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## OUTPATIENT SERVICES AGREEMENT

Welcome to my practice. This document contains important information about my professional services and my business policies. This consent form is designed to answer some frequently asked questions. Please read it carefully and note any questions that you may have so we can discuss them at our next meeting. When you sign this document, it will represent an agreement between us.

### PSYCHOLOGICAL SERVICES

Our first few sessions will involve an evaluation of you and/or your child's needs. By the end of the evaluation, I will be able to offer you some first impressions of what our work will include and a treatment plan to follow if you decide to continue with therapy. As part of the evaluation, I may recommend further assessment, including psychological testing, family sessions and/or referral to other professionals (educational specialists; pediatricians, etc.). If therapy is recommended, it is important to recognize that therapy involves a large commitment of time, money and energy.

Although psychotherapy is not easily described in general statements, the process can have benefits and risks. For example, because therapy often involves discussing unpleasant aspects of your life, you may experience uncomfortable feelings like sadness, guilt, anger, frustration, loneliness and helplessness. On the other hand, psychotherapy has also been shown to have benefits for people who go through it. For example, 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 will experience.

Please note that if at any time you have questions about any "ups" or "downs" you might feel, or my procedures, or concerns about the process, you should bring them up for discussion.

If psychotherapy is agreed upon, I will usually schedule one 45-minute session per week at a time we agree on, although, at times, sessions may need to be more frequent, or they may need to be longer. When working with minors, I include parents in the treatment in some capacity. Depending on the presenting problem, that is the issues related to why

you are seeking help, I may recommend family visits, regular parent counseling sessions or joint meetings held on a less regular basis.

In general, the privacy of all communications between a patient and a psychologist is protected by law, and I can only release information about our work to others with your written permission. Sessions with any minor with whom I work are also confidential, which is essential to my successful work with children and adolescents. Minors are free to discuss their sessions, if they choose, with anyone, but I am bound to keep private any communication obtained during a therapy session. However, there are a few exceptions to this rule. If the patient threatens harm to himself/herself, I am obligated to break confidentiality and inform parents. Additionally, if a patient is threatening bodily harm to another, I am required to take protective action. If child abuse or neglect is revealed during any evaluation or therapy sessions, I am required by law to notify the appropriate government authority or agency.

### CONTACTING ME

I may not be immediately available by telephone. When I am unavailable, my telephone is answered by voice mail that I monitor frequently. I will make every effort to return your call on the same day you make it, with the exception of weekends and holidays. If you are difficult to reach, please inform me of some times when you will be available.

If you are unable to reach me and feel that you cannot wait for me to return your call, contact your family physician or the nearest emergency room, and ask for the psychologist or psychiatrist on call.

If I will be unavailable for an extended time, I will provide you with the name of a colleague to contact, if necessary.

### FEES AND PAYMENT

My fee is \$185 for a 45-minute session. Sessions of longer duration will be pro rated at \$250/hour. Additional services, such as attendance at meetings with other professionals, preparation of records and the time spent performing any other service you may request, (or which are directly related to therapeutic services on your behalf), will be billed at \$250/hour. Telephone contacts with parents, teachers, physicians, tutors and other professionals of more than ten (10) minutes per week will be charged on a pro rated basis of \$250/hour. Please note that these fees may not be reimbursed by your insurance.

Once an appointment is scheduled, you will be expected to pay for it unless you provide 48 hours advance notice of cancellation, except in cases of serious medical emergencies or extreme weather conditions that preclude the use of automobile transportation. Please note that missed appointments may not be reimbursed by your insurance.

Payment is expected at each session. If a minor is the patient, parents may choose to pay for the month in advance in order to avoid the adolescent being responsible for each

session payment. Bills are rendered at the last patient appointment of each month, and the billing statement contains the standard information needed to swiftly process your claim. However, I do not participate with any insurance company, nor am I a “preferred provider.” You are responsible for payments in full, and any insurance reimbursement is between you and your insurance carrier.

Interest (at the rate of 10% per annum) will be assessed on any unpaid balance after sixty (60) days unless previous arrangements for payment have been made.

Your signature below indicates that you have received a copy of this document, you have read it and that you agree to abide by its terms during our professional relationship.

DATE \_\_\_\_\_ SIGNATURE \_\_\_\_\_  
(Patient, Parent or Legal Guardian)

Name (Print) \_\_\_\_\_ Home Phone: ( ) \_\_\_\_\_

Address: \_\_\_\_\_ Work Phone: ( ) \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Cell Phone \_\_\_\_\_ E-Mail \_\_\_\_\_

RESPONSIBLE PARTY (if other than patient):

Name \_\_\_\_\_ Home Phone: ( ) \_\_\_\_\_

Work Phone: \_\_\_\_\_ Cell Phone: ( ) \_\_\_\_\_

Address (if different from Patient): \_\_\_\_\_  
\_\_\_\_\_

E-Mail \_\_\_\_\_