Terasa L. Davis, Psy.D., PC

Disclosure of Policies & Consent for Treatment

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DISCLOSURE OF POLICIES & CONSENT FOR TREATMENT

Thank you for choosing Terasa L. Davis, Psy.D. for your specific individual and/or family needs. Dr. Davis strives to provide her clients with the highest level of professional, competent, and personal care. In order to meet this goal, it is necessary for Dr. Davis and the staff here to adhere to certain operating procedures. We ask that you read the following policies carefully. If you have any questions, please feel free to ask for clarification prior to signing. Your signature indicates you understand and agree to all the policies set forth in this document and consent to treatment.

Contact Information

First Name: _____ Middle Name: _____ Last Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone (home): _____ OK to leave message ☐ Yes ☐ No

(cell): _____ OK to leave message ☐ Yes ☐ No

Informed Consent

I (the client) understand that therapy may involve discussing relationships, psychological, and/or emotional issues that may at times be distressing. However, I also understand this is a process intended to help me personally and with my relationship(s). I am aware there are alternative treatment facilities available to me. _____ **Initial**

Your responsibilities as a therapy client

You are responsible for coming to your session on time and at the time we have scheduled. Sessions last for 55-60 minutes. If you are late, we will end on time and not run over into the next person's session. If you miss a session without canceling, or cancel with less than twenty-four (24) hours' notice within business hours (Monday-Friday), you will be charged for that session. _____ **Initial**

The Therapeutic Process

The therapeutic process is a partnership between you and Dr. Davis to work on areas of concern or dissatisfaction in your life, develop growth and insight, help you achieve your desired goals and improve your overall well-being. In order for therapy to be effective, it is necessary for both of us to take an active role in this process. Participation involves being open to Dr. Davis's thoughts and ideas, being honest with Dr. Davis, discussing concerns about the process with Dr.

Davis, completing outside assignments when appropriate, and providing on-going feedback to Dr. Davis about the process. While therapy is often beneficial for many people, some people may not find therapy helpful. The therapeutic process can also evoke strong feelings and sometimes produce unanticipated changed in one's behaviors, thoughts, and feelings such as anger, sadness, worry, fear, anxiety, depression, and insomnia. In order for you to maximize your experience, it is helpful to discuss with Dr. Davis any questions or discomfort you may experience during the therapeutic process. Dr. Davis will work to help you to understand the experience and/or use different methods or techniques that may be lead you towards the growth you desire, however there is no guarantee that psychotherapy will yield positive or intended results. If adequate progress is not seen, you and your therapist should discuss the treatment process and evaluate whether a different direction should be considered. _____ **Initial**

Ending therapy well

Dr. Davis wants to make your therapy as successful as possible. For that reason, it works best to find a rhythm and structure to the beginning stages with sessions that meet regularly. To support you leaving, Dr. Davis requests several weeks of notice prior to your actual leaving to allow you to have an experience of leaving well, with a sense of completion. If Dr. Davis initiates terminating you from our therapy, it will be because she feels she is not able to be helpful to you any longer. Dr. Davis's ethics and license requires that she offer quality service and have your needs as paramount in her treatment planning. If Dr. Davis no longer feels she is the best or right practitioner for you, she will offer referrals to other sources of care, but cannot guarantee that they will accept you for therapy or how they will approach your treatment. _____ **Initial**

Psychological Evaluations/Assessments

When seeking a psychological evaluation/assessment, please note the following:

a) Dr. Davis may not be able to conclude that you (or your child) have the diagnosis you are seeking testing for.
b) Dr. Davis cannot guarantee testing results or the report will result in accommodations in an educational or standardized testing situation.
c) It is your responsibility to obtain the necessary information required for Dr. Davis to perform the assessment consistent with the standards of your institution. Some institutions/testing companies have particular tests or information that they require to be included in the assessment in order to accept the report. You must contact the relevant agency to which you want your report submitted and obtain the agency's standards for testing. It is also helpful if you provide contact information for the agency to which you wish to submit the report along with a written release of information, so that Dr. Davis may follow up with any questions if necessary. _____ **Initial**

