Anchor Psychology, Inc.
1975 Hamilton Ave.
Suites 11 & 37
San Jose, CA 95125

main: 408.340.5875
anchorpsychology.net

OUTPATIENT SERVICES CONTRACT

Welcome to Anchor Psychology, Inc. This document contains important information about our professional services and business policies. Please read it carefully and jot down any questions you might have so that we can discuss them at our next meeting. When you sign this document, it will represent an agreement between us.

We are very happy you have chosen to be part of our practice. It is our desire to create a relaxing environment for you with many levels of care to offer. Our team includes a variety of personalities and specialties to help you and your loved ones achieve personal growth. We will work with you to develop goals and collaborate with you in order to achieve your goals of wellness.

PSYCHOTHERAPY SERVICES

Psychotherapy is not easily described in general statements. It varies depending on the personalities of the therapist and client, and the particular problems you bring forward. There are many different methods we may use to deal with the problems that you hope to address. Psychotherapy is not like a medical doctor visit. Instead, it calls for a very active effort on your part. In order for the therapy to be most successful, you will have to work on things we talk about both during our sessions and at home. Initial here: _____________

Psychotherapy can have benefits and risks. Since therapy often involves discussing unpleasant aspects of your life, you may experience uncomfortable feelings like sadness, guilt, anger, frustration, loneliness, and helplessness. On the other hand, psychotherapy has also been shown to have benefits for people who go through it. Therapy often leads to better relationships, solutions to specific problems, and significant reductions in feelings of distress. But there are no guarantees of what you will experience. Initial here: _______

Our first few sessions will involve an evaluation of your needs. By the end of the evaluation, we will be able to offer you some first impressions of what our work will include and a treatment plan to follow, if you decide to continue with therapy. You should evaluate this information along with your own opinions of whether you feel comfortable working with us. Therapy involves a large commitment of time, money, and energy, so you should be very careful about the therapist you select. If you have questions about our procedures, we should discuss them whenever they arise. If your doubts persist, we will be happy to provide you with three referrals. Initial here: _______

MEETINGS

We normally conduct an evaluation that will last from 2 to 4 sessions. During this time, we can both decide if Anchor Psychology, Inc. is the best place to provide the services you need in order to meet your treatment goals. Once psychotherapy has begun, we 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-

hour advanced-notice of cancellation; unless, we both agree that you were unable to attend due to circumstances beyond your control. Initial here: ________

PROFESSIONAL FEES

Our hourly fee is $ _________. Initial here: _______

In addition to weekly appointments, we charge the above hourly fee for other professional services you may need. Other services include report writing, telephone conversations, email and text correspondence, care coordination, attendance at meetings with other professionals you have authorized, preparation of records or treatment summaries, and the time spent performing any other service you may request of us. Initial here: ____________

If you become involved in legal proceedings that require our participation, you will be expected to pay for our professional time even if we are called to testify by another party (i.e., court-ordered). Because of the difficulty of legal involvement, we charge $250 per hour for preparation and attendance at any legal proceeding. Initial here: __________

PHONE, EMAIL, AND TEXTING FEES

All phone calls, exceeding five (5) minutes, will be billed at minimum of one-quarter of an hour (15-minute increments), at one-quarter of your hourly rate. For example, if you speak to your therapist for 15 minutes and your hourly rate is $160.00, you will be charged $40.00; if you speak to your therapist for 20 minutes, at the same hourly rate of $160.00, you will be charged $80.00. Initial here: __________

Each text message and/or email received by your therapist will be billed at $10.00 each. For example, if you send a text to your therapist, your therapist then responds, and you reply to the response, you will be charged $20.00. This fee will be charged at the end of each week. There are two exceptions to this rule: (1) You may text and/or email in the event of an emergency; (2) You may text and/or email to schedule/reschedule an appointment.
Initial here: ________

BILLING AND PAYMENTS

You will be expected to pay for each session at the time it is held. We accept cash, checks, and credit cards. We will be happy to store your credit card number for future payments.
Initial here: ________

In your intake folder, there is a Statement Request Form that you must fill out, in order to begin receiving statements. You may then submit these to your insurance provider, to attempt to receive out-of-network reimbursement. You will receive hard copies of your statements, should you choose this complimentary service. Initial here: ________

