



**The Psychology Practice of
Michael G. Selders, Ph.D., PLLC**
2602 Martin Luther King Jr. Blvd
Dallas, TX 75215
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CONSENT TO TREATMENT

INTRODUCTION

Welcome to my private practice. I am very pleased to begin working with you (or your child), and I hope this document is helpful in providing you the necessary information to assist you in making an informed decision regarding my services. If you have questions, please do not hesitate to ask me.

EXPERIENCE

I am a Licensed Psychologist in the State of Texas (#34549) and Illinois, and I earned a Doctorate Degree in Counseling Psychology from Loyola University in Chicago, Illinois. My training and experience covers a diverse span of ages, cultural, racial, and ethnic backgrounds and groups. My approach to working with individuals, couples, families, and groups in therapy is integrative, which allows me to conceptualize and understand my client's therapeutic needs from a broad treatment perspective.

APPOINTMENTS

Appointments typically occur once per week at an agreed upon time. However, depending on the treatment needs, there are occasions in which additional appointments may be arranged. Psychotherapy or couples therapy sessions range from 30-60 minutes in duration, while assessments and consultations are generally longer. Depending on the situation, some sessions may be shorter or longer and less or more frequent. If you need to cancel or reschedule, please provide me with a 24-hour notice.

ASSESSMENT/EVALUATION

The first 2-3 sessions offer a period of time for us to thoroughly discuss your (or your child's) existing issues, concerns, or challenges. During this time, I gather historical and other background information to better understand your (or your child's) situation. We will also discuss your (or your child's) treatment options, recommendations, and goals for therapy or assessment. Evaluation is a process, which will occur throughout the course of our working together, and this will provide opportunities for us to explore progress and modify therapy goals and interventions as needed. I work collaboratively with other mental health and medical providers, and when necessary and with your permission, I will make recommendations for a consult.

TREATMENT

Assessment, psychotherapy, and behavioral management can be very beneficial and rewarding, in that you (or your child) will have the opportunity to talk openly about concerns, work towards resolving personal issues, experience personal growth and fulfillment, and change unwanted behaviors. However, at the same time, there are some risks. These risks may include the experience of unwanted or unexpected feelings, such as sadness, anger, guilt, depression, anxiety, recalling unpleasant life events, facing unpleasant thoughts and beliefs, and changes in beliefs concerning interpersonal relationships. It is important to remember these feelings are normal and are an important part of the therapy and behavioral management process. We will discuss and explore your (or your child's) assumptions, problems, concerns, or possible side effects as we work together.

PAYMENT

You are responsible for paying for your (or your child's) weekly therapy or psychoeducational evaluation session. **My standard fee for a 60 minute initial consultation, diagnostic, or clinical interview is \$175.** Following the initial consultation, diagnostic, or clinical interview, together, we will determine and discuss the next course of action based upon your (or your child's) treatment needs. **My standard fee for a weekly 45-50 minute therapy session is \$150.00 for individual or couples therapy. Payment will be collected prior to the start of any session.** Cash, check, and all major credit cards are accepted for payment. However, the payment process is different for psychological testing or psychoeducational assessments, and will be discussed at the time of your (or your child's) pre-assessment meeting.

Services may be covered in full or in part by your health insurance or employee benefit plan. **Excluding clients using Texas Medicare and/or Medicaid insurance, for services covered in part, you are responsible for making a co-payment.** I am a credentialed provider with several insurance companies (Blue Cross and Blue Shield of Texas Participating Provider Plan (ParPlan)---Blue Choice, Blue Choice Plus, HealthSelect, and Indemnity (ParPlan), Cigna, Molina, Cenpatico Texas, and Texas Medicare, and Texas Medicaid. I am also in the credentialing process for several other insurance carriers, but until the credentialing process has been completed, you are responsible for paying for the services you receive in full. **If you are choosing to use your insurance to pay for services, you must contact your insurance carrier to check and determine the extent of your coverage carefully by asking the following questions:**

- (1) Do I (or my child) have mental or behavioral health benefits with my existing coverage?
- (2) What is my deductible and has it been met?
- (3) How many therapy sessions per year does my health insurance actually cover?
- (4) What is the coverage amount per therapy session?
- (5) How much is the co-pay amount per therapy session?
- (6) Is approval or a referral required from my Primary Care Physician in order for me (or my child) to begin services with a licensed psychologist?
- (7) Specifically, what written information will the insurance company require from the psychologist in order to process the claims for each therapy or psychoeducational session?