Psychological Evaluation/Assessment Process

Most assessments require a significant amount of information from you in addition to the testing performed in the clinic. Frequently, Dr. Davis will request that you obtain school records, prior testing reports, IEP/504 reports/plans, and any other documentation relevant to your testing concern. She may also request you sign release forms so she can obtain information from other relevant individuals, such as parents/caretakers, school officials/teachers, and physicians or other treatment providers. This information will help Dr. Davis obtain a complete picture of how you are performing in school, work and home environments, which will assist in providing the most accurate diagnosis and recommendations. In addition to the lengthy interview and information gathering described above, you will be asked to

complete a variety of standardized tests in the clinic. The specific tests you are asked to complete will depend on the problems/concerns you describe. _____ **Initial**

Evaluation/Assessment Feedback and Reports

Please note that much of the information you reveal to Dr. Davis will be described in the report. While she makes an effort to only include information that is relevant to making or ruling out a diagnosis (e.g., she would not describe a traumatic event that occurred in your life if it did not relate to your diagnosis, and even then she would make an effort to protect your confidentiality), she cannot guarantee that information would or would not be included in the report.

When the report is completed, she will contact you and request an appointment for a feedback session. During the feedback session, Dr. Davis will provide you with a detailed account of your testing results, diagnostic conclusions, and recommendations. This is a great opportunity for you to ask any questions you have about the report. Dr. Davis do not issue the report without a feedback session as it is essential to convey the information directly to the you since reports often use technical language. Clients 14 years of age or older must provide written permission before an additional person (i.e., parent, sibling, spouse, etc.) is allowed to attend the feedback session.

Reports may be forwarded to appropriate providers and/or agencies upon your request and after completion of a signed release of information. You may also be given one (1) copy of your report for your own records. _____ **Initial**

Confidentiality

Your right to confidentiality is one of Dr. Davis's highest priorities. Except in specific situations, no information regarding you or your case will be shared without your expressed, written permission. In the case of a minor child (under the age of 14), a parent or guardian of the minor child must sign for the release of information. However, there are certain situations where your permission is **NOT** needed to disclose information. These situations include:

a) In an emergency situation where the provider has reason to believe the client is a danger to him/herself or to someone else
b) A court order has been issued and signed by a judge
c) In case of suspected abuse of a minor or other individual who is unable to care for self _____ **Initial**

Fees and Payment Options

Full payment or co-payment is required upon checkout for all services rendered. Payment may be made by cash, check, or credit /debit card. There is a $30.00 fee for checks returned for insufficient funds. You must have a valid credit card on file while there is a case open. If you do not possess a valid credit/debit card, you will have pay cash for services rendered. Below is a list of common fees:

SERVICE	FEE
Intake – 90 minutes	$200
Individual therapy – 30 minutes	$80
Individual therapy – 45 minutes	$120
Individual therapy – 60 minutes	$160
Couples therapy – 55 minutes	$160
Family therapy with patient	$160

Family therapy without patient	$160
Psychological testing per hour, including preparing the report	$160
Going to school per hour – insurance does not pay for this	$120 _____ **Initial**

Paperwork Fee

Due to the high volume of paperwork required to be completed by Dr. Davis in some circumstances, an administrative fee of $30 will be billed to you in 15-minute increments as necessary for the paperwork to be completed. Examples include forms for schools, sports, or camp (when requested outside of an office visit), forms for life insurance and legal uses such as disability, and copies of medical records. _____ **Initial**

Emergency Access

In case of life threatening emergency, it is the client's responsibility to contact 911 or emergency medical services, before calling Terasa L. Davis, Psy.D. _____ **Initial**

Health Insurance & Confidentiality of Records

Disclosure of confidential information may be required by your health insurance carrier in order to process the claims. Only the minimum necessary information will be communicated to the carrier. Dr. Davis has no control or knowledge over what insurance companies do with the information she submits or who has access to this information. ____ **Initial**

