

Liza York, Ph.D, PLLC
Licensed Psychologist
16 Mountain View Ave #103
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Contract for Psychotherapy/Psychological Services

In order to give you the best service and to meet the legal requirements of the state of Colorado, this document provides you with important information about my credentials, the practice of psychotherapy, and your rights as a client. It also contains policies for us to agree on at the outset of our work together.

Background Information:

My degrees are:

Ph.D. Clinical Psychology, California School of Professional Psychology, 1997

B.S. Psychology, University of Washington, 1990

I am a Licensed Psychologist (License #2475) in the state of Colorado. I am trained in providing psychotherapeutic services to adults, children and adolescents as well as performing psychological assessments of young children through adults. I have been trained in both long-term therapy and brief forms of intervention and I can work on an individual or family basis. I abide by the ethical standards of the Colorado and American Psychological Association. I will be glad to provide you with information about my methods of therapy, the techniques I use, the estimated duration of your therapy and my sliding fee structure. Please ask if you would like to receive this information or if you have any other questions.

Psychotherapy and Your Rights as a Client:

The Colorado Department of Regulatory Agencies is responsible for regulating the practice of psychotherapy. The agency responsible for licensed psychologists is the **State Grievance Board, 1560 Broadway, Suite 1370, Denver, CO 80202, (303) 894-7766**. Any questions or concerns regarding the practice of psychotherapy should be directed to the above address. The Department of Regulatory Agencies also require that I inform you that in a professional relationship, as is therapy, sexual intimacy is never appropriate and should be reported to the grievance board. Additionally, you are always free to seek a second option from another therapist.

Fee Policy:

My regular fee is \$140.00 per 50-minute session. Payment is due at the time of each session. A receipt will be given for each payment. If you miss a payment on two or more sessions, therapy may be postponed until payment is received. My fee will slide to \$70.00, depending on client's income. If you are utilizing insurance, you will be expected to make your co-payment at the time of service and to obtain any necessary paperwork during the course of treatment for further authorization of treatment and to assist me in filing claims for reimbursement. If payment is in arrears for 90 days, your account will be turned over to a collections agency. If collections are involved, you will be responsible for a 25\$ administrative fee as well as a 1.5% finance charge, every 30 days on the delinquent balance due.

Fee: _____

Effective Date: _____

Cancellation and Missed Appointments:

Your appointment time is reserved for you. If you need to cancel or change an appointment, please contact me at least 24 hours ahead of time. Without this notice, I will charge you your session fee for the missed appointment. Your insurance company will not reimburse missed appointments and in some cases I will charge you the amount that I bill your insurance if I have not received 24hr cancellation, depending upon your insurance. If you are late for an appointment, the session will end at the regular time and you will be charged for a full session.

Confidentiality:

Information discussed during therapy sessions is legally confidential; thus I cannot disclose it without your consent. However, as specified in the Colorado statutes, there are exceptions to this general rule. Among them are:

- 1) If you (or your child) provide me information about possible child abuse or neglect, I must report it.
- 2) If you (or your child) reveal an intention to harm yourself or someone else, I am required to notify the authorities and possibly others, in an attempt to protect the person who may be harmed.
- 3) If you (or your child) have been placed on a mental health or substance abuse hold, it may be necessary for me to provide information to other health/mental health providers to facilitate continuity of care and/or hospitalization.

- 4) If a court subpoenas me, I may be obligated to testify to the questions asked.
- 5) Your insurance forms may require me to list diagnosis & confidential information in order for your claim to be paid.
- 6) If you do not pay your bill, I may use a collection agency in order to collect payment.
- 7) In the case that I seek consultation or supervision, confidential information may be shared with this supervisor/colleague who will hold it in confidence.

Termination:

Termination will usually be agreed upon mutually, but you are always free to terminate at any time. However, in a few special instances I may decide to end our work together even though you may wish to continue. These include a failure to meet the terms of our agreement, bringing a firearm into the building, regardless of owning a concealed carry permit; a need for special services outside the area of my competency, or prolonged failure to make progress in our work together. Should this occur, I will discuss the reason for termination with you and I will assist in making different plans for yourself, including a referral to a more appropriate resource.

My Availability:

When you call my office number (303) 875-4158, you will usually reach my voice mail. I check my messages throughout the day and will call you back as soon as possible. I will leave specific messages on my voicemail if I will be unavailable for an extended period of time, and will designate a back-up therapist when I am on an extended vacation.

In the event of an emergency, dial 911 and go directly to the nearest hospital emergency room.

What I Ask of You:

To benefit most fully from our work together, I invite you to:

- 1) Let me know which aspects of our work together are effective and which are not.
- 2) Give me feedback about anything in your therapy that has troubled you so that we may resolve your concerns promptly
- 3) Ask me any questions you may have about our work together. The better informed you are, the more effective our work together will be.

I have read, understand and agree to the above policies and my rights as a client. I authorize Liza York, Ph.D. to provide clinical services for evaluation, treatment and/or consultation to:

Client Name _____

Date of Birth _____

Client Signature

Date

Responsible Party's Signature

Date

Relationship to Client

Liza York, Ph.D.
Licensed Psychologist (#2475)

Date