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Welcome to my practice. The following has been prepared in order to facilitate our work together. These guidelines are intended to provide answers about fees, insurance, appointments, messages and other issues. Should you have any further questions or concerns, please feel free to discuss them with me. I look forward to working with you.

OFFICE POLICIES AND CONSENT TO TREATMENT FORM

Payment for Services

My usual and customary fee is \$200.00 for a scheduled 50-minute consultation session. Clients are expected to pay for services at the time they are rendered unless other arrangements have been made. Please notify me if any problem arises during the course of our work together regarding your ability to make timely payments.

Insurance Reimbursement

Clients who carry insurance, for which I am a Provider, should remember that professional services are rendered and charged to the insurance company, but you are ultimately responsible for payment of all services. Not all issues/conditions/problems which are the focus of psychotherapy, are reimbursed by insurance companies. It is your responsibility to verify the specifics of your coverage

If you have an insurance carrier that allows you to see the doctor of your choice (otherwise known as a PPO with “out-of-network” benefits) and you would like to use your insurance benefits for mental health services, the terms of your benefits should be understood, discussed, and agreed upon prior to scheduling your first appointment or during your first session. Where I am not a Provider, I do not accept assignment of benefits. What this means is that, I will be paid in full at the time of services rendered and then I will supply you with completed insurance forms to submit to your insurance company for reimbursement to you, the client. This can be done for one session at a time or for a number of sessions per form. For example, you may want your insurance billed on your behalf after every session or monthly. I use standard universal health insurance claim forms, if your insurance company has forms for the provider to complete, be certain to give them to me at your earliest convenience.

Remember, I am not in a position to guarantee payment from your insurance company, which is why getting these matters understood and resolved as early as possible, in your work with me, will ease your mind as to the financial reimbursements due you.

It is essential that you pay the amount agreed upon, at each session. In the event that collection becomes necessary, all reasonable collection expenses, including collection agency and/or fees, will be charged to the client.

A \$25.00 fee will be charged for bounced checks. Payment in full, including this charge, is expected within 5 days of notification or you will be charged an additional fee, as allowed by law.

Cancellation Policy

Your 50 minute appointment time is reserved specifically for you. Please try to be on time for all sessions. If you are late, we will meet for the time remaining in the session. In the event you must cancel a session, a minimum of 24-hours notice is required to reschedule or cancel an appointment. If the appointment is missed or not canceled **within 24-hours of the scheduled time**, you will be charged **in full** for that session. In the event of a cancellation without 24-hours notice and such cancellation is due to circumstances which we both define as an emergency, a fee may not be charge. If you do have a last minute cancellation, please notify me at (858) 558-8535 or leave me a voice-mail at your earliest convenience to inform me of your cancellation and allow me to accommodate my schedule as needed.

Emergency Procedures

For life threatening emergencies, call 911. If you need to contact me between sessions for routine/non-emergency matter, please leave me a voice-mail at (858) 558-8535 that I will respond to within the same 24-hour period during the business week. Calls left after 5 p.m. on Fridays will be returned at the beginning of the next week. If you need **unscheduled** phone time between sessions and you leave me a voice-mail requesting such, my fee will be equal to your regular session fee. If you do not need a full session hour, I will pro-rate your fee to the nearest 15, 30, and 45 minute increment, respectively. If the total **unscheduled** telephone consultation between normal sessions is less than 10 minutes then there will be no charge.

It is important to understand that I am not an emergency or crisis clinic, and there may be a time when I am not readily available, particularly during office hours when seeing other clients. If I am not available and you are in need of immediate support, you are urged to contact the **crisis team (a 24-hour hotline) at 888-724-7240.**

STATEMENT OF CONFIDENTIALITY:

Professional ethics and California State Law specify that communications between a client and the therapist are privileged and confidential. Confidential information may not be released or shared without the written permission of the client. There are, however, some exceptions to the rule where disclosure is required by law. Disclosure may be required in the following circumstances:

1. If you reveal information to me about **child abuse/neglect or elder abuse**, I am required by law to report this to the appropriate authority. Any reasonable suspicion of these matters may also be reportable.
2. If you indicate that you have a **plan, the means, and make credible threats to kill yourself**, I am required by law to notify potential helpers which may include law enforcement agencies, in order to provide you with a safe place where no harm can come to you. This can be done voluntarily which is ideal or if the threat is serious and of concern, an involuntary action may be taken.
3. If you tell me that you have a **plan, the means, and make credible threats to harm someone else**, I am required by law to notify/warn potential helpers, appropriate law enforcement agencies, and in those cases where identifiable others may be harmed, notification of potential victim(s) will be made as mandated under the law. **In addition**, please be notified that as of July 16, 2004, the Second District Court of Appeals held that as a result of the case *Cal Ewing v. David Goldstein, Ph.D.* “a communication from a patient’s family member to the patient’s therapist, made for the purpose of advancing the patient’s therapy, is a patient communication within the meaning of Section 43.92 (Tarasoff mandates). To be clear, if you communicate to a family member, a serious and credible threat of harm to another person and your family member notifies me of this threat, and then I am mandated by law to inform and warn appropriate law enforcement agencies and potential victim(s) for the purposes of keeping you and other safe.
4. If you are in therapy or being tested by order of a court of law (judge’s order) the results of the treatment or tests ordered must be revealed to that court.
5. If a court of law issues a legitimate subpoena, I am required by law to provide the information specifically described in the subpoena.
6. Disclosure of confidential information may be required by your health insurance carrier in order to process the claims. If you so instruct me, only the minimum necessary information will be communicated to the carrier. I have no control or knowledge over what insurance companies do with the information submitted or who has access to this information. You must be aware that submitting a mental health invoice for reimbursement carries a certain amount of risk to confidentiality, privacy, or to future eligibility to obtain future insurance.

Please ask me any questions you may have about any of the procedures mentioned above or any you may have throughout the course of your work with me. I will be available to answer any questions you have to the best of my ability.

I do keep written records of our sessions. You have the right to receive a summary of your records at any time. If you ask me to release information to other agencies or person(s), I will have you sign a written release of information form. I will inform you at the time of your request whether or not I think releasing that information to that agency or person(s) might be harmful to you in any way. If a third party makes a request for your records, I will always offer a summary of your record of treatment, versus detailed consultation notes.

You have the right to discontinue your work with me at any time. I would ask that you give us the opportunity to discuss this so as to obtain appropriate closure for us both. If you choose to continue your work with another professional and do not have referrals, I will provide you with the names of other qualified professionals whose services you might prefer. I can also be available for consultation with your new provider in an effort to help provide you with continuity of your care if so desired. Your only obligation at the point of termination is that of a financial nature for services already rendered and not yet paid in full. Arrangements can be made upon request.

I HEREBY AUTHORIZE TREATMENT AS DEEMED BY THE PRACTICE AND I ACKNOWLEDGE THAT I HAVE READ THIS DOCUMENT, THAT I WILL FULLY COMPLY WITH ITS TERMS, AND THAT I SHALL BE FULLY RESPONSIBLE FOR PAYMENT OF ALL CHARGES.

Print Name

Signature

Date