James A. Purvis, 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 that you are experiencing. There are many different methods that I may use to deal with the issues 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 that 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. Psychotherapy 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 to your therapy, 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 that 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.

PROFESSIONAL FEES

The following information pertains to my financial policy. I hope this will answer any questions that 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 **$190.00** for individual sessions and **$200.00** for couples or family therapy sessions, **paid at the end of each session**. The usual therapy hour consists of 45 minutes. Please expect that my fee will increase from $5.00 to $10.00 per year each January. The fee for the initial diagnostic session is **$215.00**. Charges for services outside the usual therapy hour that you may request of me will be determined on an individual basis. These services might include report writing, telephone conversations (lasting longer than **10** minutes), consulting with other professionals with your permission, and the preparation of records or treatment summaries. 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 **$200.00** per hour for preparation and **$350.00** per hour for attendance at any legal proceeding.

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BILLING AND PAYMENTS

Payment is expected at the end of each session. Please discuss any exceptional circumstances with me at the first session. Visa and MasterCard are accepted for your convenience. An insurance receipt is available should you wish to submit your insurance claims personally. If you are a member of a managed care company in which I participate, I am required to file insurance for you. After our 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. I will fill out forms and provide you with whatever assistance I can in helping you to receive the benefits to which you are entitled; however, you, **NOT your insurance company**, are responsible for the full payment of my fees. For that reason, it is very important that you find out **personally** what mental health services your insurance policy specifically covers.

*** **NOTE**: The amount we are required to collect is based on information we receive from your insurance company. However, **we do not always initially receive accurate and reliable information from the company**. Therefore, please be aware that you may receive a future bill for services after a session, if your insurance company declines to pay for the service.

Initial Here _____

Since your appointment time is reserved solely for you, please notify me as soon as possible if you find that you must cancel an appointment. Appointments not cancelled with at least **24 hours' notice** will be billed at the usual fee of $190 or $200.00. **Missed appointments cannot be billed to the insurance company.** You may leave a message on my confidential voicemail after hours and on weekends if you need to cancel an appointment.

Occasionally, patients will ask why I charge for missed appointments not cancelled with 24-hours notice. Your appointment time is reserved solely for you. When you are unable to keep it without at least 24-hours advanced notice, I am often unable to fill that time with another patient. Unlike other types of providers, who may be able to schedule multiple patients per hour, and even double book appointments, I schedule only one patient each hour, so that I can take the proper time and give proper attention to the quality care that you deserve. If you do not keep your appointment, I have no other way to offset the expenses that I remain responsible for during that lost time.

CONTACTING ME

Due to my work schedule, I am often not immediately available by telephone. When I am unavailable, my telephone is answered by my assistant or by my confidential voicemail. I will make every effort to return your call on the same day that you make it, with the exception of weekends and holidays. In the event of an emergency, a doctor is on call through Atlanta Psych Consultants 24 hours a day, 7 days a week. If you are difficult to reach, please inform me of some times when you will be available. You may contact the doctor on call through the answering service (770-928-5044). If I will be unavailable for an extended period of time, the answering service can provide you with the name of a colleague to contact, if necessary.

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STATEMENT OF CONFIDENTIALITY

Under Georgia law communications between patients and psychologists are confidential, and under ordinary circumstances **only the patient** can waive this privilege. 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) there may exist actual or suspected incidents of child abuse or elder 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.

MINORS & PARENTS

Patients under 18 years of age (who are not emancipated), and their parents, should be aware that the law allows parents to examine their child's treatment records, unless I believe that doing so would endanger the child, or the parents agree to suspend their right to examine the treatment record. Because privacy in psychotherapy is often crucial to successful progress, particularly with teenagers, it is my policy to request an agreement from parents that they consent to give up access to their child's records. If they agree, then during treatment I will provide them only with general information about the progress of their child's treatment, and his or her attendance at scheduled sessions. Any other communication will require the child's Authorization for Release of Information, unless I feel that the child is in danger or is a danger to someone else, in which case, I will notify the parents of my concern. Before giving parents any information, I will discuss the matter with the child, if possible, and do my best to handle any objections he or she may have.

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 Signature Date

_____ _____

Parent (or Guardian of minor) Signature Date

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INSURANCE WAIVER

IF YOU ELECT **NOT TO UTILIZE** YOUR INSURANCE BENEFITS, YOU HEREBY ACKNOWLEDGE THAT YOU ARE WAIVING THE RIGHT TO FILE FOR ANY SERVICES FROM THIS POINT FORWARD AND THAT **NO CLAIMS WILL BE FILED RETROACTIVELY**.

YOU DO RETAIN THE RIGHT TO CHANGE YOUR DECISION AT ANY TIME AND BEGIN TO USE YOUR BENEFIT. HOWEVER, CLAIMS WILL **ONLY BE FILED GOING FORWARD** FROM THE POINT THAT YOU DECIDE TO UTILIZE YOUR INSURANCE BENEFITS.

My signature below indicates that I have read and understand the notification above:

_____
Printed Name

_____ _____
Signature Date

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Patient Information:

NAME: _____

ADDRESS: _____

_____

PHONE: Home: _____ Cell: _____ Work: _____

Can a message be left at Home? Yes ___ No ____

Work? Yes ___ No ___ Cell? Yes ___ No ____

Email address: _____

Last four digits of your SSN: _____ SEX: Male ____ Female ____

MARITAL STATUS: S M D W 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 issue? Yes _____ No _____

If yes, with Whom? _____

Where? _____ When? _____

Next of Kin not living with you: _____

Phone #: _____

Address: _____

_____

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Responsible Party/Spouse/Parent Information:

Name: _____

Date of Birth: _____ Last four digits of SSN: _____

PHONE Home: _____ Cell: _____ Work: _____

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. James A. Purvis**, 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 #: _____

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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. James A. Purvis 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

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Confidential Patient Information

Please list any current medical conditions, past major surgeries, illnesses, or injuries:

_____

Please list all current medications and dosages (medical and psychiatric):

Please list all past psychiatric medications and dosages:

Family Psychological History (Please specify which relative for each condition):

__ Depression _____
__ Anxiety/ Panic Disorder _____
__ Bipolar Disorder _____
__ Alcoholism _____
__ Drug Abuse _____
__ Suicide _____
__ Other (specify) _____

Personal Substance Use History (specify past or current, amount and frequency):

__ Tobacco _____
__ Alcohol _____
__ Marijuana _____
__ Stimulants _____
__ Cocaine _____
__ Opiates _____
__ Other (specify) _____