Jessica P. Harrell, Ph.D.
Licensed Clinical Psychologist
248-767-5985
drjessicaharrell@gmail.com

CONSENT TO TREATMENT

I do seek and consent to take part in the treatment provided by Jessica P. Harrell, Ph.D. I understand that developing a treatment plan and regularly reviewing our work toward meeting the treatment goals are in my best interest and will be completed collaboratively with her guidance and my input. I agree to play an active role in this process. I understand that no guarantees have been given to me as to the results of treatment or any procedures provided by this therapist. I am aware that I may stop my treatment with this therapist at any time and, in that case, my only continued commitment would be to provide payment for services I have already received.

I am aware that Dr. Harrell maintains a fee-for-service practice. This means that I am responsible to pay in full for services at the conclusion of each treatment session. Dr. Harrell will provide me with information to facilitate reimbursement by third party payers, and in doing so, I understand that she will need to release some protected health information to facilitate this process. I understand that Dr. Harrell does not submit bills to insurance companies, nor does she accept payment from insurance companies. I also understand that I will be responsible for submitting the proper paperwork to receive reimbursement from my insurance company, if I so choose.

I know that I must call or email to cancel an appointment at least 48 hours before the time of the appointment. If I do not cancel at least 48 hours in advance and/or do not show up, I will be charged for that appointment. I agree to pay for missed appointments or those where I fail to give enough notice that I will not attend.

During the process of treatment, I understand that at times I may feel an increase of distress. I will discuss this with Dr. Harrell so that she may facilitate management of the discomfort and ensure that it is therapeutically necessary. I understand that my sessions will be kept confidential. Exceptions to confidentiality include should I become at risk to harm myself or another person and in cases of suspected child or elder abuse or neglect. I agree to disclose thoughts of hurting myself or others to Dr. Harrell and to work with her to develop and implement a plan for my safety. Dr. Harrell is legally and ethically obligated to breach confidentiality if I am at serious risk or harming myself or another person.

My signature below shows that I understand and agree with all of these statements.

Signature: _____ Date: _____

Printed Name: _____

Jessica P. Harrell, Ph.D.
Licensed Clinical Psychologist
248-767-5985
drjessicaharrell@gmail.com

OFFICE POLICIES

Please carefully review the following office policies, as they have been established so that I may best serve my clients:

Session Length Psychotherapy sessions are 45 minutes in length, with the exception of an initial intake session, which is 90 minutes in length. Extended psychotherapy sessions can be arranged in advance. The fee/charge for extended sessions is pro-rated at regular rate, usually in 15-minute increments.

Cancellation Policy and Missed Appointments To provide the best service and availability for all of my clients, I require **48 hours** notice if you need to reschedule an appointment (please call before 4:00pm on Friday for a Monday appointment). Without this 48-hour notice, you are responsible for paying the standard fee as I will likely be unable to fill that time slot. This policy also applies to appointments for which you do not show. Please note that insurance companies will not reimburse for late cancellations or missed appointments.

Extenuating Circumstances I understand that unforeseen illnesses, emergencies, and severe driving conditions may result in an unavoidable late cancellation or missed appointment. In these cases, the late cancellation fee will be waived. If extenuating circumstances happen repeatedly and/or within a short period of time, the late cancellation fee will likely be applied.

Consultative Services and Telephone Sessions Fees for out-of-office meetings (e.g. school IEPs) are based on my standard rate. Phone consultations and collateral contact (with teachers, psychiatrist, etc.) is also billed at the standard rate in 15-minute increments, as is travel time. On occasion, you may be unable to attend therapy in person, and, in those cases, I am happy to provide therapy via telephone. However, it is important to note that, as a general rule, insurance companies will not reimburse for telephone sessions.

Payment Payment is expected at the conclusion of each therapy session. Receipts and invoices are provided at the time of service with necessary diagnostic and procedure code information for those wishing to seek reimbursement from insurance companies.

If you have any questions or concerns about these policies, please do not hesitate to speak with me. I look forward to working with you.

Please sign and date to acknowledge receipt of these policies, effective January 1, 2019.

Signature: _____ Date: _____

Printed Name: _____