If you have gone three (3) sessions without payment, we will stop sessions and work with you to bring your balance to zero. If your account has not been paid for more than 60 days, and arrangements for payment have not been agreed upon, we have the option of using legal means to secure the payment. This may involve 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 we release regarding a client's treatment is his/her name, the nature of services provided, and the amount due. Initial here: _________

CONTACTING ME

We are often not immediately available by telephone. When we are unavailable, we monitor our voicemail frequently. We will make every effort to return your call on the same day you make it, with the exception of weekends and holidays. If you are difficult to reach, please inform us of some times when you will be available. If you are unable to reach us and feel that you can't wait for us to return your call, contact your family physician or the nearest emergency room and ask for the psychologist on call. If we will be unavailable for an extended time, we will provide you with the name of a colleague to contact, if necessary. Initial here: ____________

PROFESSIONAL RECORDS

The laws and standards of our profession require that we keep treatment records. You are entitled to receive a copy of the records, unless we believe that seeing them would be emotionally damaging, in which case we will be happy to send them to a mental health professional of your choice. Because these are professional records, they can be misinterpreted and/or upsetting to untrained readers. We recommend that you review them in our presence so that we can discuss the contents. Clients will be charged an appropriate fee for any time spent on preparing information requests (see above Professional Fees).
Initial here: _________

MINORS

If you are under eighteen (18) years of age, please be aware that the law may provide your parents the right to examine your treatment records. It is our policy to request an agreement from parents that they agree to give up access to your records. If they agree, we will provide them only with general information about our work together, unless we feel there is a considerable risk that you will seriously harm yourself or someone else. In this case, we will notify them of our concern. We will also provide them with a summary of your treatment when it is complete. Before giving them any information, we will discuss the matter with you, if possible, and do our best to handle any objections you may have with what we are prepared to discuss. Initial here: ________

CONFIDENTIALITY

In general, the privacy of all communications between a client and a therapist is protected by law, and we can only release information about our work to others with your written permission. But there are a few exceptions.

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In most legal proceedings, you have the right to prevent us from providing any information about your treatment. In some proceedings involving child custody, and those in which your emotional condition is a prominent issue, a judge may order our testimony (i.e., court-ordered) if he/she determines that the issues demand it. Initial here: ___________

There are some situations in which we are legally obligated to take action to protect others from harm, even if we have to reveal some information about a client's treatment. For example, if we believe that a child, elderly person, or disabled person is being abused, we must report it to the appropriate state agency. Initial here: ________

If we believe that a client is threatening serious bodily harm to another, we are required to take protective actions. These actions may include notifying the potential victim, contacting the police, or seeking hospitalization for the client. If the client threatens to harm himself/herself, we may be obligated to seek hospitalization for him/her or to contact family members or others who can help provide protection. Initial here: ___________

These situations have rarely occurred in our practice; however, in the event they do, we will make every effort to fully discuss it with you before taking any action. Initial here: ________

We may occasionally find it helpful to consult other professionals about a case. During a consultation, we make every effort to avoid revealing the identity of our clients. The consultant is also legally bound to keep the information confidential. If you don't object, we will not tell you about these consultations unless we feel that it is important to our work together.
Initial here: ________

We will be happy to discuss any questions that you may have regarding confidentiality or any other concerns.

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PRIVACY POLICY

In accordance with Health Insurance Portability and Accountability Act (HIPAA), this policy describes how information about you may be used and disclosed, and how you may get access to this information. Please read it carefully.

Privacy and Confidentiality

Therapists have always managed psychological records with great concern for privacy and confidentiality. Although the security of psychological records has continuously been addressed by Psychology Codes of Ethics as well as State and Federal laws, the rules have been considerably strengthened by the provisions of the Health Insurance Portability and Accountability Act (HIPAA). The following information provides details about the provisions of HIPAA and your rights concerning privacy and your psychological records.

Who will observe these rules?

The following individuals are required by HIPAA to comply with the privacy rules:

- Your treating therapist.
- Any administrative assistant or office staff.
- Any billing agency or collection agency that handles information about you (name, address, diagnostic codes, treatment codes, consultation dates, but not actual clinical records).

