DESCRIPTION OF SERVICES

delivered by

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Welcome to my practice. I am a licensed Psychologist in the states of New Hampshire and Vermont, with over 30 years of experience in general psychological services, with specialties in child/adolescent/family issues, trauma work and women's issues. My professional vita can be found on my website, drcauthorne.com, or I will supply you with a paper copy upon request. I have written this handout to provide information helpful in making an informed decision concerning my services. This document was written in the spirit of the American Psychological Association (2010) Ethical principles of psychologists and code of conduct. A copy is available upon request. Please ask questions at any time.

PSYCHOLOGICAL SERVICES:

Psychological services involve evaluation, education, and treatment components. The length of time to complete treatment varies depending on the complexities of your presenting problems. During our initial meetings, I will work with you to develop an initial impression of your issues and to offer a plan for addressing them. We will determine during our first session whether I am the appropriate therapist to address your issues. However, this initial consultation may require a second session. If we decide that treatment with me is not appropriate, I will work with you to identify more appropriate alternatives. If no treatment would appear warranted at the time of assessment, that too will be discussed. This initial assessment will be a verbal exchange documented in your record and can be written up at your request, but time associated with write-up will be billed to you (see services not covered by insurance). If you plan on using insurance, a diagnosis is required, a preliminary one will be discussed also at this juncture. Given that I am a certified EMDR Consultant and Therapist and a Sensorimotor Psychotherapist., dependent on your issues, I may discuss with you the benefits of these additions to talk therapy. You may elect to consider or to reject these approaches and rely exclusively on more traditional talk therapy. With any therapy approach or process, there can be an increase in discomfort, especially if the experiences being considered are very painful. Being asked to reconsider experiences in depth, or even being asked to try something new, as part of the psychological healing or growth process can lead to increased discomfort no matter what method is used. This is true in psychotherapy just as it is in medicine, or any other creative process, and you should be aware of this before proceeding with any therapist. The overall effectiveness of our work together is a function of many variables and cannot be necessarily predicted. Our working relationship and your readiness to change are two important ingredients, and thus I will do all that I can to assist you with this needed foundation. If at any juncture after treatment has begun, if issues arise with which I am unable to work, or other approaches which would benefit you, in which I am not skilled, I will offer a referral to the appropriate clinician or organization.

CONTACTING ME:

As we work together, you will notice that I rarely accept phone calls while I am with my clients. I check for messages frequently from my voice mail number, **924-6005**, during the work day, and I am able to return 90 to 95 percent of my calls the same day. Phone calls over ten minutes will be considered a partial session and will be charged to you. If you are difficult to reach, please leave some times when you will be available. My cellular phone number of **603-562-5799** can be used for after hour/weekend/holiday emergencies. Remember that cell phones are not always reliable, and since I **can not** guarantee immediate or timely availability given that I am not a clinic or an emergency room with 24 hour staffing, but a sole practitioner, you should consider and/or work with me to identify other resources including calling your family physician or emergency room at the nearest hospital or utilizing other support services like friends, family, clergy, or Good Samaritans. If I am unavailable for an extended time, and you are i**n a state of emergency, my 924-6005 number will direct you to a trusted colleague**. We will need also to discuss how you can deal with my absence. I typically take a two week vacation in early August, as well as at least one week off at Christmas and periodic long weekends throughout the year. If you feel that you will need more immediate and more frequent response availability, please speak with me about the limitations of my practice in terms of your needs as well as the limitations of out-patient treatment with a sole practitioner.

I prefer to not communicate with any of my patients via e-mail. I can not assure you of any confidentiality if and when you use e-mail to communicate with me. Furthermore, I do not check my e-mail on a regular basis. Therefore, if you elect to e-mail, be aware that you are the owner of the e-mail, I may elect to not respond via e-mail due to the nature of your communication, as well as there may be some delay in responding in any fashion.

FEES, MEETINGS & BILLING:

My fee is $130/session for a therapy hour, and $150/hour for court related activities. Each session typically lasts 45-50 minutes and is scheduled according to the severity of the problem. You are responsible for your appointment time. Unless other plans are arranged, late cancellations (less than 24 hour notice) and missed appointments will be charged to you. Missed sessions **cannot** be submitted to insurance. Medical emergencies, illnesses that are the cause of a late cancellation, or cancellations because of inclement weather are not charged to you.

I expect payment or co-payment fees at the time of service. I prefer to not bill you individually except under exceptional circumstances. A fee of $25 will be added to the amount of returned checks. If you do not respond to repeated billings on my part, your account may be submitted to my collection service. If you then elect to pay off your balance directly to me, you will also be charged the fee that my collection service will charge me: 40% of the balance for accounts under 6 months and 50% for accounts over 6 months.