CANCELLATION OF APPOINTMENT

Because your treatment needs are very important to Dr. Selders, an agreed upon time for your appointment will be scheduled promptly. **If you must cancel your appointment for any reason, please do so at least 24 hours in advance of your scheduled appointment. However, if you fail to cancel your appointment at least 24 hours in advance, you will be responsible for paying the full amount for the scheduled service prior to Dr. Selders scheduling your next appointment.**

TERMINATION

Termination may occur at any time and may be initiated by either you or me. I request that if a decision to end treatment is reached, that you would give me a minimum two week notice so that we may have adequate time to discuss and explore the reasons for termination, and establish a plan for your aftercare if necessary. Termination can be a very constructive and useful part of the therapy and growth process. It can also be a time when treatment gains can be meaningfully consolidated and integrated into one's daily life. If any referral or plan for further treatment is warranted, these will be made during the termination process.

CLIENT'S RIGHTS

As my client, you (or your child) may question or refuse therapeutic or diagnostic procedural methods, or gain whatever information you wish to know about the process or course of therapy. You are assured confidentiality, which is protected

by ethical practice and Texas law. There are several important EXCEPTIONS to confidentiality that are legally mandated. In general terms, these exceptions include: (1) I must notify relevant others if I judge that you (or your child) have an intention to harm yourself (or yourself) or another identified person, (2) I must report child abuse, elder abuse, neglect, or molestation to the Texas Department of Family and Protective Services (DFPS) as required by law, (3) in legal proceedings, I and/or my records may be subpoenaed by the court, and (4) I may need to notify relevant others if I judge that you (or your child) are at imminent risk or danger of harming yourself (or yourself). Confidentiality will be respected in all cases, except those noted above. If you request that I disclose information to another person or professional, I must have your written permission to do so. We will also discuss the possible risks and benefits of requesting release of information to a third party, such as insurance providers. In such cases, I have release of information forms, which can be signed by you if you make the request to disclose information. It is my duty to always act so as to protect you (or your child's) privacy even if you do release me in writing to share information about you (or your child).

RECORD KEEPING

To better serve you, I am required and will keep very brief, but concise records of the psychological services I provide for you (or your child). These records will note general information such as your name, length of session, documentation of attendance, a general description of the topics and/or issues discussed, a diagnosis if applicable, and interventions used. All records are locked and maintained in a secure location in my office. Except in unusual circumstances that involve danger to yourself, you have the right to a copy of your file.

EMERGENCIES

If you experience an emergency (crisis) during weekly office hours of 9:00 a.m. to 5:00 p.m. feel free to contact me directly. However, if you experience an emergency at any other time, you should contact or visit the nearest hospital emergency room or call 911.

HIPAA NOTICE OF PRIVACY PRACTICES

The information that follows is the Privacy Notice that health care providers offer in compliance with HIPAA laws. In addition to the information in the HIPAA Privacy Notice, we follow state and federal laws regarding the confidentiality of mental health information. Before or at the first meeting we will provide you with more detailed written information about confidentiality, since we feel it is an extremely important part of therapy. We encourage you to ask questions about confidentiality or any other facets of treatment at any time.

Also, please note that The Psychology Practice of Michael G. Selders, Ph.D., PLLC does not collect information on people who use our website.

Notice of Psychologist's Policies and Practices to Protect the Privacy of Your Health Information

THIS NOTICE DESCRIBES HOW PSYCHOLOGICAL AND MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

I. Uses and Disclosures for Treatment, Payment, and Health Care Operations

We may use or disclose your protected health information (PHI), for treatment, payment, and health care operations purposes with your written authorization. To help clarify these terms, here are some definitions:

“PHI” refers to information in your health record that could identify you.

