BODNAR PSYCHOLOGICAL SOLUTIONS

828 Dulaney Valley Rd., Suite 3

Towson, MD 21204

443-608-5405

drbethbodnar@gmail.com

Psychological Intervention Information for Families

This document is designed to inform you about some important policies and procedures of this practice. You are asked to sign the last page, indicating that you have read, understood, and agree to abide by the policies and procedures.

PATIENT AND PARENT RIGHTS

You are an important participant in your child's care. You are entitled to know treatment goals and have access to data tracking treatment progress. You are entitled to withdraw from treatment at any time, though I may recommend a session to complete termination related activities and make recommendations for post-termination services if needed.

GENERAL INTERVENTION INFORMATION

My approach to therapy is primarily behavioral and cognitive behavioral intervention. These types of treatment methods are research-based and have been shown to decrease problem behaviors, as well as mood and anxiety symptoms. These services can also help to build skills, including coping, daily living, and executive function abilities. While the research to support the use of these interventions is sound, every individual is different and therefore, it is impossible to guarantee any particular experience or outcome.

That being said, I guarantee to work collaboratively with you. While I know the interventions, you know your child and family. When we work as a team, we can make the most progress. I will be straightforward in my recommendations and am always happy to discuss concerns or questions related to treatment approaches and progress. If I have concerns that I can not meet your child's needs, I will tell you and we can discuss alternative interventions. I will ask you and your child to actively work toward our treatment goals both inside and outside of the treatment sessions. I will expect that you will bring any treatment concerns to me for discussion and resolution.

SESSIONS

Each session typically lasts 45-55 minutes. If you are late, that time will be lost from your session. Please provide 24-48 hours notice of cancellation. If you cancel with less than 24 hours notice or do not attend your scheduled appointment, I reserve the right to charge a fee of $50. This fee may be waived after discussion if the cancellation is due to an emergency situation. I respect that your time is valuable as well and pledge to keep our appointments except in case of emergency.

CONTACTING ME

Due to my work schedule, I may not be immediately available by telephone. When I am unavailable, I monitor my voice mail and will make every effort to return your call within 24 hours, with the exception of weekends and holidays. If you leave me a message and

anticipate that you will be difficult to reach, please inform me of times of availability and preferred contact information. If there is an emergency situation and I am not immediately available, please utilize your local hospital emergency room. If I will be unavailable for an extended time, I will make arrangements to ensure continuity of care. You are welcome to use email to contact me. However, email and other internet and wireless communications, have limitations in confidentiality and you will need to sign the agreement at the end of this document indicating you are aware of these limitations.

CONFIDENTIAL INFORMATION

I want to emphasize my extreme caution in handling the confidential information that you or your child share with me. Except under specific circumstances, information gathered in the course of contact with you and your family is privileged and will be held confidential. I cannot reveal any information, including test results, to other agencies (for example, schools, pediatricians, psychologists) without written permission of the child's legal guardian.

You should know, however, that there are exceptions to confidentiality:

1. If the parent of a child or the child is believed to be potentially harmful to him/herself or someone else, confidentiality may be broken in order to protect people from imminent physical or psychological danger.

2. According to Maryland Law, health care professionals who know or suspect neglect, physical or sexual abuse of a child under 18 years of age must report their concerns to Children's Protective Services or other appropriate law enforcement personnel.

3. If a court of law issues a subpoena, a psychologist may be required to provide information specified by such a subpoena.

In addition, information regarding your child will be shared with identified individuals or agencies under the following conditions:

1. The child's parent or legal guardian has signed an Authorization for the Exchange of Information form.

2. The child's parent or legal guardian requests information to be used for insurance reimbursement. This information will be provided directly to the parent, unless another specific agreement is made.

3. I may feel the need to consult with other health and mental health professionals about a case. During consultation, I make every effort to avoid revealing patient identity and the consulting professionals are legally bound to keep the information confidential. You will not be charged for these consultations. If you wish to be informed of consultations, please let me know.

4. If a government agency is requesting the information for health oversight activities, I may be required to provide it for them.
5. If a patient files a complaint or lawsuit against me, I may disclose relevant information regarding that patient in order to defend myself.

