

Rich & Associates
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PSYCHOTHERAPY SERVICES AND POLICIES

This document contains important information about our professional services and business policies. Please read it carefully and ask us any questions that arise. When you sign the last page of this document, it represents an agreement between us.

PSYCHOLOGICAL SERVICES

Psychotherapy varies depending on the particular problems you and/or your child bring and the approach of the therapist. It is important to select a therapist that fits your style and goals. By the end of the intake evaluation, we will be able to offer you our recommendation of whether you and/or your child can benefit from our services. If not, we will try to refer you to a more appropriate therapist/therapy group. Therapy involves a commitment of time, money, and energy, so you should make sure you feel comfortable working with us. If you have questions about our work together, we should discuss them whenever they arise. If your doubts persist, we will be happy to provide a referral to another mental health professional.

Should you decide to move forward with our services, it is because the treatment goals that you identified for yourself or your child are in line with those that are covered by the group's curriculum or as outlined by your child's individual therapist. Group curriculums are designed to meet the needs of the majority. Fortunately, our group sizes are small, allowing for some individual work to occur within the group. However, it is important for you to accept the stated curriculum as the major focus of the treatment. In individual therapy the focus is specifically on you and/or your child and is tailored to fit individualized needs. Referrals for additional services will be provided as needed and upon request. It is also important to remember that the results of therapy cannot be guaranteed.

CONFIDENTIALITY

Your discussions with a licensed psychologist are considered *confidential*, which means these discussions are protected by law. We may not disclose confidential information about you without your formal consent. However, when working with an unlicensed associate, your case will be discussed with the supervising psychologist. There are also situations in which we are required to break confidentiality. These include the following circumstances: if you or your child are in danger of harming yourself or another person; if you are unable to care for yourself; if there is suspected abuse or neglect of a child, older adult (65 or older), or dependent adult; if we are court ordered to release information as part of a legal proceeding; or as otherwise required by law.

PROFESSIONAL FEES, BILLING, AND PAYMENTS

Payments are to be made at the beginning of each individual appointment, program, or service. **Cash or checks only.** The intake fee is non-refundable regardless of future participation in one of our programs. When your child is participating in a group, half of the group fee is required before a spot in the group will be held for your child, with a portion of this fee being non-refundable. The balance is due on the first session:

*No refunds will be given for sessions missed for **any reason**, including illness, childcare difficulties, vacation, traffic, or inclement weather.* Should you decide to drop from the program, you will not be refunded money for the remaining sessions. In extenuating circumstances, a limited payment schedule may be arranged.

Individual Sessions: Our 45-minute session fee varies by clinician. There will be no charge for *brief* telephone calls and *quick* e-mail exchanges (i.e., limited to updates and scheduling).

Other services include telephone consultations, report writing, in-home visits, comprehensive school consultations, team meetings, IEP advocacy, case management, or other services you may request of us at our regular hourly rate, including travel time. We do not charge for typical consultations with other professionals involved in your child's care (i.e., brief updates). If you become involved in legal proceedings that require our participation, you will be expected to pay for the professional time we spend preparing records or treatment summaries. You will also be expected to pay for our time spent testifying, even if we are called to testify by another party. There is typically a small increase in fees each year.

Cancellation Policy: There is a 24-hour cancellation policy for individual appointments and other individually scheduled services (e.g., school visits). Should you cancel or no-show with less than a 24-hour notice *for any reason*, you will be charged the full session fee.

Late Fees: There is a \$15 fee for returned checks. A late fee will be added for any charges past due by 30 days, with additional charges accruing monthly. If your account has not been paid for more than 60 days, we may use legal means to secure the payment and include its costs in the claim.

INSURANCE REIMBURSEMENT

Certain health insurance policies (e.g., PPO plans) will provide some coverage for "out of network" mental health treatment, however, you (not your insurance company) are responsible for full payment of our fees. You will be provided with superbills for services paid in full that contain information your insurance company may require, however, it will be your responsibility to complete insurance forms and obtain reimbursement. It is very important that you find out exactly what mental health services your insurance policy covers and the status of your deductible. Of note, insurance companies typically do not reimburse for missed sessions. If you have an HMO, please ask us about pursuing a single case agreement for insurance coverage.

CONTACTING RICH AND ASSOCIATES

Our preferred method of communication is via e-mail for the most rapid response. You may also contact your therapist at their direct line listed on our website or call or text Dr. Erika Rich at (310) 709-6427. Although we are often not immediately available by telephone, we check our voicemail regularly. If you are unable to reach your therapist and feel that you cannot wait for them to return your call, contact your family physician, your psychiatrist, or the nearest emergency room. It is important to note that we do not provide crisis services and are not available 24 hours a day. Should your child become a danger to him/herself or someone else, you should take him/her to the nearest emergency room for care or dial 911 for assistance.

Please note that although the internet provides a fast and convenient method of communication, confidentiality cannot be guaranteed through electronic mail, as e-mails can sometimes be intercepted. Similarly, it is possible for wireless phone conversations to be overheard. Please inform your therapist *in advance* if you have concerns about privacy through e-mail or wireless phone use.

ENDING THERAPY

You may end therapy at any time. A final individual session is important so that your child has closure with his/her therapist. If you end a group early, it is important to give your child a chance to say goodbye in a final session.

Please Note: This policy is subject to change at any time; current clients will be kept updated.

I have read and understand this document and I have had my questions answered to my satisfaction. I accept, understand, and agree to abide by the contents and terms of this agreement. Please initial the statements below to indicate your agreement and sign below to indicate your consent for treatment:

_____(initial) I understand that cell phone and e-mail correspondence can potentially be intercepted and is therefore not guaranteed to be confidential.

_____(initial) I understand that individual therapy and consultation appointments must be cancelled within 24 hours of the appointment to avoid paying the full fee. I further understand that once an appointment is scheduled, it is my responsibility to record the date and time. Reminders are not given.

_____(initial) I understand that I will be charged for phone calls beyond 10 minutes and for lengthy e-mail exchanges. I will be warned of a charge beforehand.

_____(initial) I understand that Rich and Associates will provide me with a “superbill” to submit to a PPO insurance company periodically for past paid sessions. Insurance does not reimburse for missed sessions. All receipts or invoices will be e-mailed unless otherwise indicated.

_____(initial) I understand that my child’s spot in group therapy may be given away unless the non-refundable deposit payment is made by the deadline.

_____(initial) I understand that there is no reimbursement for missed group therapy sessions for any reason, even if I decide to drop out of the group.

_____(initial) I pledge to uphold the confidentiality of all group members when participating in group therapy. This means keeping personal information about group members to myself. It also means describing the social skills group as a “playgroup” to people who may know both my child and another child in the group.

_____(initial) I agree to refrain from making playdates with other group members until one or both of the children have ended their participation in the group. A playdate that goes well could cause a clique to form and a playdate that goes poorly could cause friction in the group.

_____(initial) I understand that Dr. Rich’s associates may not be licensed, and therefore work directly under Dr. Rich’s supervision. When my child works with an unlicensed therapist from Rich and Associates, Dr. Rich will be discussing my child’s treatment with that therapist on a regular basis.

_____(initial) I certify that a copy of Rich and Associates’ Notice of Privacy Practices detailing the provisions of HIPAA and my/my child’s privacy rights was made available to me at www.socialskillsgroup.com/forms.html.

Name of Child (please print)

Name of Parent/Legal Guardian (please print)

Signature

Date

Relationship to Child: _____