Karyn Goldberg-Boltz, Ph.D.
Licensed Clinical Psychologist,

2930 Camino Diablo, Suite 305
Walnut Creek, CA 94597
CA License: PSY11181

(925) 788-7888
karyn.goldbergboltz@gmail.com

Practice Policies, Billing Agreement and Informed Consent for Treatment Form

Welcome to my practice. I look forward to meeting you soon. Please read the following information about my policies and procedures, and sign below indicating you understand and accept all of them.

Psychotherapy Services

Psychotherapy is a process that varies depending on the personalities of the therapist and patient, and the particular problems you are experiencing. I use a variety of methods to help you deal with the problems that you want to address. In our first few sessions I will offer you some sense of what therapy will entail. We will work together to come up with a treatment plan that best suits your needs and addresses your concerns. Psychotherapy calls for an active effort on both our parts. To be most successful, you will need to be honest and forthcoming about yourself and the feelings that arise during our work. If you ever have questions about my procedures, concerns about your ability to pay for my services, or any questions or feelings that arise during our meetings, please discuss them with me during our sessions. I can be more effective if you give me feedback about things I do or say that are helpful or not; my goal is to help you.

Types of Services and Fees

• Diagnostic Evaluations (Initial Consultations): $360//hour for individuals, $450/hr. for couples.
The first session we meet will involve the gathering of information and assessment of your situation. I will provide you with feedback and we can begin to design a treatment plan. If it turns out you or I decide I can't provide the best services for you, I will attempt to help you find someone with the appropriate expertise.
• Ongoing Sessions: $320/hr individual and $400 /hr couples. If you would like extra time, I will prorate my fee accordingly.
• Other Professional and Administrative Services:
I charge your same fee for additional work outside of your regular therapy sessions, including: phone calls over 10 minutes, report-writing, non-scheduling related email exchanges, consultation/collaboration on your behalf, emergency procedures, management of insurance or billing related issues and duplicating invoices. (Time required to collect payments or pursuant to any legal issues that arise on your behalf, including my transportation and consultation time, is billed at the rate of $450/hr.)

Cancellations

I respect your time and work hard to accommodate the schedules of my clientele. If you need to cancel your appointment, I appreciate as much notice as is possible. I do *maintain a standard 24 hour cancellation policy*. When we book an appointment, I reserve that time for you; you agree to pay for that time, whether you are able to make it or not. *Please remember to give me at least 24 hours notice for a cancellation, or, even if there is a great reason, you will be charged in full for your missed session.*

Payments and Insurance

Please be prepared to pay for services at the beginning of your session so we don't have to use your therapy time. I can take cash, check, VNMO and Zelle. Please remember that you are responsible for the payment of my services, at the time of service. I am not on any insurance panels, and do not work with any carriers directly. I will provide a statement at the end of the month that you can submit to your insurance company for reimbursement, if applicable. (Most carriers offer mental health benefits, so please check to see if your policy covers "out of network providers," find out your rate of reimbursement and be aware of any potential limitations or requirements.) Therapy will be postponed after two unpaid sessions. *Late fees at the rate of 10% will accrue for any unpaid bill after 60 days*.

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Contacting Me

Please call me at (925) 788-7888. If I am not available, please leave a message on my private voice. If you need to contact me regarding your appointment schedule, you may email me. If you need to contact me immediately regarding your upcoming session you may text me. (Please refer to my Social Media Policies and remember that email and texting are not fully secure methods of communication.)

Emergencies

If you, or your dependent are having an emergency and are unable to reach me, please call the Contra Costa Crisis Center at (925) 939-1916, go to the nearest emergency room, or call 911 for assistance.

