Judith A Freed, MA
PA Licensed Psychologist
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610-524-8988

Professional Services Agreement

This document has been developed to provide you important information related to the practical issues of your therapeutic work with me. Please feel free to discuss any questions or concerns you may have regarding these policies or any other aspect of our professional relationship.

Confidentiality

Because trust is critical in the therapeutic process, matters discussed during the course of therapy are held in confidence and not shared with anyone without your written permission. There are a few exceptions to this rule as follows: first, professional reporting is required if a psychologist has reason to believe that a client may present an imminent threat of harm to another individual. Second,
if I have reason to suspect, based on my professional judgment, that a child is or has been abused, I am required to report my suspicions to the authority or government agency vested to conduct child abuse investigations even if I do not see the child in my professional capacity. I am mandated to report suspected abuse if anyone aged 14 or older tells me that he or she committed child abuse even if the victim is no longer in danger. I am also mandated to report suspected child abuse if anyone tells me that he or she knows of any child who is currently being abused. At times a judge may issue an order compelling a psychologist to release confidential information. In insurance reimbursement situations, you may authorize me in writing to share information for a specific purpose such as insurance coverage. Outside of these exceptions the Health Insurance Portability and Accountability Act (HIPAA) provides privacy protection and patient rights regarding the use and disclosure of your Protected Health Information (PHI). Attached is a copy of the provisions of this law that apply to the records of your treatment with me.

In the treatment of minors, it is my policy to request that parents respect the confidentiality between the child and me. Therefore, I suggest parents refrain from questioning their child regarding the specifics discussed during sessions. I do encourage children to share important information and feelings with their parents. If circumstances arise I consider important for parents to be informed about, I will arrange a meeting for the child and parents to discuss the relevant issues. If such a meeting cannot be arranged, I will meet alone with the parents after informing the child of my intentions. In addition, as one of the goals of family therapy is to encourage appropriate and open communication among family members, our efforts in therapy will be directed toward this end. In such situations, I will be available to answer questions and make suggestions to parents regarding their relationship with their children and other specific situations that may arise during treatment.

If another professional is involved in the care and treatment of you or your family members, particularly a mental health professional, I will request that a release be signed

so that we may communicate to coordinate efforts. It is also helpful in planning our work together for me to obtain information from any previous counseling relationship or results of a psychological evaluation and your written consent will be requested for such. These policies are all intended to increase the efficiency of our time working together by minimizing wasted time and effort.

Appointments

All services are provided by appointment only. Therapy sessions are 45-55 minutes long and generally scheduled once a week at least at the outset of therapy. As therapy progresses and treatment is beginning to wind down, sessions are usually scheduled less often in preparation for ending therapy. Every effort will be made to schedule sessions at times mutually convenient. **Once an appointment is scheduled, cancellations will be accepted up to 24 hours in advance. After this time you will be expected to pay for time reserved.** The exception to this is an emergency or inclement weather which causes dangerous road conditions**.** Scheduling an appointment means the time has been reserved for you and cannot be used by another person. When canceling a session, please leave a message on my voicemail at 610-524-8988 or you may email me at judy@judithfreedma.com . I will return the call/email to re-schedule the appointment as soon as I am able. Please note that insurance companies do not provide reimbursement for cancelled sessions. It is also important to remember that coming regularly and on time is an indication of your commitment to therapy.

Emergencies

It is important, of course, to work on issues as they arise to prevent a crisis from occurring. However, should a crisis occur, you are free to call my office (610-524-8988) and leave a message which I will return as soon as possible. In the event of a true emergency call my office and follow directions on my voice mail. If you are unable to reach me during a significant crisis, you are encouraged to call Chester County Crisis Hotline 610-918-2100 or to contact your local hospital emergency room.

While the telephone is not a good substitute for talking face to face, there may be times when calling makes good sense such as dealing with a crisis or problem situation in the moment. At these times feel free to call me. Brief and occasional phone calls will not require reimbursement however, lengthy calls will be billed at $150 an hour ($165 court related) or portioned thereof.

Financial Arrangements:

Payment in full is expected at the time of service unless other arrangements have been made. The fee for initial consultation (60 – 75 minutes) is $165($180-court related) and ongoing sessions are $150/45-55 minutes ($165-court related). If I am an in-network provider with your health insurance plan, your co-payment is expected at the time of service. Should your insurance plan decline payment for any reason, responsibility for full payment of the fee rests with the client. If you maintain other health insurance, part of your expenses may be covered. I will prepare a monthly statement reflecting services provided, fees paid and other information your insurance company needs to reimburse you directly. Simply attach this statement to your insurance claim form. You should also be aware that your contract with your health insurance company requires that I provide it with information relevant to the services that I provide to you. I am required to provide a clinical

diagnosis. Sometimes I am required to provide additional clinical information such as treatment plans or summaries, or copies of your entire Clinical Record. In such situations, I will make every effort to release only the minimum information about you that is necessary for the purpose requested. This information will become part of the insurance company files and I have no control over what they do with it once it is in their hands. Other services outside of scheduled appointments such as report writing, extended telephone conversations, email, consultation with other professionals with your permission, preparation of records or treatment summaries, etc will be based on this hourly rate.

Contacting Me:
Due to my work schedule I am often not immediately available by telephone. If you need to contact me between sessions, you may call my office phone (610-524-8988) and leave a message on my confidential voice mail. I will make every effort to return your call in a timely manner. Weekend and holiday calls will be returned on the next business day. Administrative issues such as scheduling and changing appointments can be handled by either calling my office phone or emailing me at judy@judithfreedma.com. It is important to note that email is not always a secure means of communication, particularly if you are using a public Wi-Fi network, such as a store or coffee shop.

Terminating Therapy:
Frequently, clients know intuitively when it is time for them to move on and work more on their own. I firmly believe in your ability to recognize when you have obtained the most benefit from therapy and whether or not it is of benefit to you. It is important you feel comfortable discussing this issue with me at any time. However, sometimes clients wish to terminate therapy prematurely because it is difficult to preserve with the work of maintaining long term changes or because the issues discussed in therapy are painful. Whatever the reasons, it is important that your feelings and plan be raised for thorough discussion and termination be planned within the sessions. Of course, I will raise the topic whenever I believe it is in your best interest to change frequency of sessions, or stop treatment.

Participation:
My commitment is to provide you the best possible care in a safe and supportive environment. Whatever your goals or needs may be in therapy, your participation is essential. It is important that we maintain an open relationship and that you feel free to discuss any aspect of our work together, including any questions you may have about the services being provided. At times therapy may bring up uncomfortable feelings, thoughts or memories and in an effort to make the best use of the therapeutic process, I encourage you to speak candidly of these issues within our sessions.
If you have questions regarding any of the above information, please feel free to ask.

Treatment Contract:
Your signature below indicates that you agree to enter into a professional relationship with me under the terms as set out in this document. It further indicates that you understand that you may terminate therapy at any time and that I may terminate treatment at some time if I feel you are not benefiting from treatment or you do not comply with these policies. Finally, your signature also acknowledges receipt of the HIPAA notice.

I have read and understand this document and agree to abide by it. I recognize that psychotherapy frequently brings up issues difficult to discuss and which may cause discomfort to explore. Knowing this, I accept the terms/conditions stated herein and consent to treatment with Judith Freed, MA.

_____ _____

(Signature) (Date)

On behalf of _____, my minor child or person entrusted to me for guardianship, I agree to the above policies and give permission for Judith Freed to provide treatment for my child.

_____ _____

(Signatures of both parents/legal guardians) (Date)