

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.

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 your 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

Psychotherapy sessions last 45 minutes, unless otherwise arranged. 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** reimbursement for cancelled sessions, so the full \$200.00 fee will be your responsibility.

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**. If you would like a copy of this form for your records, I will be happy to provide one for you.

My fee is **\$200.00** for individual sessions and **\$210.00** for couples or family therapy sessions, **paid at the end of each session**. 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 **\$225.00**. Charges for services outside the usual therapy hour 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.

James A. Purvis, Ph.D.

Psychotherapy Services Agreement

If you become involved in legal proceedings that require my participation, you will be expected to pay for 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.

BILLING AND PAYMENTS

Checks, credit cards and HSA cards 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 claims for you. 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. If your insurance company declines to pay for a service, please be aware that you may receive a future bill for services if sessions are declined by the company,

Initial Here _____

NOTE: 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 \$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 within 24 hours, 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 our answering service (770-928-5044).

James A. Purvis, Ph.D.

Psychotherapy Services Agreement

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 a specific threat to harm an identifiable third person, or (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.

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

James A. Purvis, Ph.D.
Psychotherapy Services Agreement

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 SSN: _____ 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 issue? Yes ___ No ___

If yes, with Whom? _____

Where? _____ When? _____

Next of Kin not living with you: _____

Phone #: _____

Address: _____

James A. Purvis, Ph.D.

Psychotherapy Services Agreement

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 #: _____

James A. Purvis, Ph.D.

Psychotherapy Services Agreement

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

James A. Purvis, Ph.D.
Psychotherapy Services Agreement

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

James A. Purvis, Ph.D.
Psychotherapy Services Agreement

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:

James A. Purvis, Ph.D.
Psychotherapy Services Agreement

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) _____