

Integrative Psychological and Assessment Services
Christina Zampitella, Psy.D., FT, (PSY20878)
4565 Ruffner St., Suite 203
San Diego, CA 92111

FOR YOUR INFORMATION

This form is provided to give you important information regarding your rights and responsibilities as a client. After you have read this material, I will be happy to answer any questions you might have.

CLIENT RIGHTS

1. You have the right to ask any questions about the procedures used in therapy. If you wish, I will explain my usual methods of practice to you.
2. I will inform you if I intend to use unusual procedures and will explain the risks involved, as well as alternative methods that could be used in its stead. You will have the right to refuse the use of any therapeutic techniques.
3. You have the right to learn about alternative methods of treatment and I will gladly discuss these, at your request, during our work together.
4. You have the right to end your psychotherapy at any time without prejudice. If you wish, I will provide you with names of other qualified psychotherapists.

CONFIDENTIALITY

Anything you tell me is considered privileged information and will be held in confidence by me. I will not release any information to others about you unless you give me explicit permission to do so in writing. If you request that I release information about you, I will tell you are the time if I believe making your records public could be harmful to you.

Please be aware, however, that there are certain situations in which I am required by law to reveal information without your permission. These are listed below:

1. Serious threats to harm yourself.
2. Serious threats to harm another person or their property.
3. Child, elder, or dependent adult abuse.
4. Some information is often requested by your insurance company (if you use insurance), such as diagnosis, progress, prognosis, and treatment plan
5. Court-ordered requests for information about you.

Also, I send all my billing is done by Katie Tone, our in house billing specialist. If you have any questions, we can discuss this and other available options.

EMERGENCY COVERAGE

You may leave a message for me 24-hours a day at (760) 470-4274. When I am out of town, I will make arrangements for another qualified therapist to cover any crisis that may arise. In the even that I cannot be reached quickly, you should call your physician or

psychiatrist, dial 911, and go to the emergency room of a local hospital, or call the San Diego Crisis Line at (619) 479-3339.

PSYCHOLOGICAL SERVICES

Once an appointment is scheduled, you will be expected to pay for it unless you provide 24 hours advanced notice of cancellation. You will also be charged for all appointments for which you fail to appear. If you usually pay a co-pay, or your insurance carrier pays for your entire treatment, please note that your insurance company cannot be billed for any missed or cancelled sessions. Therefore you will be responsible for the hourly rate of your therapy.

My hourly fee is \$150.00. You will be expected to pay for each session at the time it is held, unless we agree otherwise. In circumstances of unusual financial hardship, I may be willing to negotiate a fee adjustment or payment installation plan. Should additional services be provided or should fees be changed, fair notice will be given to you.

My testing fees vary based on what is needed for the evaluation. My policy is to collect half of the assessment fee at the start of the assessment (Diagnostic Interview) and collect the balance at the time of the report feedback. My general fee for a full ADHD/Learning Disability Evaluation is \$1500.00. Please ask me about any questions regarding this arrangement.

I also reserve the right to utilize a collection agency for outstanding balances not paid in full by the time therapy is terminated.

It is my policy to request payment at the time services are provided, unless other arrangements are made in advance. Although I will assist in billing your insurance carrier and accept assignments of benefits on our behalf, your fees are a contract between you and me. You will be responsible for those fees, including those not paid by your insurance carrier. If circumstances have lead to a time of difficulty for you, I urge you to contact my office so we can make appropriate financial and session arrangements.

ABOUT PSYCHOTHERAPY

Assisting you to reach your goals in therapy is the purpose of our work together. You can do your part openly and honestly communicating your thoughts and feelings, although this may be difficult at times. These communications may make you feel worse before you feel better. There is a risk that you may recall unpleasant events or come to painful conclusions, which may cause you to feel anxious, depressed, frustrated, or hopeless at times. These feelings are a normal part of the therapy process and are usually temporary. We will work together to get through the difficult times. If you are ever concerned that our work is not helping, please discuss this with me.

By signing below, I acknowledge that I have read this for and have had any questions answered to my satisfaction.

Signature of Client

Date

Signature of Therapist

Date

(6/20/10)