DEBORAH S. LYONS Ph.D.

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GROUP THERAPY CONTRACT

20__ - 20__

Deborah S. Lyons, Ph.D.
Licensed Psychologist, Licensed Specialist in School Psychology

The goal of therapy with children and adolescents is to promote child competence and social and emotional adjustment. In order for group therapy to be successful, regular and consistent attendance is necessary. This not only allows your child the best opportunity for growth, but also provides him/her with a secure, safe, and dependable setting in which to explore and build social relationships.

By agreeing to have your child participate in one of my groups, you are committing to do the following:

1. Attend all scheduled weekly sessions through May.
2. Assume financial responsibility for the fees for all of the above even if your child is unable to attend the session(s), or you decide to withdraw your child from the group after its inception and prior to its conclusion in May.
3. Provide payment in advance and in full at the first session of each month for all sessions scheduled during that month.
4. Prompt arrival to and departure from each session.
5. Attend a 45-minute appointment with me in February and in May to discuss your child's progress and to revise goals as needed. Additional appointments can be scheduled at your request or when I deem them to be of medical necessity.

The fee for each 60-minute group therapy session is $ ______ ( ). The fee for each 45-minute appointment with you is $ ______ ( ). You will be provided with receipts at the first appointment of each month that you can submit to your insurance company for reimbursement as your policy benefits allow. It is your responsibility to verify the specifics of your coverage, including pre-certification/authorization of treatment.

If payment for services is not received within 30 days of the time it was rendered, use of a collection agency or legal measures will be used to collect overdue accounts at the client's expense. Routine visits will terminate and you will be referred to another provider if your account becomes delinquent. Please notify me immediately if a situation should arise that prohibits you from your ability to make timely payments.

This contract serves as an Addendum to the "Psychologist-Patient Services Agreement" contract that you have signed and which shall remain in effect in its entirety. Note that while your child may discuss his/her experiences in the group with you, all other limits regarding the confidentiality of treatment shall apply. You must sign this document before your child can participate in group therapy with me. You will be provided with a copy for your records.

I have read and understand this contract and have asked any questions I had pertaining to it.

____
Child's name (Print)

______________________________ ________ ______________________________
Parent/Guardian's name (Print) Date Signature

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