Amanda DeVillez, PsyD, PLLC

Licensed Psychologist NV# PY0826, CA# 32760

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Client Communication Agreement

I give permission for the Psychologist to communicate with me via the following methods: (check **YES** or **NO** below)

Yes	No	Method of Communication
		Email (Address):
		Cell Phone:
		Home Phone:
		Work Phone:
		Leave a message on my answering machine
		Leave a message on my cell phone or work phone
		Other: ____

____
Client Name (print)

_______________________________ ______________
Client Signature (sign) Date

____
Legal Guardian/Parent Name (print)

_______________________________ ______________
Legal Guardian/Parent Signature (sign) Date

INITIAL INFORMATION FORM

If completing this form for someone else, please use the indicated client information and identify yourself on the signature page.

Identifying Information- Please Print Legibly

Client Name:____

Date of Birth:________

Age: ______ Gender: ☐ Male ☐ Female Race/Ethnicity:_______ ____

Phone Number: ____________________

Street Address: ____

City: ______________________________State: _________________Zip code: ________

Employment: ☐ Full-time ☐ Part-time ☐ Not employed

Place of Employment: ________________________________

Job Title: ____

Appointments and Fee Schedule

When you make an appointment with Psychologist, you are reserving that specific time for yourself or your child. Please understand that if you are late for your session, the session will end on the initial scheduled time. If you cancel your appointment with more than 24-hour notice, this will allow time to schedule an appointment with another client and you will not be charged for the appointment. If you cancel with less than a 24-hour notice, you will be responsible for paying a missed appointment fee, unless it's due to a medical emergency, before your next session will be conducted. **All late cancellations and missed appointments will result in a cancellation fee equal to the cost of the scheduled appointment.**

The fee for the initial clinical intake session for therapy services is $200.00. The fee for individual therapy (40 – 50 minutes in length) is $200.00. Psychological testing/assessment fees vary according to the level of service needed. All fee payments and/or insurance copayments are due at the start of each session or they may be billed to the client, if prior arrangements have been made. The office accepts cash, checks, and credit/debit cards.

I have read this document and agree to the policies and procedures written herein.

________________________________ ____________________________ _______________

Client Name (please print/type clearly) Signature Date

________________________________ ____________________________ _______________

Parent/Guardian Name (if client is a minor) Signature Date

OUTPATIENT SERVICES CONTRACT

This document contains important information about my 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.

PSYCHOLOGICAL EVALUATION SERVICES

Psychological evaluation is a process of using interviews and standardized measures to answer a question(s) about your psychological, cognitive, and/or neurological functioning. The assessment process usually begins with an in-depth interview with me about your developmental, family, mental, medical, criminal, and substance use history. Other areas, as pertinent, may be discussed. Following the interview one or more measures will be used to help me better understand your psychological, cognitive, and/or neurological functioning. This process may involve you filling out questionnaires and/or completing various tasks and/or answering questions. This process may be completed in one session or may require multiple sessions. Sessions frequently last more than an hour. After our session(s) I will score, interpret, and document my findings in a report that can be provided to you or another authorized party with your consent. I can also provide verbal feedback to explain my findings and address any questions or concerns you may have about the results.

BILLING AND PAYMENTS

You will be expected to pay for each session at the time it is held, unless we agree otherwise or unless you have insurance coverage that requires another arrangement. Payment schedules for other professional services will be agreed to when such services are requested.

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 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 I will release regarding a patient's treatment is his/her name, the dates, times, and nature of services provided, and the amount due.

INSURANCE REIMBURSEMENT

It is important to evaluate what resources you have available to pay for your evaluation. If you have a health insurance policy, it may provide some coverage. 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.

You should carefully read the section in your insurance coverage booklet that describes mental health services. If you have questions about the coverage, call your plan administrator. Of course, I will provide you with whatever information I can based on my experience and will be happy to help you in understanding the information you receive from your insurance company.

