7807 E. Funston; Wichita, KS. 67207

 (316) 636-1188 Fax: 316-636-1190

 www.therapycenterwichita.com

**SERVICE AGREEMENT AND CONSENT FORM**

Welcome to The Therapy Center. We aim to provide you with a professional service in a comfortable, safe, and friendly environment. This document will convey useful information about your rights and responsibilities as a client. Please let me know if you have any questions or concerns regarding the information below.

**Psychological Service**

Outpatient psychological services may include diagnostic services, crisis intervention, parent training, and individual therapy. Dr. Eskridge utilizes Cognitive-Behavior Therapy as well as Behavioral Therapy and Parent Management Training. These therapies have a significant research showing their effectiveness in a variety of problems. However, there is no guarantee about the degree of benefit that will occur to you or your child. Dr. Eskridge will only use evidence based therapies. If you have questions about the type of therapy Dr. Eskridge is using, please ask.

Dr. Eskridge will try her best to help you and/or your child based on my clinical experience. If Dr. Eskridge cannot help you, she is obligated to refer you to someone who may have more experience/expertise in a specific area. Please note that if you are divorced and have a shared custody arrangement, consent to treatment of the child will need to be obtained by both parties before services can be rendered. Dr. Eskridge does not become involved in custody disputes. If you are looking for recommendations regarding custody issues, Dr. Eskridge will refer you to a professional who has expertise in this area.

As part of provide psychological services to you (or your child) we will need to collect and record personal information from you that is relevant to your current situation. This information is a necessary part of your or your child’s psychological assessment and treatment.

The information is gathered as part of the assessment, diagnosis, and treatment of the client’s condition, and is seen by only the psychologist and supervising psychologist. The information is retained to document what happens during sessions and enable the psychologist to provide relevant and informed psychological services.

**Educational and Licensing information**

Dr. Samantha Eskridge holds a Ph.D degree in Clinical Psychology from Wichita State University. She is licensed in Kansas as a Licensed Psychologist. With this license, Dr. Eskridge assumes responsibility for compliance with the statutes and regulations that govern the practice of Psychology in the state of Kansas. If you would like to see Dr. Eskridge’s full Curriculum Vitae please visit www.therapycenterwichita.com

**Confidentiality**

Clients have the right to confidentiality during psychological services with a few exceptions. All personal information gathered by the psychologist during sessions will remain confidential, unless:

1. It has been subpoenaed by a court or authorized by law.
2. Failure to do so would place you or another person in serious risk such as but not limited to threatening to harm yourself or someone else.
3. Your prior approval has been obtained such as releasing information to another agency or mental health provider. In the case of a child, the parent would have to consent to release information.
4. You should be aware that most insurance companies require you to authorize Dr. Eskridge to provide them with a clinical diagnosis. Sometimes, Dr. Eskridge must provide additional clinical information such as treatment plans or summaries, or copies of your entire record.
5. You have a right to access your records as the laws and standards of psychology require treatment records to be kept. Due to the professional nature of these records, they may be misinterpreted by untrained readers. If you wish to see these records, Dr. Eskridge recommends that you review them in the presence of Dr. Eskridge so that you can discuss the contents with Dr. Eskridge. However, at your written request, you are entitled to receive a copy of these records or Dr. Eskridge can prepare a summary of them for you.
6. When treating teenagers, they are more sensitive to information being released to their parents. If your adolescent does not trust Dr. Eskridge, then Dr. Eskridge cannot help him or her. As a result, Dr. Eskridge will typically give parents general information regarding therapeutic progress and avoid giving specific details unless the adolescent is in danger of hurting themselves or others.
7. Once a child turns 18, all information is confidential and requires written permission to release information.

