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SERVICES CONTRACT & CONSENT TO TREATMENT

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

This document (hereafter referred to as the Services Contract) contains important information about my professional services and business policies. Please read it carefully and plan to discuss with me any questions you may have at our first appointment. When you sign this document, it becomes a contractual agreement between us.

THE PROCESS OF THERAPY: Therapy is a joint effort between psychologist and client, the results of which cannot be guaranteed. Progress depends on many factors including motivation, effort, and other life circumstances such as the client's interactions with family, friends, and other associates. It requires your very active involvement, honesty, and openness. Participating in therapy can result in a number of benefits to the client including improving interpersonal relationships and resolution of the specific concerns that led you to seek therapy. Therapy unleashes strong feelings and may result in changes that were not originally intended, or in decisions to change behaviors, employment, substance use, schooling, housing, or relationships. The goals may change as therapy progresses. You share the responsibility for clarifying the goals of therapy, evaluating its progress, and making recommendations for changes in the therapy process. Therapy never involves sexual relationships, or a dual relationship that could impair my objectivity, clinical judgment, or therapeutic effectiveness.

Our first few sessions will involve an evaluation of the client's needs. By the end of the evaluation, I will be able to offer you my initial impressions of what our work will include and a treatment plan to follow. During the course of therapy I am likely to draw on various psychological approaches based on the problem that is being treated and on my assessment of what will best benefit you. These approaches include psychodynamic, systemic/family, cognitive-behavioral, psychoeducational, and psychometric. If you have any questions about any of the procedures used in the course of therapy, their risks, or about the treatment plan please ask and you will be answered fully. When psychological test instruments are used, you will be given information about their purpose, validity and reliability for their intended use, how the data will be used and who will have access to the results. You have the right to ask about other treatments for your problem(s), their risks and benefits. If you could benefit from any treatments that I do not provide, I will assist you in obtaining those treatments.

If I conclude I am not being helpful to you, I will tell you so and will offer you recommendations and/or referrals. If at any time you wish another professional's opinion or wish to consult with another therapist, I will assist you in finding a qualified person. If I have your written consent, I will provide that therapist with the essential information needed.

You have the right to terminate therapy at any time. If you choose to do so I will encourage you to attend at least one more session to discuss your reasons for ending therapy, and to make plans for further treatment and a referral, as needed. If you have a complaint about the services rendered, I am eager to discuss your complaint with you at any time. If we are unable to reach a resolution, you may pursue the matter further by contacting the Texas State Board of Examiners of Psychologists.

PAYMENTS & INSURANCE REIMBURSEMENT: Payment is required at the time services are rendered. The fee of $_____ ( ) is for the initial 90-minute appointment. Fees are $_____ ( ) per 60- minute appointment or $_____ ( ) per 45-minute session thereafter unless other arrangements have been made. Payment must be provided either with cash or check. Credit card payments are not accepted. Fees are charged for telephone conversations, record or report reading, consultation with other professionals, and release of information or copying of records at the standard fee rates shown above and payment is due when such services are requested or at the next appointment.

Separate fee schedules and payment requirements exist for the following services: Group therapy, psychological and neuropsychological assessments, report writing, and site visits or out-of-office meetings (including travel time) and will be provided as needed or upon request.

Cases I deem to be more complicated will be required to provide a case management services retainer of $300.00 from which payments will be drawn as services are rendered while working on your case. The retainer may need to be replenished over time and you will be required to do so immediately upon request.

By signing this Contract, you agree to pay all stated and applicable fees. If payment for services is not received within 30 days of the time the service was provided, interest will be charged to the balance due and use of a collection agency or legal measures will be used to collect overdue accounts. All fees incurred for this purpose, including attorney and/or court costs, shall be entirely at the client's expense. Routine visits will terminate and/or the client may be referred to another provider in the case of a delinquent account. Please notify me if any problem arises during the course of therapy regarding your ability to make timely payments.

