OUTPATIENT SERVICES CONTRACT

Welcome. This document contains important information about my professional services and business policies. Please read it carefully and address any questions or concerns that may arise. When you sign this document, it will represent an agreement between us.

PSYCHOLOGICAL SERVICES

We will work together to address your needs, concerns, and goals. It is my belief that every person has strengths and resources that can be developed to manage and cope with life's challenges and to enhance life's pleasures. Therapy, which is a personal journey, can be a rewarding process of self-discovery. It does, however, call for a very active effort on your part. In order for therapy to be most successful, it will be important to remain mindful of the topics discussed while in session, as well as, during the time outside the sessions. Our first few sessions will involve an evaluation of your needs. Together we will develop a treatment plan and treatment goals. I welcome your feedback and invite you to share any questions or comments you may have along the way. If, at any time, you feel that our collaboration is not helpful to you, please feel free to discuss any concerns with me.

FREQUENTLY ASKED QUESTIONS

1) What are the benefits of therapy? The potential benefits of treatment include improved mental health, improved relationships, and improved ability to cope with life's stressors.
2) What are the risks of therapy? The risks of treatment include disappointment over expectations of treatment being unmet and failure to experience improvements immediately. Since therapy involves discussing unpleasant aspects of your life, you may experience uncomfortable feelings like sadness, guilt, anger, frustration, loneliness, and helplessness.
3) What are some alternatives to therapy? Alternatives to treatment include self-help books, self-help groups, spiritual activities, dance, music, exercise, or any activities that improve mental health functioning.
4) What is the "therapy hour"? The "therapy hour" lasts 45-60 minutes. We will begin to wrap up five minutes prior to the close of the session. Please keep in mind that late afternoon appointment slots are

highly desirable, especially for children and adolescent. If you schedule allows for earlier appointment times, your flexibility will be greatly appreciated.

5) What information will be shared with the insurance company? When I bill your insurance company, I am required to provide them with a clinical diagnosis. I will explain to you the nature of any diagnosis that I give you. Some insurance companies may also require additional information about you, and some insurers may require a treatment plan. I will inform you if such a request occurs.
6) What can I expect during the initial visit? You will be asked to complete initial paperwork unless you have had the paperwork sent to you ahead of time. Please ensure that you arrive on time to allow sufficient time for the session. The initial visit with me is expected to last 45 – 90 minutes and is designed to provide a comprehensive diagnostic evaluation, not treatment services. At the end of the visit I will share my thoughts with you concerning diagnosis or primary issue, and a proposed treatment care pathway will be offered. Since there is a lot of information to cover and different perspectives, I will structure the evaluation to ensure sufficient time to gain all critical information. Two sessions may be used to complete the initial assessment.
7) What will I be expected to do? You will be asked to actively participate in your treatment. This will include reading informational packets provided, becoming familiar with community agencies and resources, become knowledgeable about your illness, engage in experiential exercises that aim to improve your overall well-being. Your health is truly dependent on how much time and effort you invest.

Minors: The process of therapy with minors can be challenging when the minor suspects that information shared in session will eventually be shared with parent/guardian. In order to maintain a safe space for the minor to process their concerns, needs, and fears, information will usually be shared if it is necessary to maintain the minor's health and safety. Please be respectful of the therapeutic relationship between the provider and minor. Please be prepared with documentation indicating current custody agreement, if one exists, when you arrive for your initial appointment.

Availability: I am generally available my phone between sessions for scheduling/rescheduling appointments. If you need to contact me between our scheduled sessions for therapeutic concerns that cannot wait until the next scheduled appointment, I will make every effort to return your call within a 48-hour period, with the exception of weekends and holidays. **If you are experiencing a crisis or emergency, please indicate that in your message. If you are feeling suicidal, homicidal or otherwise in need of immediate assistance, call 9-1-1 or present directly to an emergency room.**

TELEHEALTH SERVICES

As an option to providing psychotherapy services, I offer teletherapy which has the same purpose or intention as psychotherapy or psychological treatment sessions that are conducted in person. Teletherapy services are delivered through a HIPPA compliant video conferencing platform. Due to the nature of the technology used, the experience may be somewhat different that face-to-face treatment sessions. Additionally, there are limitations using teletherapy that may not be prevented or predicted, including, the risk of confidential information being breached, the instability of the internet connection, and the nuances of non-verbal communication that may be missed. I do frequent check-ins to ensure optimal communication of non-verbal behaviors. There are certain responsibilities that are involved with this service, including: client needs to be physically present in Hawaii.