At present, I have available a reduced fee arrangement for those with financial limitations and/or no insurance or insurance which has a low reimbursement rate. Please feel free to inquire about this option which requires signing a form agreeing to this good faith arrangement,

with the understanding that if your financial circumstances change, that we will renegotiate the fee. My standard fee can not be altered in terms of deductibles and new fee arrangements will only apply once the deductibles are met, if insurance is being utilized.

INSURANCE COVERAGE:

I am not a provider presently for insurance companies since I do not feel ethically I can be affiliated with any of these organizations. If your insurance company will reimburse me as an **out-of-network provider**, you will need to be clear about the limitations of your policy. We will discuss at the initial consultation your co-pay which may be higher than would be paid to an in-network provider and will be in effect after your deductible is satisfied. My office is willing and able to submit these claims for you so that all you generally will be responsible for at the time of the service is the agreed upon co-pay. If we become aware that the co-pay amount is inaccurate, adjustments will have to be made and you will be required to pay whatever balance results, or a credit will be applied to your account, or you will be reimbursed. **Regardless of your insurance status, you are ultimately responsible for the balance on your account for professional services rendered.**

Services not generally covered by mental health insurance include:

1. Psychological/educational testing for children requested by or for a school system to assist in academic development.
2. Psychological services required for a legal evaluation. Testing or therapy including but not limited to criminal, domestic, or custody situations, civil litigation involving psychological injury or damages, and testing required by law to fulfill certain job requirements. Testifying in a legal dispute.
3. Report writing, record reviews, updates on therapy for attorneys, schools, parents, or other concerned individuals. Duplication of records may be charged $.25/copy and a $25/hour labor fee.

Unless otherwise indicated, these services will be billed to you individually at the above noted fee per hour.

CONFIDENTIALITY:

I realize that confidentiality is one of the most important factors in the decision to seek services from a mental health professional. For your protection, the following are certain limitations that the law may impose:

1. If you provide written permission to disclose information from your clinical record;
2. I am required by law to disclose child abuse and/or neglect as well as the abuse of incapacitated adults;
3. I am required by law to communicate the threat of violence to myself, other people, or property to the persons who might be harmed or law enforcement personnel, or to seek civil commitment pursuant to New Hampshire law;
4. If you are (or become) involved in a legal proceeding in which your psychological condition is an issue (e.g. personal injury, worker's compensation, disability, other insurance requests);
5. If a court orders the release of clinical records.

If the client is a minor child, I strive to respect the child's confidentiality, while also meeting the needs of the parent(s) to understand what is transpiring in treatment.

If the client is an adolescent, I consider the sessions confidential unless the adolescent is a danger to her or himself or others.

The new HIPAA regulations require that you be assured that your records are held in a locked file cabinet, that no one other than myself has access to those records, and that they will not be released without your expressed written permission, except in those cases outlined in my Notice of Privacy Practices handout.

PHYSICAL EXAMINATION:

N.H. Law requires me to encourage you to obtain a physical examination within 6 months of receiving psychological services, unless you have had a physical examination within the prior 6 months. This insures that I am aware of any major medical condition(s) that may affect your psychological status.

My most recent physical examination by Dr._____, took place on _____, 201 . If the client is a minor, s/he was examined by Dr._____ on _____201 .

CONSULTATION / PROFESSIONAL / ETHICAL ISSUES:

I am professionally and ethically required to consult with senior Psychologist colleagues and attorneys versed in mental health issues. Such consultations are bound by the same confidentiality as are individual sessions. I will delete identifying information from such consultations to protect your privacy. If you object to my consulting with colleagues about your situation, please inform me so we can speak about the ramifications. Furthermore, I am professionally and ethically required to designate a colleague who will assist with record management/distribution upon my death or disability. Although a summary of your treatment will be available to you for a minimum of seven years after treatment cessation, the actual record is typically only forwarded to a fellow mental health practitioner. Finally, all the rules listed in description of my practice as well as my APA Ethical Code of Conduct and the New Hampshire Mental Health Bill of Rights reflect our deep concern for the safety of our clients and their relatives, friends, and acquaintances. The law encourages us to remind them that they are legally protected against sexual contact and various other “boundary violations” by clinicians- behavior that, of course, would never be tolerated by any ethical practitioner, regardless of legal dictates.

TERMINATION:

Termination of psychotherapy can be an indication of the completion of the original treatment plan. If you wish to terminate prior to completion of the treatment plan, a final session is preferable to summarize progress, to discuss any major unresolved issues, and/or to transfer to another clinician and to sign any and all release of information forms for the transfer of your file.

INFORMED CONSENT AGREEMENT

I have read and agree to each of the previous sections of the agreement. I have asked questions about any parts that I did not understand fully or about which I have concerns. By signing below, I indicate that I understand and agree to the terms of this agreement.

_____ _____

Date Client's Name/s or Responsible Party (Parent)

_____

Signature (Primary Client or Child/Adolescent)

_____

Signature (Secondary Client or Parent)

_____

Dr. Catherine G. Cauthorne/Witness