Stephanie J. Wong, PhD

Clinical Psychologist

PSY 25170

OUTPATIENT PSYCHOTHERAPY CONTRACT AND CONSENT

This document contains important information about my professional services and business policies. Please read it carefully and ask me any questions that arise. When you sign this document, it represents an agreement between us.

PSYCHOLOGICAL SERVICES

Psychotherapy varies depending on the specific problems being treated and the theoretical approach practiced by the providing psychologist. It is therefore important that you take care in selecting a therapist that fits your style and treatment goals. Our first four sessions will involve an evaluation of your current problems, concerns, and needs. By the end of the evaluation period, I will offer you my clinical impressions and a recommended approach to treatment. During this time, it is important that we both consider if I am the best person to provide the services you need to meet your specific treatment goals. If indicated (e.g., your presenting problem is outside the scope of my clinical expertise), a referral to a more appropriate therapist will be provided. If you consent to enter therapy with me after these four sessions, we will then be formally entering into treatment. As therapy involves a commitment of time, energy, and money, it is important that you feel comfortable working with me. The goals of therapy are arrived at by mutual collaboration between us. The goals we establish will be reviewed during our work in order to assess and/or modify the focus of therapy according to your needs. If any questions or concerns about our work together arise at any point during treatment, please bring them to my attention.

CONFIDENTIALITY

In general, the privacy of all communications between a client and a psychologist is protected by law. Your records are never shared with anyone else without your specific authorization and written consent, unless a situation develops that could be harmful to yourself or another person. If I have reason to believe you are at risk for injuring or killing yourself, I am legally and ethically required to work with you to prevent this from occurring. This may range from developing and agreeing to a “no harm” contract, contacting family members or others who can help provide protection, arranging for hospitalization with your consent, or in the event of an emergency, facilitating involuntary hospitalization.

In certain situations, I am also legally obligated to take action to protect others from harm, even if this requires that I reveal some limited information about a client’s treatment. For example, if I believe that a child, older adult (age 65 or older), or a dependent adult is being neglected or abused, I must file an immediate report with the appropriate county or state agency. If I believe that a client is threatening serious bodily harm towards another individual, I am also legally and ethically required to take preventative and protective actions. These actions may include notifying the potential victim, contacting the police, or seeking hospitalization for the client.

In addition, although I will make every effort to safeguard your privacy, your records may be subpoenaed by a court of law. In most legal proceedings, you may have the right to restrict access to information about your treatment. In some proceedings, such as those involving child custody and those in which your emotional condition is an important issue, it is possible that a judge may order that my records and/or testimony be released. Confidentiality may also be limited by other situations in which the law requires or directs that confidentiality does not apply.

PROFESSIONAL FEES

The general fee for a 45-minute individual therapy session is $250. Longer sessions can be arranged, if desired, for a prorated amount. In addition to weekly appointments, similar fees will be charged for other needed professional services, such as home-based visits or legal proceedings requiring my participation. In general, payment is expected at the time of each session. Personal checks, E-payment, and credit card are all acceptable forms of payment. If your account has not been paid for more than 60 days and arrangements for payment have not been agreed upon, I reserve the right to use legal means to secure payment, which may include retaining the services of a collections agency or initiating a small claims suit. Please note that if you pay by credit card, you will be responsible for service fees of up to 7%. Please note, my professional fees may increase by as much as 5% at the start of each calendar year. You may use Venmo (@colorofsuccess) as a payment method, and you acknowledge Dr. Wong is not responsible for the data, as it is not encrypted or HIPPA-compliant. You may mark the transaction as ‘private’ instead of ‘public’ if you choose this payment method.  
  
**2. Cancellations/No Shows**: **Dr. Wong’s Cancellations and Missed Appointments Policy per this Outpatient Psychotherapy Contract and Consent form is: “If you wish to change a scheduled appointment, it is important that you provide at least 48 hours’ notice in order to avoid being billed for the session (45-minute session is $250).**

INSURANCE REIMBURSEMENT

Certain health insurance policies will provide some coverage for “out of network” mental health treatment. This usually occurs as reimbursement for fees you have already paid for clinical services. I will complete forms and provide you with any information you may need to receive these benefits; however, please be aware that it is your responsibility to provide payment before submitting this information to your insurance company. Because not all clinical services are covered by every insurance provider, it is important that you find out exactly what mental health services your insurance policy covers at the outset of therapy.

Please be aware that most insurance companies require psychologists to provide them with certain information regarding their client’s treatment (e.g., diagnosis, treatment plan, treatment summary, fees). If I am required to provide information about your treatment to an insurance company for purposes of fee reimbursement, I will first request your authorization and written consent for release of this information.

CONTACTING ME

You may contact me at (415) 971-9722. Although I am often not immediately available by phone, I check my voicemail on a regular basis. I will make every effort to return your call on the same day you make it, or by the next business day at the very latest. If you are unable to reach me and feel that you cannot wait for me to return your call, dial 911 or proceed to your nearest emergency room immediately.

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

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Printed Name of Client Date

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Signature of Client

VERIFICATION OF PROFESSIONAL FEES

I acknowledge that I have read the section concerning Dr. Wong’s professional fees and am aware of the 48-hour cancellation policy. If I miss a session, I agree to have Dr. Wong charge me the full amount for the missed session.

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Printed Name of Client Date

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Signature of Client

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Zip code of credit card

VERIFICATION OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have read a copy of Dr. Wong’s Notice of Privacy Practices of the Health Insurance Portability and Accountability Act (HIPAA), and agree to its terms.

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Printed Name of Client Date

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Signature of Client