DR KELLY ASSOCIATES LLC

24 North Third Avenue • Suite 203B • Highland Park • NJ 08904
908-349-0822 • FAX: 723.335.4888 • *www.drshalondakelly.com*

OUTPATIENT SERVICES CONTRACT

This provides basic information about psychological treatment. Please read and sign at the bottom to indicate that you have reviewed this information.

LENGTH OF TREATMENT

Psychotherapy involves regular sessions, usually 50 minutes in length per week, although sometimes the frequency and length of the sessions can increase. Treatment duration varies depending on the nature of the problem(s) and your individual needs. Our first 2-4 sessions are typically longer, and will involve an evaluation of your needs, after which I will offer you some initial impressions of what our work will include and an initial treatment plan to follow, if you decide to continue.

CONFIDENTIALITY

Information shared with a psychologist is kept strictly confidential and is not disclosed without your written consent. However, confidentiality is not guaranteed in cases of (a) life threatening situations involving yourself or others, or (b) situations in which children are endangered, such as with physical abuse, sexual abuse, or neglect.

FEE POLICIES

The ordinary charge for an individual or joint session is $150. If you need to cancel an appointment, 24 hours notice is appreciated. Otherwise you will be charged for the session. You will be expected to pay for each session at the time it is held, unless we agree otherwise, or unless you have insurance coverage that requires another arrangement.

If you carry mental health insurance coverage, you are responsible for filing your own claims and getting reimbursed for our sessions, unless otherwise arranged. You also have the right to pay for my services yourself and forego the use of insurance plans. If you choose to use an insurance company, I would appreciate a copy of your insurance information. Please note that you, and not your insurance company, are responsible for full payment of the fee to which we have agreed, though I may at times assist you with insurance reimbursement, such as providing them with requested information. Most companies require clinical information, such as a diagnosis to authorize treatment, which they are obligated to keep confidential. All payments should be made at the time of the office visit or upon a mutually agreed upon arrangement.

In addition to face-to-face sessions, you can be charged for other psychological services. I charge the fee above on a prorated basis for other psychological services such as report writing, telephone conversations lasting longer than 10 minutes, attendance at meetings, preparation of records or treatment summaries, or the time required to perform any other service which you may request of me.

I reserve the right to engage the services of a collection agency if there are unpaid balances; charges for collection efforts also become the client's responsibility.

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PHYSICIAN AND OTHER SERVICE PROVIDER CONTACT

Physical and psychological symptoms often interact, and I encourage you to seek medical consultation if warranted. In addition, medication may be helpful. When appropriate, referral for medication evaluation can be arranged.

In addition, if you are receiving services for problems related to your mental health, it is strongly recommended that you consider signing a release of information that would permit contact with your other service provider, to best coordinate your care. Such service providers include but are not limited to a psychiatrist or medical doctor, another therapist or social worker, or teachers in the case of children. A release of information is available for this purpose, but no interaction with other providers will be done without your consent.

FREEDOM TO WITHDRAW

You have the right to end therapy at any time. If you wish, I will give you names of other qualified psychotherapists.

INFORMED CONSENT

I have read and understood the preceding statements; I have had an opportunity to ask questions about them, and agree to enter a working relationship with Dr. Kelly.

Name_____ Date: _____

Name_____ Date: _____

Name_____ Date: _____

Witness_____ Date: _____

Dr. Kelly Ph.D., Clinical Psychologist, NJ License # 4346