Your Rights:

The right to inspect and obtain a copy of your records:

Professional records constitute an important part of the therapy process and help with the continuity of care over time. According to the rules of HIPAA, your consultations are documented in two ways:

1) The *clinical record* (required) may include the date of your consultations, your reasons for seeking therapy, diagnosis, therapeutic goals, treatment plan, progress, medical and social history, treatment history, functional status, any past records from other providers, as well as any reports to your insurance carrier.

You have the right to inspect and obtain a copy of your *clinical record*. Viewing the record is best done during a professional consultation, in order to clarify any questions that you might have at the time. You may be charged a nominal fee for accessing and photocopying the record.

2) *Psychotherapy notes* (optional), consisting of the specific content or analyses of therapy conversations, how they impact the therapy (including sensitive information that you may reveal that is not required to be

included in your clinical record), and notes of your therapist that may assist in treatment. Psychotherapy notes are kept separately from your clinical record, in order to maximize privacy and security.

Psychotherapy notes, however, if they are created, are not disclosed to third parties, HMOs, insurance companies, billing agencies, clients, or anyone else. They are for the use of a treating therapist in tracking the many details of the sessions that are far too specific to be entered into the clinical record.

The right to request a correction or addendum to your psychological record

If you believe that there is an inaccuracy in your clinical record you may request a correction. If the information is accurate, however, or if it has been provided by a third party (e.g., previous therapist, primary care physician, etc.), it may remain unchanged, and the request may be denied. In this case, you will receive an explanation in writing with a full description of the rationale. You also have the right to make an addition to your record if you think it is incomplete.

The right to an accounting of disclosures of your psychological information to third parties

You have the right to know if, when, and to whom your psychological information has been disclosed (except for purposes of carrying out treatment, payment, and health care operations). However, you likely would already be aware of this, as you would have signed consent forms allowing such disclosures (e.g., disclosures to other psychotherapists, primary care physicians, specialists, etc.). This accounting must extend back for a period of seven years.

The right to request restrictions on how your information is used

You have the right to request restrictions on certain uses or disclosures of your psychological information. These requests must be in writing. These requests will most likely be honored, although in some cases they may be denied. This office does not use or release your protected health information for marketing purposes or any other purpose aside from treatment, payment, healthcare operations, and other exceptions specified in this notice.

The right to request confidential communications

You have the right to request that your therapist communicates with you about your treatment in a certain way or at a certain location. For example, you may prefer to be contacted at work instead of at home to schedule or cancel an appointment, or you may wish to receive billing statements at a post office box rather than your home address.

The right to receive a copy of this notice upon request

You have the right to have a copy of this Privacy Policy.

The right to file a complaint

You have the right to file a complaint if you believe your privacy rights have been violated. You must do so in writing. Your complaint may be addressed directly to your therapist or to the Secretary of the Department of Health and Human Services. If you have any questions or concerns about this notice or this health information privacy policy, please contact your therapist at the phone number printed on this policy.

How Your Therapist May Use and Disclose Psychological Information about You

For treatment

Your therapist may use psychological information about you to assist in the continuity of treatment and services. This information will not be shared with other health care professionals, however, unless you specifically request or agree to it and sign a consent form to that effect.

For payment

Your therapist may use and disclose psychological information about you for billing purposes. This is generally restricted to your name and other personal identifiers (e.g., address, and other relevant information such as social security number or other needed information), diagnostic and treatment codes, dates of services, and similar information.

For health care operations

Your therapist may share basic identifying information with other office staff to assist in scheduling or other treatment procedures. This would not normally include the contents of your psychological record.

As required by law

It is possible (but unlikely) that the Department of Health and Human Services may review how I comply with the regulations of HIPAA. In such a case, your personal health information could be revealed as a part of providing evidence of compliance.

Therapist agreeing to appear in court. Yes_____ No_____

Business associates

Your therapist may contract with a billing agency or attorneys to attend to business aspects on an as-needed basis. In this case, there will be a written contract in place with the agency requiring that it maintain the security of your information, in compliance with the rules of HIPAA.

