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Treatment/Evaluation Agreement

This document contains important information about the professional services and business policies of Simone Madan, Ph.D. Please read this carefully and discuss any questions you have with Dr. Madan prior to initialing and signing where indicated.

ASSESSMENT AND TREATMENT:

During the initial consultation phase, Dr. Madan will assess my symptoms and difficulties. At the end of the consultation, she will review her initial impressions, recommendations, and available treatment options. Dr. Madan will also offer, if I would like, an estimate of the number of sessions for treatment she recommends for me. For most patients, this ranges between 5 and 50 sessions. Dr. Madan's estimate of the duration of treatment is only an estimate, and no guarantees can be made as to the length of treatment required. Dr. Madan will help secure a consultation with another mental health professional whenever it is requested or if she recommends it.

RISKS AND BENEFITS OF TREATMENT:

Psychotherapy is a joint effort, the results of which cannot be guaranteed. This process can be time-consuming and uncomfortable. It can lead to strong negative emotions and may result in changes that were not originally intended. For people in some professions, the fact of being in treatment may negatively impact their career. There is a small risk that my condition will worsen due to treatment.

PATIENT'S ROLE:

I am expected to play an active role in my treatment, including working with Dr. Madan to outline treatment goals and complete questionnaires as needed for the assessment phase and for treatment phase to assess my progress. Homework assignments in between sessions will be an important part of treatment and my willingness to do these is likely to lead to a successful outcome. I am entitled to ask questions about the assessment and all aspects of the treatment. If at any point I am unhappy about the progress, process, or

outcome of the treatment, I can discuss this with Dr. Madan to resolve any difficulties that arise and to arrive at a treatment plan that better meets my needs.

TELEPSYCHOLOGY/TELEHEALTH:

Dr. Madan provides psychotherapy exclusively using remote telehealth/telecommunication technologies. There are benefits but also risks associated with such technologies. Benefits include convenience, efficiency, and continuity of care for different circumstances. Risks include disruptions to the technology itself, access to conversations by others or access to stored data by unauthorized entities. Dr. Madan takes reasonable steps to protect my privacy while conducting our remote psychotherapy sessions and suggests that I do the same. She recognizes her legal and ethical responsibility in protecting our communications and takes careful steps to ensure my privacy during our sessions, and overall, by using strong passwords, virtual private network, firewalls, and HIPAA compliant platforms that provide Business Associate Agreements. Dr. Madan prefers to communicate minimally in between sessions and prefers postal mail for payments by checks, billing statements and forms. This is to minimize risk to me since these contain personal health information. The nature of all electronic communications with and without Business Associate Agreements is such that she cannot guarantee that our communications will be kept confidential by any unauthorized users. If the telehealth/telecommunication-based modality does not meet my needs, Dr. Madan will help facilitate referrals to other providers. On the other hand, Dr. Madan understands that I may prefer the convenience of technologies and therefore she wants me to understand the risks and I provide her with consent to use telehealth / telecommunication technologies between us. Initial: _____

HOURS/AVAILABILITY:

Dr. Madan will be available to provide therapy sessions on weekdays. Usually, therapy sessions are scheduled for 45-50 minutes unless indicated otherwise based on my treatment plan and as agreed upon by me and Dr. Madan. During the assessment or treatment phases, if Dr. Madan determines that more intensive and frequent treatment sessions are needed, she may facilitate referral to another therapist or treatment program. For any planned unavailability, Dr Madan will keep me informed and provide the name and telephone number of another covering therapist if needed.

EMERGENCIES:

Dr. Madan will let me know how she can be reached in the event of urgent need after hours. In addition, during a crisis, I can contact my primary care physician or go to the local emergency room in addition to contacting Dr. Madan about my urgent need. If I am in immediate danger, I will call 911 for emergency assistance.

CONFIDENTIALITY:

Dr. Madan maintains a paper clinical chart for each patient. Information in the chart includes background information on symptoms, treatment goals, progress in treatment, dates of and fees for sessions, and notes describing each therapy session. She also keeps records of any consent, release, assessment, insurance, or other forms completed during my treatment. Clinical records are kept in a locked file cabinet.

