Pacific Sunrise Psychological Services
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CONSENT FOR TREATMENT

Welcome to my practice. This document contains important information about my professional services and business policies. Please read it carefully and let me know if you have any questions during our next meeting. When you sign this document, it will represent an agreement between us.

PSYCHOLOGICAL SERVICES

As a client in psychotherapy, you have rights and responsibilities that are important for you to understand. There are also legal limitations to those rights of which you should be aware. I, as your mental health provider, have responsibilities to uphold and rights to you as well. These will be described in the following paragraphs. You have the right to receive understandable explanations regarding the mental health assessment, treatment, interventions, and/or diagnostic procedures used by your mental health professional during the course of care. The purposes and procedures will be explained to you upon your request. You also have the right to refuse treatment and procedures used by your treatment provider at any time. You may terminate treatment at any time without consequence. Additionally, you may request to be transferred to another provider without consequence.

There are inherent risks and benefits of participating in psychotherapy. You understand that while the course of therapy is designed to be helpful and lead to change, it may at times be difficult and uncomfortable. Risks may include experiencing uncomfortable feelings, exploring painful events and memories, and progressing through challenging activities and interventions. You agree to inform your provider immediately of any increases in symptoms as well as any thoughts of hurting yourself or someone else. You authorize your provider to contact emergency services and/or your emergency contact in the case of an immediate crisis when it is in the best interest of your health. Psychotherapy has been found to have many benefits, such as reduction in feelings of distress, increased life satisfaction, increased relationship satisfaction, greater personal awareness or insight, and increased skills for managing stress and conflict resolution. There are no guarantees these changes will occur. Psychotherapy is a very active and collaborative process, and requires your participation and dedication to making change in your life and self. You understand that therapy is a joint effort between the psychologist and the client, the results of which cannot be guaranteed. If at any point you are dissatisfied with your treatment, you are encouraged to discuss these feelings with your therapist so that treatment may be changed or altered to best fit your wishes and treatment aims.

Our first few sessions will involve an evaluation of your needs. This is an important part of the therapy process for several reasons. You will have a good sense of our "fit" after our initial meeting(s). Research shows that the "fit" of psychologist and patient is one of the most important factors associated with positive outcomes of psychotherapy. Also, by the end of the initial evaluation, I 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. My approach to therapy, and its length, will depend on your particular needs and goals. Therapy involves a large commitment of time, money, and energy, so you should be very selective with the therapist you choose. If you have any questions about the course of your treatment, we should discuss them whenever they arise.

CONFIDENTIALITY

The privacy and confidentiality of our sessions is extremely important, and is protected by federal and state laws, and by the American Psychological Association's professional standards and ethics. To the degree allowed by law, your provider will speak with no one about you or your treatment without your written consent. If you would like your therapist to talk with someone, you may complete a Release of Information form. There are several specific exceptions to confidentiality, including situations in which:

1) The client presents an immediate physical danger to self.
2) The client presents an immediate physical danger to others.
3) Abuse or neglect of a child, elder person, or disabled person is suspected.
4) A report of sexual misconduct by a licensed mental health professional is made.

Your mental health provider is required by law to contact legal authorities, medical facilities to coordinate hospitalization, and/or the appropriate licensing board if any of these is reported to them. Your therapist will communicate as fully with you as possible about any actions that must be taken. In addition to the above situations, medical records may be subject to subpoena by a court of law. In this case, your therapist will make every attempt to maintain your confidentiality. The law also allows your provider to release information to an insurance company or auditor, as well as to a collection agency in order to collect on an overdue account. While this written summary of limits to confidentiality is intended to help inform you about potential issues, it is important that we discuss any questions or concerns that you may have at our next meeting.

Protecting your privacy is important, as well as the privacy of other patients in shared office areas such as the waiting room. Please be respectful of maintaining the privacy of others in these situations.

PARTIES TO THE PROFESSIONAL RELATIONSHIP

The professionals in this suite of offices share only the physical facilities. Each of our practices is separate and independent from one another. Therefore, this agreement is entirely between you and Kristi L. Mueller, Psy.D., a licensed clinical psychologist practicing independently.

PROFESSIONAL FEES

My hourly fee is $200 plus applicable Hawaii State General Excise Tax of 4.712%. In addition to therapy appointments, I charge this amount for other professional services you may need, billed per quarter hour of work performed. These fees are likely not covered by your Health Insurance so I will discuss this with you prior to conducting any such service.

BILLING AND PAYMENTS

You will be expected to pay for each session at the time it is held. If you have insurance, your copay is due at the time of your session. Payment schedules for other professional services will be agreed to when they are requested. You will be charged a $25.00 processing fee for any check returned to me unpaid. This fee is not covered by insurance. 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.

INSURANCE REIMBURSEMENT

In order for us to set realistic treatment goals and priorities, it is important to evaluate what resources you have available to pay for your treatment. If you have a health insurance policy, it will usually provide some coverage for mental health treatment. I will fill out forms and provide you with whatever assistance I can in helping you receive the benefits to which you are entitled; however, you (not your insurance company) are responsible for full payment of my fees. It is very important that you find out exactly what mental health services your insurance policy covers. Insurance benefits have increasingly become more complex. It is sometimes difficult to determine exactly how much mental health coverage is available.

You should be aware that most insurance companies require you to authorize your providers (such as Dr. Mueller) to provide them with a clinical diagnosis. Sometimes additional clinical information such as treatment plans or summaries, or copies of the entire record (in rare cases) may also be necessary. Once your medical information leaves my office, I do not have control over what the insurance company does with it.

Once we have all of the information about your insurance coverage, we will discuss what we can expect to accomplish with the benefits that are available and what will happen if they run out before you feel ready to end our sessions. It is important to remember that you always have the right to pay for services yourself to avoid the potential problems described above.

CONTACTING ME

My usual business hours are Mondays through Fridays between 9 AM and 6 PM. I am often not immediately available by telephone. I will not answer the phone when I am with a patient. When I am unavailable, you can leave a voice mail that I monitor frequently. I will make every effort to return your call on the same day you make it. If you are difficult to reach, please inform me of some times when you will be available. I cannot respond to emergencies on the phone. If you are unable to reach me and you feel that you can't wait for me to return your call, you must call 911 or go to the nearest emergency room and ask for the psychologist or psychiatrist on-call. You may also contact the 24-hour Crisis Hotline at (808) 832-3100.

NO-SHOW / CANCELLATIONS

I value your time, and I ask that you do the same for me and the other clients who receive services from me. I require at least 24-hour notice for all cancellations or re-scheduling requests. You will be charged a fee of $100 if you do not cancel your appointment in a timely manner or if you do not show up for them, with only rare exceptions (e.g., hospitalization). I realize that sometimes clients have a last minute emergency, so I will consider these on a case-by-case basis. Unlike other doctor's offices where you may be waiting for up to an hour or more for an appointment, that does not happen in my practice. Each patient has a scheduled appointment time that no other patient is scheduled into. This means when a patient late cancels or no-shows, I am unable to see another patient in that time slot. If you are having scheduling challenges, please discuss this with me. I will do my best to work with you to make your treatment program work for you.

By signing below, I am indicating that I have read and understand the informed consent statement above, and that any questions I have about this document and/or the therapy process have been answered to my satisfaction. I am hereby agreeing to enter into a professional therapeutic relationship with Kristi Mueller, Psy.D. and I will be responsible for the payment of all professional fees.

_____

Client signature

_____ _____

Printed Full name of Client (please print) Date

_____ _____

Kristi L. Mueller, Psy.D. Date