PROFESSIONAL FEES

Initial Evaluations (90-120 minutes): $320

Follow-up Sessions (30 minutes): $100

Follow-up Sessions (45-50 minutes): $160

PHONE CALLS & EMAIL COMMUNICATION & OTHER SERVICES

Please be advised that I reserve the right to charge for telephone conversations lasting more than 25-minutes, consulting with other professionals at your direction, and time spent performing any other service you have requested of me (such as preparing additional or lengthy documentation for insurance reimbursement). My rate for these services is $50 per hour and when I work for less than 1 hour, I will break the fees into 5-minute increments.

BILLING AND PAYMENT

All fees are payable each session at the time of service. Cash, check, and credit cards are accepted. You are also welcome to use flexible health spending accounts to pay for services.

I am "out-of-network" with insurance providers. If your insurance includes out-of-network provider coverage, you may be eligible for some level of insurance reimbursement for services. Please contact your insurance directly to find out the details of your coverage.

I will provide statements or superbills for your records or insurance reimbursement upon request. Upon request, these can be issued on a bi-weekly, monthly, or quarterly basis. If you do not request a statement, they will not automatically be given to you. Statements may also be sent via email in pdf format with your approval (email is not secure and therefore may limit your confidentiality).

Regardless of the payment mechanism, payment is expected at the time services are rendered and will be collected at each session. If you are paying by check, please have the check made payable to **Bodnar Psychological Solutions, LLC**

Please discuss with me when financial circumstances make it difficult to pay your bill on a weekly basis as large balances may result in straining both you and me personally and in our work together.

If your account is more than 60 days in arrears and suitable arrangements for payment have not been made, I have the option of suspending or discontinuing services and after a brief time period devoted to the termination of our work, will provide the names of other therapists or clinics. I also have the option of using legal means to secure payment. This may involve hiring a collection agency or going through small claims court which will require me to disclose otherwise confidential information. In most collection situations, the only information I release regarding a patient's treatment is his/her name, the nature of services provided, and the amount due. [If such legal action is necessary, its costs will be included in the claim.]

PROFESSIONAL RECORDS

You should be aware that, pursuant to HIPAA, I keep Protected Health Information in two sets of professional records. One set constitutes your Clinical Record. Except in unusual circumstances that disclosure is reasonably likely to endanger the life or physical safety of you or another person, you may examine and/or receive a copy of your Clinical Record, if you request it in writing. Because these are professional records, they can be misinterpreted and/or upsetting to untrained readers. For this reason, I recommend that you initially review them in my presence, or have them forwarded to another mental health professional so you can discuss the contents. If I refuse your request for access to your Clinical Records, you have a right of review, which I will discuss with you upon request.

In addition, I may also keep a set of Psychotherapy Notes. These Notes are for my own use and are designed to assist me in providing you with the best treatment. These Psychotherapy Notes are kept separate from your Clinical Record.

Minors and Parents

Patients under 16 years of age who are not emancipated and their parents should be aware that the law may allow parents to examine their child's treatment records. While privacy in therapy is important, particularly with teenagers, parental involvement is also essential to successful treatment. Therefore, it is usually my policy to discuss privacy concerns as necessary with children. In a situation where the child does not want specific information shared with a parent, I will use my clinical judgment to determine whether it is necessary to disclose said information. If I feel disclosure is necessary, I will do my best to handle any objections the child may have.

TERMINATION OF SERVICES

It is always my hope that services are terminated by mutual agreement when treatment goals are obtained. However, if you decide to discontinue services prior to that point, please let me know. I welcome your feedback. If at any point during therapy, I feel that I am not able to meet a client's therapeutic needs, I will discuss it with you immediately so that we can arrange a plan of care that is a better match. If I have not seen you or the designated client or received any communication regarding services for three months since the last appointment date, our therapeutic relationship will be considered terminated.

Your signature below indicates that you have read the information in this Services Contract and agree to abide by its terms during our professional relationship.

_____ _____

Client or Responsible Party Signature Date

_____ _____

Printed Name Email

_____

Phone Number(s): This authorizes me to contact you at this number).

_____

Address for Billing, Office Correspondence (This authorizes me, to send identifying information to this address).

_____

Signature regarding approval of receiving e-mail from me knowing limits of confidentiality. Pdf monthly statements and appt scheduling, among other related correspondence may be sent via email to your email address or cell phone if requested. (Please be advised that **NO** e-mail correspondence is considered confidential and may be recovered by other parties at any time. **You may lose your right to confidentiality by corresponding with me by e-mail and by receiving correspondence from me by e-mail).**