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## Office Practices and Consent to Evaluation / Treatment Form

Welcome to my practice – I appreciate the opportunity to serve you as a psychologist. This document contains important information about my professional services and business policies. Please ask me if you have specific concerns or questions about this information.

Consent to Treatment: Our first few sessions will involve an evaluation of your needs, from which I will provide impressions of what our work will include and an initial treatment plan. Therapy is most beneficial when you are an active participant in determining the therapeutic process and goals. Psychotherapy has both risks and benefits. Usually people find psychotherapy helpful, although it can cause disappointing, unexpected, or negative results or outcomes. If you have concerns about your progress or any aspects of treatment, it is my hope that you will discuss this with me in person or in writing. You are free to terminate at any time, however, I hope you will discuss this prior to stopping. I can provide a referral to other providers if you choose to discontinue our work together. If we cannot resolve your complaints, or if you feel I have acted in an unprofessional manner, you may contact the State of Nevada Board of Psychological Examiners.

**Payment:** Payment for services rendered are due at the time of service, unless other clear arrangements are made with me. My fees are based on the service provided, as outlined in the financial information sheet, or as otherwise agreed.

I am willing to submit claims to your insurance provider(s). However, you are responsible for all services not covered by your provider. You are responsible for knowing what your insurance covers (i.e., type and amount of services) and may ask for assistance with this. Additional related information is on the financial information sheet

Appointment Cancellation: Appointments cancelled with less than 24 hours notice will be billed to you, at the rate of the normal office visit, since that the hour has been reserved for you. Insurance companies will not pay for a missed session. Since the cancellation policy applies regardless of the reason for your absence, consider calling me and using your session time over the phone if illness or weather prevents your presence in my office (note, however, that your insurance company will likely not cover telephone appointments). With sufficient notice, appointments can often be rescheduled. Please keep your appointment card for each session until after your appointment so we can easily resolve misunderstandings about scheduling; in the event we have different memories of the appointment time, the regular fee will be charged if you do not have your card.

**Telephone Contact and After-Hours Coverage**: To reach me by telephone, call (775) 786-1234. You may leave a confidential message if I am not available. I will return the call as soon as possible, although this may take more than 24 hours. Please state if you are calling about an urgent matter. If you are experiencing a crisis and I am not available, please contact an emergency service such as a hospital emergency room. When I am out of town or otherwise unavailable, a colleague will cover for me, as indicated on my voicemail message.

**Access to Records**: I keep written records of our sessions, as well as other correspondence. All records are kept for a minimum of seven years. In the event of your death, the privilege to access your record passes to your estate. If you request access to your records, we will discuss the best way to facilitate this. When more than one person is involved in the therapy, all participants must give permission to release records.

Confidentiality: Our discussions, as well as your record and testing material, are kept confidential. Information is never released to anyone, including your spouse/partner or family, without your written consent, except as required by law or ethical conduct as noted below:

- 1) I am required by law to report any suspicion of <u>abuse or neglect of children or vulnerable/elderly adults</u>.
- 2) If a threat of <u>physical harm is made against yourself or toward a specific person</u>, I will take steps to protect those in danger. This may include notifying law enforcement personnel and the intended victim, contacting a friend or relative, hospitalization, or referral for medication assessment.
- If you use <u>insurance coverage</u>, your insurance carrier has the right to inquire about your treatment, including the ability to review your chart or reports, which may include diagnostic and prognostic information. In filing an insurance claim, your future applications for health and life insurance might be negatively impacted.
- 4) If the <u>issue of your mental status is raised in a court of law</u>, the information in your case file can be subpoenaed and I can be compelled to testify about your treatment and your mental health. Examples of situations in which this might occur include: SIIS claim, competency hearing, insanity plea, child custody suit, being a witness or a defendant in a criminal case or law suit, or issues related to emotional damage or mental distress. I will not release information to the court without your permission (or the parent/guardian's permission) unless I am ordered to do so by a court order. If an individual who participated in couple or family therapy does not wish to release information to the court, I will again attempt to refrain from releasing information, unless ordered by the court.
- 5) Your records will be released if you file a <u>complaint with a professional licensing board</u>.
- 6) To provide the best possible treatment, <u>I regularly consult</u> with other professionals about my cases; no identifying information will be given in these consultations.
- 7) <u>All billing agents and report typists</u>, <u>as well as professionals who cover for me, are bound by this confidentiality agreement</u>.
- 8) <u>I make all efforts to protect your confidentiality when I call you</u>. If you have special instructions for how I leave a message, please let me know; otherwise, I usually state my name, Dr. Ribnick, and leave a brief message. I ask that you return the call as soon as possible.

I have read and understand the office practices, limits of confidentiality, and financial arrangements as described in this consent form.

(Each participant is to sign once below)

Printed Name	Signature	Date	
Printed Name	Signature	Date	
Printed Name	 Signature	Date	