me or by my direct voicemail. I will make every effort to return your call within 24 hours, 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 feel you can't wait for a return call from me either contact your

family physician or the nearest emergency room and ask for the psychologist on call. When I will be unavailable for an extended time, the answering service (770-928-5044) can provide you with the name of a colleague to contact, if necessary.

Statement of Confidentiality: Under Georgia law communications between patients and psychologists are confidential, and under ordinary circumstances this privilege can be waived **only** by the patient. However, there are three clear exceptions in which a psychologist is legally and ethically bound to break confidentiality: (1) the patient is imminently dangerous to him or her self, (2) the patient is imminently dangerous to others and/or has made specific threats to harm an identifiable third person, (3) actual or suspected incidents of child abuse. Although legally and ethically bound to break confidentiality under the aforementioned circumstances, I generally
will not do so without attempting to discuss it with you.

Consent to Pay for Treatment: I acknowledge responsibility for all fees incurred, and if it is necessary, I consent to have my account collected through an attorney or collection agency. I also agree that I will be responsible for all costs of litigation including attorney's fees. I have read and understand the above policies.

_____ _____

Patient's Signature Date

_____ _____

Parent or Guardian's Signature of minor Date

_____ _____

Patient/ Parent or Guardian Signature Date

Patient Information:

NAME: _____

ADDRESS:_____

_____

PHONE/H:_____C:_____W:_____

Can a message be left at Home? ____Yes ____No Work? ____Yes ___No Cell? ____ Yes ____

Email address, if you'd like to have email appointment reminders_____

SOCIAL SECURITY#: _____

SEX: _____ Male _____ Female

MARITAL STATUS: _____ DATE OF BIRTH:_____

AGE: _____

EMPLOYER: _____

POSITION: _____

REFERRED BY: _____ May I contact this person?

____ Yes ____No Have you been in therapy before? _____ Yes _____ No

For your current problem? _____ Yes _____ No If so, with Whom?

_____ Where? _____

When? _____

Next of Kin not living with you: _____

Phone #: _____

Address: _____

Responsible Party/Spouse/Parent Information:

Name: _____

Date of Birth: _____ SS #: _____

Phone: _____ _____
_____ Work Home Cell

Primary Insurance:

Name of Carrier:
_____

Name of Insured: _____

Phone #: _____

ID#:_____

Group #: _____

Insurance Patients: Please read and sign the following assignment of benefits if you would like us to file your insurance for you.

Release of Authorization/Assignment of Benefits

I authorize the release of any medical/psychological information necessary to process my insurance claims. I authorize and request payment of medical benefits directly to my psychologist, Dr. Joni E. Prince, for services rendered. I agree that a photocopy of this form may be used in place of the original. All professional services rendered are charged to the patient. I understand that I am financially responsible for all charges, including those determined to be "not medically necessary" by my insurance carrier.

Signature: _____

Date: _____

Cell; _____

Primary Care Physician Information

Name _____

Address

_____

_____

Phone _____

How long have you been a patient of this physician?

_____

For purposes of continuity of care, may we contact your physician to let him/her know of your visit today? Yes _____ No _____

If yes,

I _____ give permission to Dr. Joni E. Prince to send a general statement notifying my primary care physician of my visit today. The information sent will be used for coordination of care, and will be limited to a brief description of the problem area and/or diagnosis, and a general outline of treatment.

_____

Patient Signature

_____

Date

Patient Information

Please list your current medical conditions:

_____

_____

Please list the medications and dosages you are currently taking:

_____

_____

_____