Michael D. Smith, Psy.D, P.C.

Licensed Psychologist
A Professional Company
5277 Manhattan Circle, Suite 110
Boulder, Colorado 80303
(303) 424-8250

CONTRACT

Client Name: _____
First Middle Last
Address: _____

City: _____ State: _____ Zip: _____

Home Phone Number: _____ Work #: _____

Client Date of Birth: _____ Client Social Security #: _____

Name Party Responsible for Payment: _____

Responsible Party's Date of Birth: _____

Occupation: _____ Employer: _____

Social Security #: _____

Consent for Treatment and Statement of Financial Responsibility

- I voluntarily consent to participate in mental health treatment through Michael D. Smith, PsyD, P.C.

Initials_____

- I understand that I am responsible for payment of $200.00 for 50 minutes session, at the time services are rendered.

Initials_____

- I agree to give at least 24 hours' notice in the event that I need to cancel an appointment. If I fail to give such notice, I understand that I am responsible for full payment of the session ($200.00).

Initials_____

- I further understand that I am liable for charges in the event of a claim's denial. I agree to provide/ release any necessary forms or documentation to assist in settling my account.

Initials_____

- I understand that after-hours phone calls and third-party consultations including reports are charged at my standard hourly rate ($200.00 an hour) or prorated accordingly. There is a $25 minimum charge for these sessions.

Initials_____

- I understand that a delinquent account (over 30-days past due) will be charted interest of 1.5 percent (18 percent annual rate) thereafter until paid.

Initials_____

- I understand that fees charged by Dr. Michael D. Smith PsyD, PC for services rendered to me, or to the person(s) for whom I assume financial responsibility, may exceed the fees considered as “usual and customary or contracted rate” due to the specialized services provided. I, however, agree to pay fees in full, even if the amount is greater than what I am reimbursed from my insurance company.

Initials_____

MEETINGS

I normally conduct an evaluation that will last from 2 to 4 sessions either in person or via teletherapy. During this time, we can both decide if I am the best person to provide the services you need in order to meet your treatment goals. If we agree to begin psychotherapy, I will usually schedule one [50-minute] session (one appointment hour of [50] minutes duration) per week, at a time we agree on, although some sessions may be longer or more frequent. Once an appointment hour is scheduled, you will be expected to pay for it unless you provide 24 hours [days] advance notice of cancellation unless we both agree that you were unable to attend due to circumstances beyond your control. If it is possible, I will try to find another time to reschedule the appointment.

PROFESSIONAL FEES

My hourly fee is $200.00. If we meet more than the usual time, I will charge accordingly. In addition to weekly appointments, I charge this same hourly rate for other professional services you may need, though I will prorate the hourly cost if I work for periods of less than one hour. Other professional services include report writing, telephone conversations lasting longer than 5 minutes, attendance at meetings with other professionals you have authorized, preparation of treatment summaries, and the time spent performing any other service you may request of me. If you become involved in legal proceedings that require my participation, you will be expected to pay for any professional time I spend on your legal matter, even if the request comes from another party. [I charge $250.00 per hour for professional

services I am asked or required to perform in relation to your legal matter. I also charge a copying fee of $.50 per page for records requests.]

BILLING AND PAYMENTS

Due to the complex nature of treating children whose parents are divorced or in the process of litigating custody, **I cannot honor agreements for payment of my fee that are a part of your divorce decree**. By signing this treatment contract, you agree to payment of my fee at the time services are rendered or in accordance with a payment plan negotiated between us.

If your account has not been paid for more than 60 days and arrangements for payment have not been agreed upon, I have the option of using legal means to secure the payment. This may nvolve

hiring a collection agency or going through small claims court. [If such legal action is necessary, its costs will be included in the claim.] in most collection situations, the only information I wil release regarding a patient's treatment is his/her name, the dates, times, and nature of services provided, and the amount due.

CONTACTING ME

I am generally in my office Monday through Thursday and on Saturdays. When I am unavailable, my telephone is answered by voice mail, that I monitor frequently. I will make every effort to return your call within 24 hours of your call, with the exception of weekends and holidays. If you are difficult to reach, please inform me of some times when you will be available. [In emergencies, you can try me at my cell number.] if you are unable to reach me and feel that you cannot wait for me to return your call, contact your family physician or the nearest emergency room and ask for the psychologist [psychiatrist] on call. If I will be unavailable for an extended time, I will provide you with the name of a colleague to contact

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 our work to others with your written permission. But there are a few exceptions.

In most legal proceedings, you have the right to prevent me from providing any information about your treatment. In some legal proceedings, a judge may order my testimony if he/she determines that the issues demand it, and I must comply with that court order.

There are some situations in which I am legally obligated to take action to protect others from harm, even if I have to reveal some information about a patient's treatment. For example, if I believe that a child is being abused or has been abused, I must make a report to the appropriate state agency.

If I believe that a patient is threatening serious bodily harm to another, I am required to take protective actions. These actions may include notifying the potential victim, contacting the police, or seeking hospitalization for the patient. If the patient threatens to harm himself/herself, I may be obligated to seek hospitalization for him/her or to contact family members or others who can

help provide protection. If a similar situation occurs in the course of our work together, I will attempt to fully discuss it with you before taking any action.