I will provide you a receipt with information necessary for you to file a claim with your health insurance company. I am not a provider on any insurance panels and do not submit or process claims for payment to health insurance companies. Patients always bear responsibility for payment of all charges incurred during the course of treatment. Note that not all issues/conditions/problems which are the focus of psychotherapy may be reimbursed to you by insurance companies. The most common of these includes the length, frequency, or mode of treatment (e.g., family, marital, or group therapies). It is your responsibility to verify the specifics of your coverage, including precertification/authorization of treatment when needed.

MISSED OR CANCELED APPOINTMENTS: As a courtesy and when possible, you will be offered a card at each session reminding you of the details of your next appointment. Should you miss an appointment, your signature herein authorizes my office to contact you at the phone number you have provided me. **You are required to notify me twenty-four (24) hours in advance of the scheduled time of any appointment if you intend to cancel it**. Missed appointments or those cancelled with less than twenty-four (24) hours notice are charged at the session rate and payment due immediately or at the next scheduled appointment. Failure to attend 2 consecutive sessions without notification will be interpreted as your intent to terminate services with me. Nonetheless, you are still responsible for the charges incurred for those missed appointments.

Since the scheduling of an appointment involves the reservation of time specifically for you, the minimum twenty-four (24) hour notice is required without exception to cancel an appointment. It is not acceptable to appear at appointments when you are ill or with sick children as a means of circumventing this policy. While I am sympathetic to the many reasons that a patient may not be able to keep their appointment, failure to comply with this policy will require us to re-evaluate the therapeutic relationship and your treatment with me.

TELEPHONE AND EMERGENCY PROCEDURES: If you need to contact me between sessions please leave a message on my mobile phone (512-459-1272). I am often not immediately available by telephone, as I will not answer the phone when I am with a patient. I will make every effort to return your call within 24 hours, with the exception of weekends and holidays.

If an emergency situation arises or you need to talk to someone immediately, call the MHMR Integral Care hotline (512-472-4357), the police (911), or your psychiatrist or physician (Medical Exchange 512-458-1121). When my

office is closed and I am unavailable, I will provide you with the name of a colleague to contact, if necessary, for professional clinical care.

CONFIDENTIALITY: The privacy of the client's sessions is extremely important. All information disclosed within sessions and the written records pertaining to those sessions are confidential and may not be revealed to anyone without your written permission, except when disclosure is required by law. If you are in treatment with another professional I may find it necessary at times to consult with that person and will ask you to sign a release form allowing me to do so in writing, by phone, or via email. I may consult at times with other professionals regarding your care for the purposes of professional development. Names or other identifying information are never revealed in this situation and confidentiality is fully maintained.

Disclosure of confidential information may be required in the following circumstances:

- √ Where there is a reasonable suspicion of abuse or neglect to a minor, disabled or elderly person;
- √ Where a client presents a danger to him/herself or to others;
- √ If you file suit against me;
- √ If a judge orders me to release the records;
- √ In pursuing matters in which payment for services has not been provided;
- √ When information revealed regards the transmission of contagious or transmittable diseases;
- √ If during the course of therapy information is divulged regarding ethical violations by other mental health professionals (I will inform you if such an obligation arises about your records).

The situations outlined above are not routine and have no impact at all on the vast majority of people seeking therapy.

By signing this Services Contract, you authorize my office to appoint a qualified professional to serve as custodian of your treatment record in the event of my death or disability. Notice regarding how you may obtain your record in such an event will be posted on my website.

LEGAL PROCEEDINGS/CLIENT LITIGATION MATTERS:

I do not participate in court proceedings, including child custody proceedings. In accord with my ethical and professional responsibilities I do not believe that it is in a client's best interests to supply information provided to me within the safe and trusted therapeutic relationship to other parties to be used as evidence in a court proceeding, or at a deposition. My role is limited to providing my clients with psychological treatment. In working with me you agree to treat anything that is said in session with me as confidential, and not to use that information in any legal proceeding. Once I have been ordered to participate in a legal proceeding, you agree to release me from my duty as your psychologist and terminate our therapeutic relationship.

