



Be the author of your story...

# Emergent Pathways Psychotherapy

www.emergepsych.com | 346.232.5060

## PSYCHOTHERAPY SERVICE CONTRACT

Welcome to **Emergent Pathways Psychotherapy**. This document contains important information about my professional services and business policies. Please read it carefully and jot down any questions you might have so that we can discuss them at our first meeting. When you sign this document, it will represent an agreement between us.

### The Therapeutic Process

Psychotherapy is not easily described in general statements. It varies depending on the personalities of the psychologist and patient, and the particular difficulties your child brings forward. There are many different methods I may use to deal with the concerns that you hope to address. Psychotherapy is not like a medical doctor visit. Instead, it calls for a very active effort on your child and the family's. In order for the therapy to be most successful, you and your child will have to work on the things we discuss both during our sessions and at home. Sometimes, therapy "homework" will be assigned to facilitate the change that is desired.

Psychotherapy can have benefits and risks. Since therapy often involves discussing unpleasant aspects of life, and certain approaching feelings or thoughts may cause your child to experience uncomfortable feelings like sadness, guilt, anger, frustration, loneliness, and helplessness. Making changes in a person's beliefs or behaviors can be scary, and sometimes disruptive to current relationships. Alternately, psychotherapy has also been shown to have benefits for people who go through it. Therapy often leads to better relationships, solutions to specific problems, and significant reductions in feelings of distress. But there are no guarantees of what you and your child will experience, as everyone takes something different from this process.

## PSYCHOTHERAPY INFORMATION DISCLOSURE STATEMENT

Therapy is a relationship that works in part because of clearly defined rights and responsibilities held by each person. This frame helps to create the safety to take risks and the support to become empowered to change. As a patient in psychotherapy, you and your child have certain rights that are important for you to know about because this is your child's therapy, and the goal is your child's well-being. There are also certain limitations to those rights that you should be aware of. As a therapist, I have corresponding responsibilities to you and your child.

### My Responsibilities to You as Your Child's Therapist

#### Confidentiality

With the exception of certain specific exceptions described below, you have the absolute right to the confidentiality of your therapy. Although as a parent, you have a legal right to your child's

information, it is important to limit my disclosures to parents unless in emergency situations. This will help me foster a sense of trust with your child. I cannot and will not tell anyone else what you or your child has told me or even share that your child is in therapy with me without your prior written permission. Under the provisions of the Health Care Information Act of 1992, I may legally speak to another health care provider for the purpose of consultation without your prior consent. I will always act so as to protect your child's privacy even if you do release me in writing to share information about your child. You may direct me to share information with whomever you choose, and you can change your mind and revoke that permission at any time. You may request anyone you wish to attend a therapy session with you and your child.

You are also protected under the provisions of the Federal Health Insurance Portability and Accountability Act (HIPAA). This law insures the confidentiality of all electronic transmission of information about patients. When and if I transmit information about your child electronically (for example, sending bills or faxing information), it will be done with special safeguards to insure confidentiality.

If you elect to communicate with me by email at some point in our work together, please be aware that email is not completely confidential. I do use encryption software as a means of protecting your child's private health information. All emails are retained in the logs of your or my internet service provider. While under normal circumstances no one looks at these logs, they are, in theory, available to be read by the system administrator(s) of the internet service provider. Any email I receive from you, and any responses that I send to you, will be kept in your child's treatment record.

**The following are legal exceptions to your child's right to confidentiality. I will inform you of any time when I think I will have to put these into effect.**

- 1) If I have good reason to believe that your child will harm another person, I must attempt to inform that person and warn them of your child's intentions. I must also contact the police and ask them to protect the intended victim.
- 2) If I have good reason to believe that a child or vulnerable adult is being abused or neglected, or if you give me information about someone else who is doing this, I must inform Child Protective Services and/or Adult Protective Services immediately.
- 3) If I believe that your child is in imminent danger of harming him or herself, I will immediately disclose this information to you so that a safety plan can be made and/or arrangements for an evaluation at a hospital.
- 4) If your child tells me of the behavior of another named health or mental health care provider that informs me that this person has either a) engaged in sexual contact with a patient or b) is impaired from practice in some manner by cognitive, emotional, behavioral, or health problems, then the law requires me to report this to the appropriate licensing board, unless this report would break your child's confidentiality. I would inform you before taking this step.

### **Record Keeping**

Your child's record will include copies of forms you have signed, fees and other billing information, dates that your child attended therapy, what interventions were used in session, and the topics we discussed. In addition, any communication that we have outside of session (phone, email, etc.) will be noted in your child's record. Under the provisions of the Health Care

Information Act of 1992, you have a right to a copy of your child's file at any time. You have the right to request that I correct any errors in your child's file. You have the right to request that I make a copy of your child's file available to any other health care provider at your written request. I maintain your records in a digital format on a password protected computer that also has up-to-date encryption software and malware detection software as a means of protecting your child's private health information.

### **Other Rights**

I view therapy as a dynamic, collaborative process that, much like relationships in your child's life, may require certain revisions over time. You have the right to ask questions about anything that happens in therapy. I am always willing to discuss how and why I've decided to do what I am doing, and to look at alternatives that might work better for your child. You can feel free to ask me to try something that you think will be helpful. You can ask me about my training related to the concerns you are bringing to therapy, and can request that I refer your child to someone else if you decide I am not the right therapist for your child. You are free to leave therapy at any time.