Changes to this Notice

Please note that this privacy policy may be revised from time to time. You will be notified of changes in the laws concerning privacy or your rights as your therapist becomes aware of them. If at any time you have questions regarding this information, please contact your therapist.

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CANCELLATION POLICY

Dear valued client,

As our appointment schedules become increasingly full, it has become even more important that our clients provide at least 24-hours' notice before missing an appointment. In order to reduce scheduling problems and to allow all clients the best availability of appointment times, we will be enforcing the following cancellation policy:

Each client will be required to pay the full session fee for any missed appointments, where notice has not been given 24 hours before the appointment time. This fee will be due at the session following the missed appointment, without exception. Of course, we understand that on rare occasions, emergencies arise and we will consider waiving the fee in such instances. Please be aware that the fee applies to all clients and you should be aware that the majority of insurers will not reimburse for missed appointments.

Thank you for your understanding and cooperation.

Anchor Psychology, Inc.

I agree to pay the full session fee specified in the "Professional Fees" section of this contract, for any appointment that I miss and do not give at least 24-hours' advance-notice.

Your signature below indicates that you have read the information in this document and agree to abide by its terms during our professional relationship.

Client/Parent signature: ______________________________________ Date: __________

Client name (print): ____

Clinician signature: ____ Date: ___________

Clinician name (print): ______________________________________

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BIOGRAPHICAL INFORMATION (MINOR & YOUNG ADULT)

Please fill out this biographical background form for yourself as completely as possible. It will help me in our work together. Information is confidential as outlined in the Outpatient Services Contract. You might decide to discuss some of the information requested in this form in person rather than providing a written response. If you do not desire to answer any question, merely write, "**Do not care to answer**." If you are pressed for time, please complete as much information as possible.

Date: ________________________________

IDENTIFYING INFORMATION

Name of Parent Completing this Form: ____

Name of Other Parent: ____

Name of Minor: ____

Date of Birth: ____ Age: __________________________

Gender: ☐ Male ☐ Female ☐ Other: ______________________________________

Preferred Pronouns: ☐ He/His/Him ☐ She/Her/Hers ☐ They/Them/Theirs ☐ Other: _______________

Parents are: ☐ Married ☐ Separated ☐ Divorced ☐ Other: ____________________________

Minor currently lives with: ____

Visitation Schedule if Divorced/Separated: ____

Address: ____
____
____

Phone #: ____

E-Mail: ____

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REASONS FOR SEEKING THERAPY

1. Presenting Problem (Be as specific as you can: When did it start? How is it affecting your daily functioning?): ______________________________

____

____

____

2. Estimate the severity of above problem: ☐ Mild ☐ Moderate ☐ Severe ☐ Very Severe

3. What have you tried so far to correct/manage the problem(s)? ______________________________

____

____

____

4. Please list all previous counseling treatment.

Dates	# of Sessions	Therapist	Problem Treated & Diagnoses	Reason for Termination

5. Have you ever been evaluated by a psychiatrist or tested by a psychologist? Please list:

Dates	# of Sessions	Therapist	Problem Treated & Diagnoses	Reason for Termination

6. Have you ever sought counseling for your personal/marital life? Please list:

Dates	# of Sessions	Therapist	Problem Treated & Diagnoses	Reason for Termination

7. Have you or your child ever been hospitalized for emotional reasons? If YES, please explain. ______________

____

____

____

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8. Please list any developmental, emotional, learning or psychiatric diagnosis (along with the date when the diagnosis was given) that your child/teen has received in the past: ______________________________

____
____
____

9. Has your child/teen ever seen an occupational or physical therapist? If so, please include diagnoses.

____
____
____

10. Does your child/teen suffer from any recurring pains and/or medical problems? If so, please describe.

____
____
____

11. Please list any additional stressful/traumatic circumstances that have affected or are currently affecting your child/teen:

Relational Problems: ______________________________
Financial Problems: ______________________________
Legal Problems: ______________________________
Educational Problems: ______________________________
Housing Problems: ______________________________
Physical Abuse: ______________________________
Sexual Abuse: ______________________________
Domestic Violence: ______________________________
Medical Trauma/Problems: ______________________________
Other: ______________________________

