SUZANNE MARTIN, PSY.D.
License no. PS016195

OUTPATIENT SERVICES CONTRACT

PSYCHOLOGICAL SERVICES

Length of treatment and approach vary with each individual. Since therapy often involves discussing unpleasant aspects of your life, you may experience uncomfortable feelings. It also involves a commitment of time, money and energy. You should feel free to ask questions and should definitely let me know how you are feeling and what you think about the process as we go along.

FEES AND PAYMENT

My hourly fee is 170.00. Many people use insurance, but there is often a copayment or deductible, for which you are responsible. Please check with you plan before you start so you know how much sessions will cost you.

CANCELLATION POLICY

Because scheduling an appointment involves setting aside a time just for you, a minimum of 24 hours notice is required for cancelling a session. If you cancel with less than 24 hours notice you will be expected to pay for the session in full. Insurance does not pay this fee.

CONTACTING ME

I am often not immediately available by phone. I do frequently monitor my voicemail, and will make every effort to return your call as soon as possible, and within 24 hours barring weekends and holidays. If you are unable to reach me in an emergency and you are in danger, call 911 or go to your nearest emergency room.

CONFIDENTIALITY

In general, the privacy of all communications between a patient and a psychologist is protected by law, and I can only release information about you with your permission. But there are a few exceptions. If I have reason to believe that a child, elderly person or disabled person is being abused, I may be required to file a report with the appropriate state agency. If I have reason to believe that a patient is threatening serious bodily harm to someone, I may be required to take protective actions such as calling the police or notifying the person being threatened. If the patient is at risk of self harm, I may be obligated to seek hospitalization for him/her or to contact family members or others who can help keep the person safe. Your insurance company requires a diagnosis and may request other information. More information regarding your health information is included in the Pennsylvania Notice Form that you can find on my website. Your signature below indicates that you have read the Form and understand and agree to abide by its terms.

TELEPHONE AND ELECTRONIC CONTACT

Ordinary privacy precautions such as voicemail and secured computers are by no means foolproof; your confidentiality is always potentially compromised when communicating by phone or electronic devices. Your use of such means of communication with me constitutes implied consent for reciprocal use of electronic and phone communication.

Please sign below to acknowledge your informed consent to this agreement.

Patient Signature:_____Date:_____

Witness:_____Date:_____