### **YOUR RESPONSIBILITIES AS A THERAPY PATIENT**

#### **Keeping Appointments**

You are responsible for coming to your session on time at the time we have scheduled. Sessions last for 50 minutes unless other arrangements have been made. If you are late, we will end on time and not run over into the next person's session. **If you miss a session without canceling, or cancel with less than 24 hours notice, you must pay for that session (full fee of \$180) at our next regularly scheduled meeting.**

#### **Payment for Services**

You are responsible for paying the insurance copayment or else the session fee of \$180.00. If we decide to meet for a longer session, I will bill you a prorated fee based on my hourly rate. I typically do not charge for emergency phone calls of less than ten minutes. I cannot accept bartered goods for therapy. I do accept credit cards, cash PayPal, Venmo, and personal checks. A convenience fee is added to the charge when using a credit card. If I am unable to collect my fees from you I reserve the right to give your name and the amount due to a collection agency.

#### **Insurance**

I do accept several forms of insurance at this time, including Aetna, Cigna, and BCBS (PPO). Any diagnosis that is made will become part of your child's permanent insurance records. You may also pay out-of-pocket and be reimbursed by your insurance carrier if I am not in-network.

### **PSYCHOLOGICAL SERVICES**

#### **Therapy**

I normally conduct an evaluation that will last from 1 to 3 sessions. During this time, we can both decide if I am the best person to provide the services your child needs in order to meet your therapy goals. If psychotherapy is begun, I will usually schedule one 50-minute session (one appointment hour of 50 minutes duration) per week at a time we agree on, although some sessions may be longer or more/less frequent. **Once an appointment hour is scheduled, you**

**will be expected to pay for it unless you provide 24 hours advance notice of cancellation unless we both agree that you were unable due to circumstances beyond your control.**

The first few sessions will involve an evaluation of your child's needs. By the end of the evaluation, I will be able to offer you and your child some first impressions and we will work collaboratively to decide what our work will include, if you decide to continue with therapy. You should evaluate this information along with your own opinions of whether you and your child feel comfortable working with me. Therapy involves a large commitment of time, money, and energy, so you should be very careful about the therapist you select. If you have questions about my process or procedures, we should discuss them whenever they arise. If your doubts persist, I will be happy to refer you to another mental health professional.

You and your child normally will be the ones who decide when therapy will end, with three exceptions. A) If we have contracted for a specific short-term piece of work, we will finish at the end of that contract. B) If I am not in my judgment able to help you, because of the kind of difficulty your child is bringing to therapy or because my training and skills are in my judgment not appropriate, I will inform you of this fact and refer you to another therapist who may meet your child's needs. C) If you or someone close to you do violence to, threaten, verbally or physically, or harass myself, my office, or my family, I reserve the right to terminate you unilaterally and immediately from treatment. If I terminate you from therapy, I will offer you referrals to other sources of care, but cannot guarantee that they will accept you for therapy. If you decide to discontinue therapy, please contact me so that we can schedule a final session. Termination itself can be a very constructive process, and I encourage you to discuss any plans to end your therapy as soon as is necessary. If any referrals are needed, I can provide those when we meet.

### **Psychological Evaluations**

My base evaluation fee for gender transition-related hormone assessment is \$650. For facial, chest, or genital surgery, it is \$750; and for legal name/gender change is \$200. This fee includes meeting with you and your child to conduct the evaluation over several sessions, consulting with other health and mental health providers with your permission, and writing a report or letter. If I determine that your child would benefit from further therapy related, or unrelated, to gender identity and transitioning, your fee will be \$180 per session or your insurance copayment.

If you become involved in legal proceedings that require my participation, you will be expected to pay for all of my professional time, including preparation and transportation costs, even if I am called to testify by another party. Because of the difficulty of legal involvement, I charge \$200 per hour for preparation, travel, and attendance at any legal proceeding, as per a separate fee schedule for such services that I will provide if you require these services.

### **Contact**

I am often not immediately available by telephone. When I am unavailable, please leave a voicemail. I will make every effort to return your call within 24 hours, with the exception of weekends and holidays. If you are difficult to reach, please inform me of some times when you will be available. Although e-mail has its limitations listed above, I do respond to e-mails more quickly. Again, e-mail is not a secure means of communication, but I am comfortable having conversations over e-mail, with your consent, that may include more personal information beyond scheduling and logistical issues. My email address is: ks@emergepsych.com.

I am away from the office several times in the year for vacations or other professional obligations. If I am not responding to phone or e-mail messages during those times I will have another therapist cover my practice. I will tell you well in advance of any anticipated lengthy absences, and give you the name and phone number of the therapist who will be covering my practice during my absence. If you are experiencing an emergency when I am out of town, and believe that you cannot keep yourself safe, please call 911, or go to the nearest hospital emergency room for assistance.

### **Complaints**

If you are unhappy with what is happening in therapy, I hope that you will talk about it with me so that I can respond to your concerns. I will take such criticism seriously, and with care and respect. If you believe that I have been unwilling to listen and respond, or that I have behaved unethically, you may file a complaint about my behavior to the Texas Board of Examiners of Psychologists.

### **PATIENT CONSENT TO PSYCHOTHERAPY**

I have read this statement, had sufficient time to be sure that I considered it carefully, asked any questions that I needed to, and understand the statement. I understand the limits to confidentiality required by law. I agree to pay my insurance copayment or else the fee of \$180.00 per session. If I plan to be reimbursed by my insurance company I consent to the use of a diagnosis in order to complete this process. I understand my rights and responsibilities as my child's parent/guardian, and my therapist's responsibilities to my child. I agree for my child to undertake therapy with Kaden J. Stanley, Psy.D. I understand that I can end therapy at any time I wish and that I can refuse any requests or suggestions made by Dr. Stanley.

Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

I have reviewed the above policies and informed consent with the patient and there is no misunderstanding or disagreement.

\_\_\_\_\_  
Kaden J. Stanley, Psy.D.  
Licensed Psychologist TX #36976

Date: \_\_\_\_\_