Canceling and rescheduling your appointment

If you need to cancel your appointment, please do so at least 24 hours in advance. This time is scheduled exclusively for you. Because of this, frequent "no shows" can have a significant impact on she continued ability to provide quality services at reasonable prices. Therefore, if you miss your appointment without canceling at least 24 hours in advance, you will be charged the full session fee, and payment must be received before obtaining another appointment. You may have your session by phone during your scheduled hour, at the regular fee, but insurance does not pay for this and will be charged to you. To use the option we will use the credit card on file to pay for the session. _____ **Initial**

Financial agreement

I agree to keep an encrypted credit card on file for my phone sessions, late cancellations, no shows, returned checks and to use for quick checkouts. The receptionist will swipe my card one time at my first session to encrypt the number into my file. _____ **Initial**

Legal Proceedings & Litigation Limitation

Disclosure may be required pursuant to a legal proceeding. (For example, if you place your mental status at issue in litigation initiated by you, the defendant may have the right to obtain the psychotherapy records and/or testimony by Dr. Davis). Due to the private nature of psychotherapy, it is agreed that should there be legal proceedings (such as, but not limited to divorce and custody disputes, injuries, lawsuits, etc.), neither you, your attorney, nor anyone else acting on your behalf will call on Dr. Davis to testify in court or at any other proceeding, nor will a disclosure of the psychotherapy records be requested. _____ **Initial**

Disclosure of Policies

Confidentiality of E-mail, Cell Phone and Faxes Communication

It is important to be aware that computers, email, texts, and other online communication can be relatively easily accessed by unauthorized people and hence can compromise the privacy and confidentiality of such communication. If you communicate confidential or private information via online, text message, fax or phone messages, it assumes you have made an informed decision, and will be seen as your agreement to take the risk associated with such communication. **Please do not use texts, e-mail, voice mail, or faxes for emergencies**. _____ **Initial**

There is a new messaging app that is HIPPA compliant called **pMD** (https://www.pmd.com)
pMD is a free HIPAA compliant messaging app that enables efficient patient communication and care coordination in a modern healthcare communication platform. This allows me to communicate to you in a much more secure manner than regular text messages. I would like to communicate with you through this app if you desire the communication. If you wish to communicate with me, please let me know and I can send you the invitation.

☐ YES, I would like an invitation to **pMD** to be able to text Dr. Davis as needed

Cell: _____

Dual relationships

Not all dual relationships are unethical or avoidable. However, sexual involvement between therapist and client is never part of the therapy process as well as other actions or dual relationship situations which might impair Dr. Davis's objectivity, clinical judgment, or therapeutic effectiveness or that could be exploitative in nature. In addition, she will never acknowledge working therapeutically with anyone without your written permission. In some instances, even with permission, she will preserve the integrity of your working relationship. For this reason Dr. Davis will not accept any invitations via social networking sites such as Facebook, Twitter, Linkedin or Pinterest, nor will she respond to blogs written by clients. _____ **Initial**

Consultation

Dr. Davis consults regularly with other professionals regarding her clients; however, the client's name or other identifying information is never mentioned. The client's identity remains completely anonymous, and confidentiality is fully maintained. _____ **Initial**

Chance Encounters

Given that Tuscaloosa/Northport is a relatively small community, you may encounter someone you know in the waiting room or cross paths with Dr. Davis out in the community. Dr. Davis will never acknowledge working with you therapeutically to anyone without your written permission. If you see Dr. Davis in a public place, she will acknowledge you only if you initiate the interaction, so as to maintain your confidentiality. Please respect the privacy of other clients you may recognize in the waiting room or outside the office by not sharing with others your knowledge of their therapy participation. _____ **Initial**

Disclosure of Policies

Again, thank you for choosing Dr. Davis. If you have any questions regarding the policies outlined here, please ask before signing.

By signing below, I am indicating I have read and had the opportunity to ask questions, which have been answered to my satisfaction and in a manner that I understand, and I agree to abide by all the policies outlined in this document.

_____	_____
Client/Parent/Guardian Printed Name	Client Date of Birth
_____	_____
Signature of Client/Parent/Guardian	Date