PAYMENTS AND FEES

Payment is collected at the end of each session (this usually involves a co-pay if it applies to you). If services are billed to your insurance company, please be advised that you are financially responsible for the co-payment and tax that is not covered by your insurance plan or for the entire payment if services are not covered by your insurance plan. While some insurance plans pay the excise tax on medical services, most do not. If your plan does not cover the tax, you are responsible for paying the tax on the eligible charge, not just the tax on the co-payment. My professional fees for services not covered by an insurance company or for services provided when I am not participating in the client's insurance company are as follows:

Individual therapy (one hour): $200

Family/Couples therapy: $250

IVY Pay app is used for payments, as well as cash or checks.

Checks made out to Clarity Psychological Services LLC

If you are covered by an insurance company with whom I am not participating and they allow for non-participating providers, an insurance form will be mailed to your insurance company on your behalf. In this instance, payment will be due in full at the end of that session.

Employee Assistance Program (EAP) Referrals: In the event that you are referred by your employee assistance program, your feels will most likely be covered by your employer for a pre-authorized number of sessions. You may also choose to continue treatment under your own insurance after preauthorized sessions have been utilized. If you are interested, previous paragraph on terms for payment and fees would apply.

CANCELLATION/NO SHOWS/MISSED SESSIONS POLICY

Please give at least 24-hour notice if you need to cancel an appointment. If you are experiencing an emergency that necessitates canceling an appointment without 24-hour notice, please contact the office as soon as possible. If you do not show for an appointment or cancel with very little notice (unless there was an emergency), there will be a no-show or late cancellation fee of **$50.** If you no show for an appointment or there is a pattern of cancellations, services may be terminated. If you are referred by your EAP and no show or cancel with less than 24-hour notice, the same conditions apply.

CONFIDENTIALITY

The therapy relationship is intended to be a confidential relationship that is built on trust between the client and the therapist. The confidentiality of this relationship and information disclosed during treatment is so protected by law. There are, however, several exceptions to confidentiality outlined below:

1. The therapist has an obligation to break confidentiality if the client is a danger to self or others. In those instances, the importance of protecting life outweighs the confidential relationship. Specifically, the therapist has an obligation to notify emergency personnel (example: police, hospital) that the client needs psychiatric hospitalization to protect self or others. In the case of danger to others, the therapist must also notify the police and persons threatened to be harmed.
2. The therapist has an obligation to notify the Department of Human Services if a minor client is being physically abused, sexually abused, neglected, or if the client is abusing or neglecting a minor, elderly person, or person with a disability.
3. The therapist has the right to notify the police if a client has committed a crime against the therapist.
4. The therapist must respond to court orders for client records.
5. The therapist must notify emergency medical personnel if, during the care of the client, the client has a medical emergency that requires immediate treatment.
6. The health insurance provider that pays for your treatment has a right to know information about your mental health services. This information includes your diagnosis and dates of service. Some health insurance providers may require a treatment plan before they authorize services and/or during your treatment episode.
7. A therapist can release information with a signed consent from you. The nature of the information to be released is agreed upon before signing. In addition, the client has a right to revoke the release at any time.
8. MINORS: Please keep in mind that parents/guardians have the right to information shared by minors in session; however, to promote a healthy therapeutic relationship between the provider and the minor it is recommended that the minor's privacy be respected and honored as much as possible. The minor's best interest will be greatly considered in determining what information is shared with parent/guardian and will always be discussed with the minor before disclosing information. In all cases, clinical discretion will be used to determine what should and will be disclosed.
9. Record Keeping: In compliance with state and federal laws and professional standards, I maintain a record on every client. The record consists of your intake documents and a note following each session. The notes contain general information such as: your name, date and time of session, diagnosis, progress

update, treatment plan, etc. The records are kept in a locked file in my locked office and/or in an encrypted file on my computer. I am the only person who has access to these files. Billing staff is only provided with your demographical information needed for billing.

NOTICE OF PRIVACY POLICIES AND PRACTICES

- Most uses and disclosures of psychotherapy notes, uses and disclosures of protected health information (PHI) for marketing purposes, and disclosures that constitute a stale of PHI require client authorization.
- Other uses and disclosures not described in the Privacy Notices will be made only with authorization from the individual.
- Patients have the right to restrict certain disclosures of PHI to health plans/insurance companies if the patient pays out of pocket in full for the health care service.
- Affected patients have the right to be notified following a breach of unsecured protected health information.

Your signature below indicates that you have read the information in the Outpatient Services Contact, Consent to Treatment, and agree to abide by its terms during our professional relationship.

_____	_____	_____
Print Name	Signature	Date

For minor clients:

_____	_____	_____
Print Name (Guardian)	Signature	Date

_____	_____	_____
Print Name (Minor over age 14).	Signature	Date

By signing below, I am acknowledging that I received a copy of the Notice of Policies and Practices to Protect the Privacy of your health information:

I am aware that I may ask Dr. Pagat for any needed clarification on any aspect of the Notice.

Name (please print) _____

Signature _____ Date _____