By signing this Services Contract, you agree you will not involve me in any court proceedings or other litigation regarding any potential family law matter, including, but not limited to testifying in court or at a deposition, communicating or consulting with any attorney involved in your case, or preparing reports for use in court or by an attorney. If I am forced through a subpoena or court order to provide/copy my records or case notes, to appear at a deposition, or to testify in court, you agree to pay me a retainer of $5,000 against which I will bill you for all my time spent involved with your court case at the rate of $ _____ ( ) per hour (which will include any time away from my office dealing with your case), or the daily rate of $ _____ ( ) per day, whichever is less. Payment is due in full at the time a subpoena or order is served. Know that you can instruct your attorney not to contact or to subpoena me.

However, if the court appoints a custody evaluator, guardian ad litem, or parenting coordinator to your case, I will not make any recommendation about the final decision, but will provide information as needed, and as required by law, with appropriately signed release of information forms in place from all parties. You will be billed accordingly for the time rendered in providing that information and payment is due immediately.

If, after signing this Services Contract, I receive a verbal request or subpoena from an attorney to produce records or testimony of my work with any client, I will produce the signed Services Contract and object based on your contractual obligations under this Services Contract. I will enlist the services of my own legal representative

whenever necessary in order to uphold this level of privacy in my work and patients/clients hereby agree that all fees associated with this endeavor shall be incurred wholly at the patient's/client's expense. By signing this Contract, you agree that any action on your part which breaches this Contract shall require you to pay to Deborah S Lyons, Ph.D. the sum of $10,000.00 for liquidated damages.

CHILD & ADOLESCENT THERAPY: Prior to beginning your child's treatment, it is important that you understand my approach to child and adolescent therapy and agree to some policies about your child's confidentiality during the course of his/her treatment. Additionally, you will provide me a copy of any court orders currently in place regarding your child before treatment can begin. Unless you are the sole-surviving parent, or have been granted the exclusive right to make mental health decisions for your child, I will also require signed consent from the other parent or any other person having court-ordered rights to make those decisions on behalf of the child prior to starting treatment.

The goal of therapy with children and adolescents is to promote competence and social and emotional adjustment. In providing treatment to children and adolescents, a combination of play and talking therapies are used to help them understand and express feelings and to change behaviors. The process can involve individual, parent, and family contacts as well as consultation with schools or other systems as necessary. The use of psychological tests will vary depending on the nature of the problem(s). While the child is considered to be the client, parents are an extremely important part of the therapeutic process and their cooperation is critical to a successful outcome.

Therapy is most effective when a trusting relationship exists between the therapist and the patient. Privacy is an important part of securing and maintaining that trust. Children, and particularly adolescents, are best helped in the therapeutic process when they feel they can freely discuss personal matters in sessions. If your child is an adolescent, it is possible that he/she will reveal sensitive information to me including information regarding sexual conduct, alcohol and drug use, or other potentially problematic behaviors. Sometimes these behaviors are within the range of normal adolescent experimentation, but at other times they may require parental intervention.

Disclosure to parents may be required in the treatment of children and adolescents as stipulated under the Family Medical Act. However, it is my policy to secure an agreement from parents/guardians to waive the right to access my records in the treatment of a minor. By signing this Services Contract you agree to this policy and waive the right to access my records. I will share information verbally with parents about the therapeutic work rather than through the sharing of written records. If ever I believe that your child is at serious risk of harming him/herself or someone else, I will inform you of that.

CONSENT FOR CARE: I give full consent, until otherwise notified, to Deborah S. Lyons, Ph.D. for completion of the evaluation and provision of treatment as necessary to the client designated below. I understand that no specific outcome can be promised or guaranteed. If I have any questions about the information I am given or about anything related to the client's treatment, I will discuss this with Dr. Lyons. Our protected relationship does not begin until: We both agree to enter into the relationship by signing this Services Contract, and Payment has been provided.

I have read and understand the above information and have asked any questions I have pertaining to it.

_____	_____	_____
Client Name (Print)	Date	Signature
_____	_____	_____
Parent / Guardian's Name (Print)	Date	Signature
_____	_____	
Deborah S. Lyons, Ph.D.	Date	

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