DEBORAH S. LYONS Ph. D.

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INTERPERSONAL SKILLS GROUP THERAPY CONTRACT

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

The goal of this therapeutic group is to learn more resilient and adaptive social skills and to become more comfortable in social situations. In order for group therapy to be successful, regular and consistent attendance is necessary. This not only allows you to have the best opportunity for success, but also provides a secure, safe, and dependable setting in which to explore and build social relationships.

The fee for each 75-minute group therapy session is $100.00. 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. Enrollment in the group 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.

By signing this contract, you agree and are committing to do the following:

1. Attend all scheduled weekly sessions per your treatment plan.
2. Assume full financial responsibility for the fees for all sessions even if you are unable to attend each session.
3. Provide payment in advance to the agreed upon party (either Dr. Lyons or INNOVATION360 Austin) 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. Provide authorization to Deborah S. Lyons, Ph.D., to use, disclose, release and receive protected health information regarding your presence/absence at each scheduled group therapy session to/from INNOVATION360 Austin for the purposes of coordination of treatment and for billing, **only IF** client is **ALSO** a client of INNOVATION360 Austin. This authorization expires when you cease to be enrolled in the Interpersonal Skills Group Therapy.

   You may revoke this authorization by notifying Dr. Lyons in writing of your wish to do so. However, doing so does not affect any actions already taken by Dr. Lyons based upon this authorization. Understand that when information is used or disclosed pursuant to this authorization, it may be subject to redisclosure by the recipient and may no longer be protected by state and federal privacy regulations.

This contract serves as an Addendum to the "Services Contract and Consent to Treatment" contract that you have signed and which shall remain in effect in its entirety. **You must sign this document before you can participate in group therapy with me.**

My signature below indicates that I have read and understand this contract, have asked any questions I had pertaining to it, and agree to abide by its terms.

_____	_____	_____
Client's name (Print)	Date	Client's Signature