I may occasionally find it helpful to consult other professionals about a case. During a consultation, I make every effort to avoid revealing the identity of my patient. The consultant is also legally bound to keep the information confidential. Ordinarily, I will not tell you about these consultations unless I believe that it is important to our work together.

Individual Parent/Guardian Communications with Me

In the course of our therapeutic work together, I may meet with your parents/guardians either separately or together. Please be aware, however, that, at all times, you are my patient – not your parents/guardians nor any siblings or other family members.
If I meet with your parent's or other family members in the course of your treatment, I will make notes of that meeting in your treatment records. Please be aware that those notes will be available to any person or entity that has legal access to your treatment record.

Mandatory Disclosures of Treatment Information

In 2017, Colorado House Bill 17-1320 lowered the age of consent to 12 years old, for minors to obtain counseling from a licensed psychotherapist without the consent of their parent or legal guardian. However, a minor may not refuse psychotherapy services when a mental health professional and the minor's parent or legal guardian agrees that psychotherapy is in the child's best interest. The age of consent not only refers to when a child may seek outpatient mental health services, it determines the age at which a child holds privilege to confidentiality over what is discussed in therapy and access to their mental health records.

Confidentiality cannot be maintained when:

- You tell me you plan to cause serious harm or death to yourself, and I believe you have the intent and ability to carry out this threat in the very near future. I must take steps to inform a parent or guardian or others of what the you have told me and how serious I believe this threat to be and to try to prevent the occurrence of such harm.
- You tell me you plan to cause serious harm or death to someone else, and I believe you have the intent and ability to carry out this threat in the very near future. In this situation, I must inform a parent or guardian or others, and I may be required to inform the person who is the target of the threatened harm [and the police].
- You are doing things that could cause serious harm yourself or someone else, even if you do not intend to harm themselves or another person. In these situations, I will need to use my professional judgment to decide whether a parent or guardian should be informed.
- You tell me, or I otherwise learn that, it appears that you are being neglected or abused--physically, sexually or emotionally--or that it appears that you have been neglected or abused in the past. In this situation, I am required by law to report the alleged abuse to the appropriate state child-protective agency.
- I am ordered by a court to disclose information.

Disclosure of Minor's Treatment Information to Parents

Therapy is most effective when a trusting relationship exists between the psychologist and the patient. Privacy is especially important in earning and keeping that trust. As a result, it is important for children to have a "zone of privacy" where children feel free to discuss personal matters without fear that their thoughts and feelings will be immediately communicated to their parents. This is particularly true for adolescents who are naturally developing a greater sense of independence and autonomy.

It is my policy to provide you with general information about your child's treatment, but NOT to share specific information your child has disclosed to me without your child's agreement. This includes activities and behavior that you would not approve of — or might be upset by — but that do not put your child at risk of serious and immediate harm. However, if your child's risk-taking behavior becomes more serious, then I will need to use my professional judgment to decide whether your child is in serious and immediate danger of harm. If I feel that your child is in such danger, I will communicate this information to you.

Even when we have agreed to keep your child's treatment information confidential from you, I may believe that it is important for you to know about a particular situation that is going on in your child's life. In these situations, I will encourage your child to tell you, and I will help your child find the best way to do so. Also, when meeting with you, I may sometimes describe your child's problems in general terms, without using specifics, in order to help you know how to be more helpful to your child.

Disclosure of Minor's Treatment Records to Parents

Colorado statute 12-45-203.5 states that, "A minor who is fifteen years of age or older may consent to receive mental health services…When a minor consents for their own health care, the HIPAA Privacy rule states that a parent or guardian's right to inspect the related medical records depends on state and other federal law. 45 C.F.R. § 164.502(g)(3)(ii). If there is nothing in state or other law, including case law, specifying whether or not a parent may have access to the information, a health care provider may provide or deny access to a parent or guardian as long as that decision is consistent with state or local law, and the decision is made by a licensed health care professional exercising his or her professional judgment. 45 C.F.R. §§ 164.502(a)(1)(i)&(iv); (a)(2)(i); (g)(1); (g)(3)(i); (g)(5)."

As a parent, the right to see any written records I keep about your child's treatment, is governed by the aforementioned statues, by signing this agreement, you are agreeing that your child or teen should have a "zone of privacy" in their meetings with me, and you agree not to request access.

Child/Adolescent Patient:

By signing below, you show that you have read and understood the policies described above. If you have any questions as we progress with therapy, you can ask me at any time.

Minor's Signature* _____

Date_____

Parent/Guardian of Minor Patient:

Please initial after each line and sign below, indicating your agreement to respect your child's privacy:

I will refrain from requesting detailed information about individual therapy sessions with my child. I understand that I will be provided with periodic updates about general progress, and/or may be asked to participate in therapy sessions as needed. _____ _____

Although I may have the legal right to request written records/session notes since my child is a minor, I agree NOT to request these records in order to respect the confidentiality of my child's/adolescent's treatment. _____ _____

I understand that I will be informed about situations that could endanger my child. I know this decision to breach confidentiality in these circumstances is up to the therapist's professional judgment, unless otherwise noted above. _____ _____

Parent/Guardian Signature _____ Date_____

Parent/Guardian Signature _____ Date_____