The confidentiality of communication between the patient and therapist is important and, in general, is legally protected. Dr. Madan will make every effort to keep the results of all evaluations and treatment strictly confidential, as is required by law. In case you participate in family or couples therapy and an outside party requests information, Dr. Madan will seek releases from all parties before confidential information can be shared. Also, individual therapy communications for minors under the age of 18 are generally considered confidential for therapeutic reasons even though parents/guardians have a legal right to such information.

Information about me will be released by Dr. Madan only with my permission, however there are these following exceptions:

- When there is suspected elder, dependent adult, or child abuse or neglect.
- When, in Dr. Madan' judgment, I am in danger of harming myself or another person or are unable to care for myself.
- When I communicate to Dr. Madan a serious threat of physical violence against another identifiable person, Dr. Madan is required by law to inform both potential victims and legal authorities.
- When Dr. Madan is ordered by a court of law to release information as part of a legal proceeding. If I am a plaintiff in a case claiming psychological injury, my psychological records are not protected by the usual confidentiality privilege.
- As otherwise required by law.

Dr. Madan conducts research, training, and supervision, and writes for professional and lay audiences. In addition, when Dr. Madan is unavailable, another colleague may be available to cover crisis calls and may be advised of the issues that could arise. I would be the one initiating contact with a covering colleague. Dr. Madan may also consult with other professionals about treatment planning for my case. My signature below gives Dr. Madan permission to use information about me and my treatment in any of these ways, provided she does not reveal any personal information that would identify me in such consultations.

UNFORESEEN CIRCUMSTANCE EXCEPTION

For any unforeseen circumstances, if Dr. Madan becomes incapacitated or in event of her death, she will have to rely on a carefully selected colleague designated to contact me and inform me of the circumstances as they impact me. Initial: _____

PAYMENT AND FEES:

Dr. Madan charges $ per 45-50 minutes session. She will specify her fee before meeting for my first session. Periodically, a slight increase in her fees will occur and will be discussed with me ahead of time so that there are no surprises. Longer or shorter sessions with me or to coordinate my care are generally prorated from this base fee. I will be charged the standard fee for telephone calls, prorated according to the length of the call. Of course, there will be no charge for brief telephone calls, such as those made to schedule appointments. Payment is due at the time of the session unless another arrangement has been made.

INSURANCE

I am aware that Dr. Madan services are fee based, and she does not belong to any insurance panels. If I wish to seek insurance reimbursement, Dr. Madan will facilitate that by providing statements to submit to the insurance company. Typical information sought by insurance companies includes date of service, location of service, type of service, diagnosis and fee. I am responsible for learning about specifics about my insurance requirements and for collecting reimbursements from the insurance company or other sources. I will also determine if my insurance covers telehealth services. I am aware that insurance may not cover her fee in its entirety. Dr. Madan will obtain a release from me to disclose information to my insurance company if I ask her to seek third party reimbursement on my behalf and this may include details of the treatment plan, treatment progress and number of sessions planned. Initial: _____

MEDICARE BENEFICIARIES

I am aware that Dr. Madan has opted out of being a Medicare provider. Thus, her services are not covered by Medicare, hence no Medicare payments can be made to any entity for her services. The cost of service rendered by Dr. Madan is my sole responsibility. Moreover, I will not ask Dr. Madan to submit a claim on my behalf to Medicare and she will not seek direct or indirect Medicare payments for services provided to me. I agree to not submit a claim to Medicare or supplemental insurances for services that she renders. If I disagree with this, I am free to seek out a Medicare provider who can bill Medicare directly.

CANCELLATIONS AND MISSED APPOINTMENTS:

If an appointment is missed or cancelled without 48 hours' notice, I will be charged for the full amount of the session unless discussed otherwise. Please be aware that insurance companies generally do not reimburse for a cancelled or missed session.

THE PATIENT'S RIGHTS:

A document entitled "Patient's Bill of Rights," link is attached for my review at the California Psychological Association website https://www.cpapsych.org/page/52/Consumer-Resources--Patient-Bill-of-Rights.htm (source: California Board of Psychology).

I have read and understood this agreement and the Patient Bill of Rights, and I have had my questions answered to my satisfaction. I accept, understand, and agree to abide by the contents and terms of this agreement and consent to participate in evaluation and/or treatment.

Name of patient (please print): _____

Signature of patient: _____

Name of patient (please print): _____

Signature of patient: _____

Signature of parent (s): _____

Name of parent (s): _____

Signature of parent (s): _____

Name of parent (s): _____

Date: _____