Informed Consent for Treatment

Child/Adolescent

Revised 09/23/24

Pate and Culp Psychological Associates is dedicated to helping people improve the quality of their lives through psychological therapy. We are a behavioral health outpatient practice, staffed exclusively with psychologists who are specialized in providing Cognitive-Behavioral Therapy (CBT) and other intervention for children, adolescents, and adults. We do not have a psychiatrist or medication-prescribing physician on staff, nor are we equipped to provide frequent or ongoing crisis management services. Speak with your therapist about a plan of contact in case of emergencies. If the plan calls for it or you cannot reach your therapist during an emergency, please contact your local ER or call 911 as needed.

##### Therapy Agreement

I understand that some parts of treatment can sometimes be uncomfortable. I also understand that at times my psychologist may ask my child to challenge him/herself in-between therapy sessions, which also may be uncomfortable, and is designed to be helpful.

As determined by my psychologist’s professional judgment, it may be recommended that therapy sessions be conducted in public places where my child or I may confront fear “in the real world.” Examples of such places include elevators, while driving, at the airport and other sites deemed appropriate and agreed upon. I understand that while conducting therapy in public places, my confidentiality, and that of my child, cannot be insured. I also understand that my psychologist does not control and therefore cannot be held responsible for adverse incidents that may occur while conducting therapy in public places. If you believe participating in exposure-based therapies has injured your child, contact Joseph Pate, Jr., PhD at 404-808-4639.

Parent Initials \_\_\_

Please read the following information regarding our fees and services, and discuss any questions or concerns with your psychologist:

**Insurance**

We do not submit claims directly to insurance companies, but will gladly provide you with a statement of services rendered for you to file with your insurance company if you so choose.

## New Patient Enrollment

For all new patients and returning patients who have not been seen by one of our psychologist for more than two years, we conduct an **initial** **diagnostic evaluation,** charged at the rate of $275. This evaluation typically includes a clinical interview lasting 60-90 minutes, with a review of key background information (e.g., prior treatment/hospitalization history, onset, course, and duration of primary symptoms, family psychiatric history), a discussion of current resources and stressors that will impact treatment, a review of responses your diagnostic evaluation forms, a summary of initial diagnostic findings, and a discussion of your treatment goals. Some preliminary forms will be emailed to you for completion prior to your first appointment or, if you prefer, they can be completed in our waiting room prior to the initial evaluation session.

For child referrals, parents may be asked to attend one or more sessions without their child in attendance.

If a patient is home-bound, or services require on-site observation (e.g., school), the initial assessment will include additional fees for travel time.

## Session Fees

Fees for the clinic are charged by professional time and have been determined in a manner that takes into account factors such as regional psychotherapy rates, levels of expertise, and the scope of focus of our specialty services. The base fee for our Cognitive-Behavioral psychologists is $225 per 50 minutes, which represents our standard session.

**All other fees are prorated in 10-minute increments for services of lesser or greater time** (e.g., family meetings and initial exposure sessions can sometimes take longer than 50 minutes; booster check-ins can be much shorter). The prorated rate for any 10-minute increment is $45. Therefore, a planned 30-minute session is at a rate of $135. A 70-minute session is at the rate of $270.

Any additional fees (e.g., possible admission fees to places for community based exposure therapy for yourself/family and, if necessary for the psychologist to accompany, the psychologist’s fees) will be your responsibility. Additional charges will be discussed ahead of time in planning sessions with your psychologist.

**Clinicians’ full rate, prorated in 10-minute increments,** will be charged for:

* In-office therapy
* Home/community-based therapy
* School assessment or IEP meetings
* Requested report writing, letters of opinion, or other documentation services not already included in initial diagnostic assessment services
* Phone Consultations with school or other professionals
* Phone sessions/phone calls
Note: Brief contacts, defined as: 5 minutes or less, usually for scheduling or for therapy homework purposes (e.g., pre-arranged check-in calls, clarification of therapy assignments) do not incur any charges
* We are also available to speak by phone with an insurance representative for a pre-approval process (*see* ***Insurance Tips and Information*** document *for more information)*. This summary and/or phone contact needs to be requested before or during the first 4 weeks following your original assessment appointment to be considered part of the evaluation package service fee. Any requested documentation outside of this initial process (e.g., communications during appeals) will be handled per our usual policies for letters and communications and billed pro-rated at your clinician’s usual rate.

*Services reimbursed by insurance can vary. Please check with your individual policy.*

**50% of the clinicians’ full rate, prorated in 10-minute increments,** will be charged for total travel time to and from home/community-based sessions, schools, etc. *Please note that these charges are rarely reimbursed by insurance.*

**Crisis Calls/ Between-appointment Phone Calls/ Phone Sessions** will incur charges prorated in 10-minute increments at that clinicians’ determined rate. *Please note these charges are rarely reimbursed by insurance.*

**Cancellations and Late Charges**

To remain available for all of our patients, we request that cancellations be made at least 24 hours in advance.  Appointments that are not cancelled in advance of 24 hours may be subject to a charge up to the regular session price and late charges may be assessed at our discretion. *Please note that these charges are rarely reimbursed by insurance*

## Payments

**Payments are to be collected at each session.** We accept cash, checks, all major credit cards (Visa, MC, Discover, and Amex), Venmo and Zelle as well as healthcare flexible spending accounts. Any returned checks or late payments may be subject to a $40 fee. Ongoing noncompliance with payment terms may incur collections charges.

*\*\*The policies and fee structure above are in effect as of September 23, 2013, and are subject to change.*

I understand that information about my treatment at The Clinic at Virtually Better will be kept confidential in accordance with the Ethical Principles of the American Psychological Association and the Laws of Georgia. These guidelines require exception to confidentiality under the following circumstances: a) a patient is a serious danger to him or herself or to another; b) when the psychologist is informed of physical or sexual abuse to a minor or elderly individual; c) when a judge orders the release of information to a Court of Law; and d) when the patient consents to the release of information to a third party.

I understand that if I choose to seek reimbursement for the costs of this treatment from an insurer, my psychologist may be required to provide information about my treatment to the insurance company. By initialing below, I give my expressed permission for Virtually Better to disclose information to my insurance provider and those who they deem appropriate.

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Parent Signature Date

My psychologist has answered all my questions about treatment at The Clinic at Virtually Better to my satisfaction. If I have further questions, I understand that my psychologist will either answer them or find answers for me. I understand that I may leave therapy at any time, although I have been informed that this is best done in consultation with my psychologist.

I have been given a copy of this consent.

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Printed Name of Patient

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Patient Signature (or parent or guardian, if minor) Date

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Psychologist (Witness) Date