

OFFICE POLICIES

1. **Service / Fees** – Psychological services for learning, emotions, and behavior, as well as social relationships and family interaction, are offered here to adults and children from infancy through adolescence. The assessment phase varies from 3 to 5 sessions. Sessions are 45 minutes and billed at \$145.00 for the first session and \$130.00 per session thereafter.
2. **Payment** – If you have insurance coverage, we will file your insurance claim. You are responsible for your co-pay, deductible, and all charges not reimbursed by your insurance carrier. Your payment is due at the time of service.
3. **Cancellation Policy** – 24 hour notice is required for any cancellations. Failure to do so will result in you being charged for the time that was reserved for you at the session rate of \$130.00 dollars. Insurance does not reimburse for late, cancelled, or missed appointments.
4. Reports prepared by this office will be done at a charge of \$90.00 and payment is due when the report is completed. Insurance does not reimburse this fee.

Telephone calls in excess of 15 minutes will be charged at \$22.00 / 15 minutes.
There will be a charge of \$25.00 for returned checks.

You will receive a statement monthly. This will reflect all activity on your account. Insurance is automatically billed and payments are posted to our account as received. Upon termination of treatment, your statement will reflect when all insurance monies have been received. Any balance will be due from you at that time.

5. Financial responsibility is that of the client. In the event of minor children, the financial responsibility is that of the parent signing the agreement and the contract form. We understand that, in a separation or divorced household, the parent bringing the child for treatment may not be the financially responsible party. However, without the signature of the other parent, you must assume that responsibility and settle between yourselves. We will gladly provide duplicate statements to assist you in pursuing reimbursement.

Copies of written reports are not routinely given to clients - since experience has shown that clients' interests are best served by having such reports maintained safely in a professional's office. Dr. Olson would be pleased to review your record or your child's record with you at any time.

If you have any questions, please feel free to ask Dr. Olson or call (937) 890-9804 and leave a message. This is important, as open communication is an integral part of seeking and receiving help.

Thank you,
Craig D. Olson, Psy.D.
Clinical Psychologist

INFORMATION ON YOUR RIGHT OF CONFIDENTIALITY

You, as the client, have the right to have your communications and records held in confidence by your psychologist. This is called confidentiality. With certain exceptions, your psychologist may release confidential information only with your authorization. For example, you might request that a report be sent to an agency. Any contact with your family, relatives, minister, teacher, lawyer or others will occur only with your approval.

The right of confidentiality is not absolute. There are instances in which your psychologist has the legal obligation to share information with others. These circumstances include:

1. When there is clear and imminent danger to you or to society. In a valid emergency of life threatening situation and after the most careful deliberation, only relevant information would be revealed to the appropriate professionals or to public authorities. This helps to insure the safety of you and others. The psychologist tries to work in cooperation with you in any such instance. The law protects the psychologist who must disclose information about an individual who is dangerous and must be hospitalized.
2. Psychologists and other professionals are required under the law to immediately notify the appropriate agency or the police when there are incidents of suspected child abuse and neglect (Section 2151.421 of the Ohio Revised Code). If your psychologist knows or suspects that child abuse or neglect has occurred, he/she is obligated under the law to report it.
3. When ordered by a judge to respond to particular questions, or to release records, the psychologist must answer.

Confidential information is also released when you ask the psychologist to submit a claim for health care insurance. The insurance company is informed as to the services rendered, the fees and diagnosis.

WAIVING YOUR RIGHT OF CONFIDENTIALITY

Please do not waive your right of confidentiality under any circumstances without first consulting your psychologist. Your psychologist will help you ascertain if waiving your right of confidentiality is truly in your best interests.

Situations in which you might be asked by others to waive your right of confidentiality would include legal matters such as judicial or quasi-judicial proceedings, for example, divorce, custody determinations, criminal or civil suits. If you do waive your right to confidentiality, your psychologist may have to answer questions that could be damaging to your best interests. In many instances, you are not permitted to partially waive your right to confidentiality in a particular proceeding. Once there is a waiver, the psychologist cannot choose which material to present. Further, you cannot later reinstate your right to confidentiality in the same legal manner.

GROUP THERAPY

The psychologist or group therapist will emphasize to all group members the importance of respecting the privacy of what is shared during the group process. You should be cautioned, however, that in most jurisdictions, fellow group members do not have any independent legal obligation to respect confidentiality, however, in signing the agreement included on this document, you will be assuming a contractual obligation designed to protect your rights and the rights of other group members to confidentiality. Furthermore, if a client is in group therapy, the psychologist will only release information about his or her participation with written permission. The names of other group members will be kept confidential.

MARITAL OR FAMILY THERAPY

A client in marital or family therapy has the right to request information to be released about his/her involvement in treatment, however, information on the spouse can only be released with his/her permission.

CHILDREN AND CONFIDENTIALITY

When the identified client is a child, the biological/custodial/legal parent or guardian needs to give written consent for information to be released. If someone other than the custodial parent is bringing the child, the custodial parent must give written approval in order for the child to be seen by the psychologist. As difficult as this may be for the non-custodial parent, information can only be shared with him or her with the permission of the custodial parent. Parents should also understand that some aspects of their child’s therapy might remain private. The psychologist will share information with the parents when it is in the child’s best interest or when it would assist the parents in relating to their child.

CASE CONSULTATION

In an effort to provide quality care, your psychologist may review your case with a consultant (s) following the guidelines of confidentiality. Such consultation enables us to provide the best possible care.

If you have any questions, please bring them to the attention of your psychologist.

CONTRACT

I have read the information on my right to confidentiality. I agree to permit consultation with other relevant professionals as deemed appropriate by my psychologist. I also agree that if I am involved in any legal proceedings, including custody, that I will only use the psychologist as an expert witness if (s)he specifically agrees to provide such expert testimony. I also agree that if I am part of a therapy group, I will not breach the right of confidentiality of other group members just as they agree not to breach my rights.

Initials

I understand that my contract to pay fees is with Craig D. Olson, Psy.D. and that I am legally responsible for any fees I incur with Craig D. Olson, Psy.D. regardless of any understanding I have about my insurance and/or managed care company. I understand that I am responsible for my entire bill.

Initials

I have received a copy of the Office Policies of Craig D. Olson, Psy.D. I have reviewed and agree to abide by the terms of these policies.

Initials

TREATMENT CONSENT

I hereby give authorization for the provision of psychological services to myself and/or child/children.

Date

Signature