Due to the rising costs of health care, insurance benefits have increasingly become more complex. It is sometimes difficult to determine exactly how much mental health coverage is available. “Managed Health Care” plans often require prior authorization before they provide reimbursement for mental health services.

You should also be aware that most insurance companies require that I provide them with your clinical diagnosis. Sometimes I have to provide additional clinical information, such as treatment plans, progress notes or summaries, or copies of the entire record (in rare cases). This information will become part of the insurance company files. Though all insurance companies claim to keep such information confidential, I have no control over what they do with it once it is in their hands. In some cases, they may share the information with a national medical information databank. I will provide you with a copy of any records I submit if you request it. ***You understand that, by using your insurance, you authorize me to release such information to your insurance company. I will try to keep that information limited to the minimum necessary.***

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. It is important to remember that you always have the right to pay for my services yourself to avoid the problems described above unless prohibited by the insurance contract.

CONTACTING ME

I am often not immediately available by telephone. When I am unavailable, my telephone is answered by a voicemail that I monitor frequently. I 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 me of some times when you will be available. I do not provide crisis or emergency services. If you are experiencing a crisis or emergency, contact your family physician, call 911, or go to the nearest emergency room. If I will be unavailable for an extended time, I will provide you with the name of a colleague to contact, if necessary.

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, elderly person or disabled person 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.

Although this written summary of exceptions to confidentiality is intended to inform you about potential issues that could arise, it is important that we discuss any questions or concerns that you may have at our next meeting. I will be happy to discuss these issues with you and provide clarification when possible. However, if you need specific clarification or advice I am unable to provide, formal legal advice may be needed, as the laws governing confidentiality are quite complex and I am not an attorney.

Your signature below indicates that you have read the information in this document and agree to abide by its terms during our professional relationship. Your signature authorizes the release of any medical or other information necessary to process any insurance claims, as well as authorizes payment of any benefits to myself for services rendered (if using insurance for services).

CLIENT SIGNATURE ________________________________ DATE _________________

MINORS

Parent Authorization for Minor's Mental Health Treatment

In order to authorize mental health treatment for your child, you must have either sole or joint legal custody of your child. If you are separated or divorced from the other parent of your child, please notify me immediately. I will ask you to provide me with a copy of the most recent custody decree that establishes custody rights of you and the other parent or otherwise demonstrates that you have the right to authorize treatment for your child.

Mandatory Disclosures of Treatment Information

In some situations, I am required by law or by the guidelines of my profession to disclose information, whether or not I have your or your child's permission. I have listed some of these situations below.

Confidentiality cannot be maintained when:

- Child patients tell me they plan to cause serious harm or death to themselves, and I believe they 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 child has told me and how serious I believe this threat to be and to try to prevent the occurrence of such harm.
- Child patients tell me they plan to cause serious harm or death to someone else, and I believe they 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.
- Child patients are doing things that could cause serious harm to them or someone else, even if they 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.
- Child patients tell me, or I otherwise learn that, it appears that a child is being neglected or abused--physically, sexually or emotionally--or that it appears that they 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.

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, 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:

Parent/Guardian Signature ____ Date__________

Parent/Guardian Signature ____ Date__________

* For very young children, the child's signature is not necessary

Nevada Residents: Pursuant to the provisions of subsection 7 of NRS 629.051,

"A custodian of health care records shall not destroy the health care records of a person who is less than 23 years of age on the date of the proposed destruction of the records. The health care records of a person who has attained the age of 23 years may be destroyed in accordance with this section for those records which have been retained for at least 5 years or for any longer period provided by federal law."

California Residents:

NOTICE TO CONSUMERS: The Department of Consumer Affairs' Board of Psychology receives and responds to questions and complaints regarding the practice of psychology. If you have questions or complaints you may contact the Board on the Internet at www.psychology.ca.gov, by e-mailing bopmail@dca.ca.gov, calling 1-866-503-3221 or writing to the following address:

Board of Psychology

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