**Appointments and Late Cancellations**

Please call (316) 636-1188 to schedule your appointments. It should be noted that Dr. Eskridge understands the desire for appointments after school/work. There are limited appointments during this time. Therefore, Dr. Eskridge employs a first come first serve policy when scheduling these appointments. If we have an appointment scheduled, that spot is reserved for you so if you are unable to keep and appointment, please notify The Therapy Center 24 hours in advance to cancel or reschedule. This allow The Therapy Center to fill your appointment with clients waiting to be seen. Since unexpected circumstances sometimes arise Dr. Eskridge will deal with each situation on an individual basis. If there are numerous no shows/late cancellations, the psychologist may choose to refer you to someone else and/or charge a **$40 fee** which you will be requested to pay prior to scheduling additional appointments. The no show/late cancellation fee will be increased to **$60** for appointments 3:00 pm and after since that tends to be a high demand time frame for appointments. If you no show or late cancel a psychological evaluation a fee of **$200** will be assessed. Insurance companies will not pay for late or cancellation fees. Exceptions for this policy will be made for emergencies. As with all parts of this document, please ask questions if you have concerns about how this policy applies in your situation.

**Contacting Your Psychologist**

Due to the nature of psychological work, your psychologist may not be immediately available by phone. If you need to talk to your psychologist call The Therapy Center at (316) 636-1188. If your psychologist can not speak with you at that time, leave your message on their voicemail. Your psychologist will return your call as soon as possible. Dr. Eskridge is in the office Monday to Thursday, so if you call Friday, Saturday, or Sunday do not expect a return call until Monday. In case of a mental health emergency in which you are unable to reach Dr. Eskridge, contact your primary care physician, or psychiatrist, or call Comcare’s crisis number at (316) 660-7500. In cases of immediate danger you should go to the nearest emergency room or call 911.

**Fees**

Please contact your insurance company to determine if services provided are covered. Fees are due at the time of service. The fee is $210.00 per hour for the following services:

1. Initial Evaluation: This includes developmental background, medical history, social functioning, and educational history. The initial examination may require 60 to 90 minutes.
2. Individual Therapy: Sessions after the initial evaluation that does not include assessment. These sessions are typically 54 minutes long and where therapeutic techniques will be utilized.
3. Psychological or Psycho-educational Assessment: This would typically include an intellectual, behavioral, personality, emotional, adaptive, social or behavioral assessments. Typically, a full assessment requires 6 hours or $1260.00. This amount may vary (e.g. 4 to 8 hours) depending on your case. Note that **insurance companies do not reimburse for identifying learning problems such as Dyslexia.** On these occasions, you will be responsible for payment for all or part of this service on the day of the assessment.

For confidentiality reasons, some clients prefer to assume responsibility for the fee of services. Others may utilize insurance to assist with the fee for services. If insurance reimbursement is used, clients will likely be responsible for a portion of the fee for services as specified by most insurance plans. If you choose to use your insurance, it is very important that you discover what mental health services your insurance policy covers including anything that insurance might exclude, deductibles that might apply, and co-payments that apply to services provided.

“Managed Health Care” plans such as HMOs and PPOs often require authorization before they provide reimbursement for mental health services. These plans are often limited to short-term treatment approaches designed to work out specific problems that interfere with functioning. While a great deal can be accomplished in short-term therapy, some patients feel that they need more services after insurance benefits end. Thus, all services that you believe to be necessary for you or your child’s progress may not be covered by your insurance.

You should be aware that most insurance companies require you to authorize Dr. Eskridge to provide them with a clinical diagnosis. Sometimes, Dr. Eskridge must provide additional clinical information such as treatment plans or summaries, or copies of your entire record. In order to seek authorization for additional sessions, this information will become part of insurance company files and will probably be stored in a computer. It is important to understand that Dr. Eskridge has no control over this information once submitted to the insurance companies.

If you choose to utilize your insurance benefits, our office will file the claims with your insurance company. Most insurance companies will send you a statement of benefits when they reimburse services. You are responsible for any part of the services not covered by insurances (e.g. co-pays, deductibles). You can see what insurance companies Dr. Eskridge is a preferred provider with by visiting the website [www.therapycenterwichita.com](http://www.therapycenterwichita.com)

**Consent**

I have read the preceding information, which will also be presented verbally, I understand my rights a client or as the client’s parent or guardian. I consent to psychological services provided by Dr. Samantha Eskridge and agree to abide by the requirements outlined above.

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Client Printed Name Date

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Client Signature (or parent/guardian signature if client is under 18)

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Parent/guardian printed name if signed for client under 18