**Robin Gans Psy.D**

**License Psy#17365**

**Practice/Therapy Agreement**

Welcome to therapy. I hope that you will be able to explore and implement the changes you seek. Please read the information below and let me know if you have any questions..

**Confidentiality**

All information disclosed within sessions or consultations is held strictly confidential and may not be revealed to anyone without a written release of information, except where disclosure is permitted or required by law. Disclosure is required in the following circumstances:

1. There is a reasonable suspicion of child abuse or neglect, or abuse to a dependent, or older adult,

2.When the patient presents an imminent danger to self.

3.When the patient presents an imminent danger to others,

4.If a judge determines that our discussions are not confidential, a judge may request specific information.

Please be aware that submitting mental health claims to your insurance company carries a certain amount of risk to confidentiality, privacy, and to future capacity to obtain health or life insurance, or even a job. I receive regular professional consultation. In such cases, neither your name, nor any identifying information about you is revealed.

**Phone & Emergency Contact**

If you need to contact me by phone, do not hesitate to call the office number. If I am not

available, you may call me on my cell phone number at 310-488-9255 You will be charged for phone calls if we have a conversation of an information exchanging

or problem-solving nature that lasts more than 10 minutes. If you cannot reach me

in an emergency, you should call 911 or go to the nearest Urgent Care or Emergency room.

**Therapy Process & Termination**

Therapy can result in a number of benefits to you, including improved relationships and a reduction in psychological symptoms. The process of talking about painful memories, thoughts, and feelings, however, can be difficult and can make patients feel worse for a time. Please discuss this with me if you are feeling worse. You are free to terminate therapy at any time. I can provide you with referrals to other therapists. I do not prescribe medication, but will refer you to your physician or to a psychiatrist if I believe you are in need of a medication evaluation.

**Fees & Insurance:** Sessions are 50 minutes in length. Your fee is due at the end of the session. Please be aware that not all issues/problems/conditions dealt with in therapy are covered by insurance. It is your responsibility to verify the specifics of your coverage. Letter writing, consultations with other professionals, telephone conversations, reading records or reports, travel time, longer sessions, etc. may not be covered by insurance payment. In the event that insurance does not cover your services, you are responsible for payment.

Returned checks are subject to a $36 fee. This agreement supersedes all previously agreed to financial agreements and is effective as of the date signed. You are responsible for the full copayment, deductible or private pay fee at the beginning of each session. If your account is overdue (unpaid) and there is no written agreement on a payment plan, you cannot be scheduled another appointment until it is cleared. In addition, I can use legal or other means (court, collection agencies, etc.) to obtain payment.

**Cancellation of Appointment**

The scheduling of an appointment involves the reservation of time specifically for you. In the event of a “No Show” or failure to give a full 24-hour notice of a cancellation, you will be charged the following fees:

Blue Shield Patients: $75

Aetna Patients: $100

Magellan EAP Patients: $65

LA Care Patients: depends upon your plan

Private Fee Patients: based upon agreed private pay fee

Please be aware that insurance companies **will not cover cancellation charges**. This fee is due prior to scheduling or attending the next session.

By signing here, you acknowledge that you have received a copy of the “Notice of Privacy Practices”, the “Patients’ Rights and Responsibilities” and that you understand the fee’s that will be charged in the case of a missed appointment.

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Patient/Legal Representative Signature Date

Consent for Treatment:

I consent to assessment, treatment, and/or diagnostic procedures for myself . I understand that the purpose of these procedures will be explained to me upon my request and subject to my agreement. I authorize the release and exchange of information between my therapist and the referral source and other co-treating providers for the purpose of treatment, payment, and Health Care Operations. I also authorize the release of information to my health plan for claims or other health plan purposes.

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Patient/Legal Representative Signature Date