12. How have you handled them up to now? ______________________________

____
____
____

13. Which of the aforementioned would you like help with? ______________________________

____
____
____

14. What areas of your child's/teen's life do you feel are affected by these problems? Please describe.

Home: ____________________
School: ____________________
Health: ____________________
Relationships: ____________________
Family Life: ____________________
Other: ____________________

15. Describe any changes in your child's/teen's:

Energy: ____________________
Sleep: ____________________
Appetite: ____________________
Other: ____________________

16. Has your child/teen ever had thoughts of harming another person? ____ YES ____ NO

If YES, describe when and how. ____________________

____

____

17. Has your child/teen ever had thoughts of harming his/herself? ____ YES ____ NO

If YES, describe when and how. ____________________

____

____

CURRENT LIVING SITUATION

18. Please list all the people you currently live with:

Name	Relationship	Age	Occupation	Employer/School

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19. PARENTS' PRESENT and/or PAST MARRIAGE(S)

Number of mother's previous marriages? _________
Name of Mother's Partner(s): ______________________________
Dates/Years: ______________________________
Nature of Relationship (i.e., friendly, distant, physically/emotionally abusive, loving, hostile): _______________
____
____
____

Number of father's previous marriages? __________
Name of Father's Partner(s): ______________________________
Dates/Years: ______________________________
Nature of Relationship (i.e., friendly, distant, physically/emotionally abusive, loving, hostile): _______________
____
____
____

20. Siblings (If passed, provide age/year and cause of death).:

Name	Age	Nature of Relationship (i.e., friendly, distant, physically/emotionally abusive, loving, hostile):

MEDICAL HISTORY

21. Medical Doctor(s) (name and phone): ______________________________
____

22. When was your child's/teen's last medical exam? ______________________________
Doctor's Name: ______________________________
Reason seen: ______________________________
____
____

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23. Past/Present Medical Care (major medical problems, surgeries, accidents, falls, head injuries, illness):

____
____
____

24. List medications your child/teen is currently taking or took in the past.

Medication	Dosage	Dates Taken	Reason

25. Family medical history (Describe any illness that runs in the family – i.e., cancer, epilepsy, etc.): __________

____
____
____

ALCOHOL/DRUG USE HISTORY

26. Your child's/teen's current alcohol and drug consumption (please check appropriate answers):

Usual Alcohol Consumption: ☐ None ☐ 1-2 drinks per sitting ☐ 3-4 drinks per sitting ☐ 5+ drinks per sitting

Frequency of Alcohol Consumption: ☐ Never ☐ 1 time/month ☐ 1 time/week ☐ 2-3 times/week ☐ Daily

Frequency of Intoxication: ☐ Never ☐ 1 time/month ☐ 1 time/week ☐ 2-3 times/week ☐ Daily

Frequency of Drug Use: ☐ Never ☐ 1 time/month ☐ 1 time/week ☐ 2-3 times/week ☐ Daily

27. Have you or anyone else had concern about your child's/teen's drinking or drug use? If YES, who and why?

____
____
____
____

28. Is your child/teen currently in a relationship with someone who uses alcohol/drugs? If YES, who and what do they use? ____

____

____

____

29. Does or did anyone in your child's/teen's family of origin (or significant person in her/his life) abuse alcohol and/or drugs? If YES, please state the relationship, drug, and pattern of use. ____________

____

____

____

FAMILY HISTORY

30. Is there history of the following? If YES, please describe who and helpful details.

Suicide	□ NO	□ YES	
Depression	□ NO	□ YES	
Psychiatric Problems	□ NO	□ YES	
Violence	□ NO	□ YES	
Alcohol/Drug Use	□ NO	□ YES	

31. Please list anyone that has died who was close to your child/teen and its impact on her/him. ________

____

____

____

32. If you are divorced or separated, what was your child's/teen's age at the time? Describe its impact on her/him: ____

____

____

____

CLINICAL & RISK ASSESSMENT

33. Areas of Clinical Concern: Please rate your level of concern regarding the following conditions:

	No Concern	Some Concern	Very Concerned	Elaborate if needed.
Depression				
Anxiety				
Impulsivity				
Hyperactivity				
Defiance				
Lack of Empathy				
Anger Control				
Suicide Risk				
Self-Mutilation				
Other Self-Harm				
Danger to Others				
Sexual Aggression				
Runaway				
Delinquency				