Confidentiality

Your (or your dependent's) trust and sense of privacy are essential in working with me and I take it very seriously. Everything you (or they) tell me, including one' name, is confidential. The law, and professional ethical guidelines, protect the privacy of all communications between a patient and a psychologist. If I need to consult with other professionals on your (or your dependent's) behalf during the course of our work to provide the best care possible, I will first ask your permission. In most situations, I can release information about your treatment to others only if you sign a written authorization form. There are, however, some exceptions in which I am permitted, or even required to disclose information about you (or your dependent) without your (or their) consent or authorization. Please review my *Notice of Privacy Practices Form* for details, but they include:

- *Pursuant to a legal proceeding or subpoena, if the court orders me to disclose information concerning your (or your dependent's) treatment, or if you file a worker's compensation claim, I must provide information about your case.
- If you (or they) were to file a complaint or lawsuit against me, or breach our professional contract, I may disclose relevant information regarding your (or their) case in order to defend myself or collect any outstanding payments.
- If I have reason to believe that a child or vulnerable adult is being or has been neglected or abused, the law requires that the situation be reported to the appropriate state agency.
- *If I believe you (or your dependent) presents a clear and substantial danger of harm to yourself (him/herself) or another/others, I must take protective actions. These may include contacting you and/or family members, seeking hospitalization, notifying any potential victim(s), and notifying the police.

If such situations arise, I will make every effort to fully discuss it with you before taking any action and will limit disclosure to only what is necessary under the circumstances.

Professional Records

The laws and standards of my profession require that I keep Protected Health Information in your or your dependent's Clinical Record. This may include information about your symptoms, diagnosis, goals for treatment, attendance, progress toward those goals, your medical history, records and reports that I receive from other providers and payment records. However, I also keep psychotherapy notes which are for my own private use and designed to aid me in providing you with the best treatment. These notes are kept separate from your Clinical Record and are not released to others, except under rare legal circumstances. Please see my *Notice of Privacy Practices Form* for additional information.

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Please initial the following treatment contract statements to indicate your consent:

_____I have read and understand the *Practice Policies, Billing Agreement and Consent for Treatment* information above, as well as Dr. Goldberg-Boltz's *Notice of Privacy Practices* and *Private Practice Social Media Policy* Forms. I have asked any questions that I needed to. I agree to all of these office policies and consent to participate, or allow my dependent to participate, in psychotherapy treatment with Karyn Goldberg-Boltz, Ph.D.

_____I consent to Dr. Goldberg-Boltz contacting my doctor(s), referring or collaborating professionals to inform them that I, or my dependent, is in psychotherapy, and to exchange necessary information on my behalf that may be helpful to the treatment and allow her to provide optimal care.

_____If I am using insurance to reimburse me for my treatment, I consent to Dr. Goldberg-Boltz providing information to my insurance company needed for the purposes of billing.

_____I understand that I am personally responsible for all fees for services and procedures provided by Dr. Goldberg-Boltz, as delineated in this form. Payments are due at the time of service and a 10% fee will accumulate on balances after 60 days.

_____I understand and consent to the late ***Cancellation Fee Policy*** and agree to pay the full fee for scheduled appointments which I, or my dependent, misses or cancels with less than **24 HOURS notice**.

Patient Name: _____ Age _____ Date of Birth: _____

Person Responsible for Payment:_____

Signature: _____ Date: _____ CA Driver's License or SSN: _____

Address (Street #, City,Zip):_____

Home Phone:_____ Work: _____ Mobile: _____

Email(s): _____ Ok to leave messages? Y/N

Patient (Dependent's) phone and email, if different: _____

Emergency Contact:_____ Phones:_____

Physician/Psychiatrist/Teacher/Others with whom I have permission to collaborate, and their phone numbers: _____

_____

Current medical conditions and medications:_____

_____

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Optional Information (please use back of page if you'd like):

Others living in your home? (Name, Age, Relationship to you, Occupation or School Grade): _____

_____

Please describe the concerns for which you are seeking help, and the results you hope to achieve:_____

_____

_____

_____

_____

_____

_____

_____

Is there anything you would like me to know about you, your relationship or your child/teen before we start? _____

_____

_____

_____

_____

_____

_____

Thank you, I look forward to meeting you, **Dr. Goldberg-Boltz**