34. Usage of Technology: Please state your perception of your child's/teen's level of usage of the following:

	Low	Average	Excessive
Social Media			
Video Games			
Texting			
General Internet Use			
Television			

PERSONAL AND PROFESSIONAL INFORMATION

35. School Details: Provide the grade level your child/teen is in, as well as the name of the school they are attending. ____

____

____

____

36. Friendships, Community, Social Support and Spirituality: Describe quality, frequency, activities, etc. ___

____

____

____

37. Are you (or your child/teen) involved in any current or pending civil or criminal litigations, lawsuits, and/or divorce or custody disputes? If yes, please explain. ______________________________________

____

____

____

38. What are your main worries and fears with respect to your child/teen? _______________________

____

____

____

39. What do you want for your child's/teen's future? ______________________________________

____

____

____

40. Please add any other information you would like me to know about your child/teen and your family in terms of the past or a present situation. ______________________________________

____

____

____

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Additional Fees

Client Initials:	Policy:
____________________	**Phone calls:** Any call over five (5) minutes will be billed in 15-minute increments, at your rate (i.e., if your individual rate is $160 and the call is 17 minutes, you will be charged $80).
____________________	**Text messages:** Each text, unrelated to scheduling, will be billed at $10 per text. If your text exceeds 40 words, you will be charged an additional $10. If you try to use scheduling as a blanket to relay additional information that is not related to scheduling, you will be charged as outlined above.
____________________	**Emails:** Each email, unrelated to scheduling, will be billed at $20 per email, as well as $20 per response. If you try to use scheduling as a blanket to relay additional information that is not related to scheduling, you will be charged as outlined above.
____________________	**Repeat requests for statements:** If you request additional copies of your statements (once they've been provided) or if you ask for a different format of your statements, you will be charged $50 per copy, per statement (i.e., if you ask for your statement and your child's statement to be amended, you will charged a total of $100 per copy).
____________________	**Court appearances:** You will be charged a minimum of $500 per day, to be paid prior to the court date. This rate may vary, depending on the location of the courthouse and the amount of time spent in the courtroom.

Client/Parent signature: ____ Date: ____________

Client name (print): ____

Clinician signature: ____ Date: ____________

Clinician name (print): ____

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CREDIT CARD AUTHORIZATION FORM

Please complete all fields. You may cancel this authorization at any time by contacting us. This authorization will remain in effect until cancelled.

Client: ____

Credit Card Information

Card Type:

☐ VISA ☐ MasterCard ☐ Discover

☐ AMEX ☐ Other: ________________________

Cardholder Name (as shown on card): ______________________________

Card Number: ______________________________________

Expiration Date (mm/yy): ____________________ **Security Code:** ________

Billing Address: ____

____

____

I, ______________________________, authorize ______________________ to charge my credit card above for agreed upon services/purchases. I understand that my information will be saved to file for future transactions on my account.

Client/Parent/Guardian Signature: ______________________________

Client/Parent/Guardian Name (printed): __________________________

Date: ______________

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AUTHORIZATION FOR RELEASE OF INFORMATION

Client name: ____ Date of Birth: ________________

Client Address: ____

Social Security #: ____- ___-_______

Parent/Guardian name (if client is a minor): ____

By my signature below, I hereby authorize the person(s) indicated below to exchange information with Anchor Psychology, Inc., regarding me or my child for purposes related to treatment. I authorize Anchor Psychology, Inc. to release clinical records and information pertaining to my mental health history, treatment, and services to the person(s) indicated below.

Name(s): ____

Organization: ____

Address: ____

____

Phone Number: ____

Fax Number: ____

I understand that this authorization will become effective immediately and will remain in effect until termination of therapy with Anchor Psychology, Inc., unless I request otherwise. I understand that I may withdraw this consent at any time. If withdrawn, I understand that Anchor Psychology, Inc. may not further use or disclose my clinical information, unless another authorization is obtained from me or unless such use or disclosure is specifically required or permitted by law.

Client/Parent/Guardian Signature: ____

Client/Parent/Guardian Name (printed): _______________________________________

Date: _____________