“Treatment” is when we provide, coordinate, or manage your health care and other services related to your health care. An example of treatment would be when we consult with another health care provider, such as your family physician or another psychologist.

“Payment” is when we obtain reimbursement for your healthcare. Examples of payment are when we disclose your PHI

to your health insurer to obtain reimbursement for your health care or to determine eligibility or coverage.

“Health Care Operations” are activities that relate to the performance and operation of our practice. Examples of health care operations are quality assessment and improvement activities, business-related matters such as audits and administrative services, and case management and care coordination.

“Use” applies only to activities within our practice such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.

“Disclosure” applies to activities outside of our practice, such as releasing, transferring, or providing access to information about you to other parties.

“Authorization” is your written permission to disclose confidential mental health information. All authorizations to disclose must be on a specific legally required form.

I. Other Uses and Disclosures Requiring Authorization

We may use or disclose PHI for purposes outside of treatment, payment, or health care operations when your appropriate authorization is obtained. In those instances when we are asked for information for purposes outside of treatment, payment, or health care operations, we will obtain an authorization from you before releasing this information. We will also need to obtain an authorization before releasing your Psychotherapy Notes. “Psychotherapy Notes” are notes your psychologist has made about a conversation during a private, group, joint, or family counseling session, which she or he has kept separate from the rest of your medical record. These notes are given a greater degree of protection than PHI. You may revoke all such authorizations (of PHI or Psychotherapy Notes) at any time, provided each revocation is in writing. You may not revoke an authorization to the extent that (1) we have relied on that authorization; or (2) if the authorization was obtained as a condition of obtaining insurance coverage, law provides the insurer the right to contest the claim under the policy.

III. Uses and Disclosures without Authorization

We may use or disclose PHI without your consent or authorization in the following circumstances:

Child Abuse – If we know or have reasonable cause to suspect that a child has been abused or neglected, we must report the matter to the appropriate authorities as required by law.

Adult and Domestic Abuse – If we suspect that an adult has been abused, neglected, or exploited and we have reasonable cause to suspect that the adult is incapacitated or dependent, we must report the matter to the appropriate authorities as required by law.

Health Oversight Activities – We may disclose PHI to the Texas Board of Examiners of Psychologists, or one of its representatives, pursuant to standards or regulations for regulation, accreditation, licensure, or certification.

Judicial and Administrative Proceedings – If you are involved in a court proceeding and a request is made for information about your diagnosis and treatment or the records thereof, such information is privileged under state law, and we will not release information without the written authorization of you or your legally appointed representative or a court order. The privilege does not apply when you are being evaluated for a third party or where the evaluation is court ordered. You will be informed in advance if this is the case.

Serious Threat to Health or Safety – If, in your psychologist’s reasonable professional judgment, she or he believes that you pose a direct threat of imminent harm to the health or safety of any individual, including yourself, she or he may disclose PHI to the appropriate persons.

Worker’s Compensation – We may disclose PHI as authorized by and to the extent necessary to comply with laws relating to worker’s compensation or other similar programs, established by law, that provide benefits for work-related injuries or

illness without regard to fault.

IV. Patient's Rights and Psychologist's Duties

Patient's Rights:

Right to Request Restrictions – You have the right to request restrictions on certain uses and disclosures of protected health information. However, we are not required to agree to a restriction you request.

Right to Receive Confidential Communications by Alternative Means and at Alternative Locations – You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations. (For example, you may not want a family member to know that you are seeing a professional at our practice. On your request, we will send your bills to another address.)

Right to Inspect and Copy – You have the right to inspect or obtain a copy (or both) of PHI in our mental health and billing records used to make decisions about you for as long as the PHI is maintained in the record. We may deny your access to PHI under certain circumstances, but in some cases you may have this decision reviewed. We must permit you to request access to inspect or to obtain a copy (or both) of Psychotherapy Notes, unless we believe that such access would be detrimental to your health. If you are denied access to Psychotherapy Notes, it is possible upon presentation of a written authorization signed by you that such notes or a “narrative” of the notes may be made available to your “authorized representative.” On your request, we will discuss with you the details of the request and denial process.

Right to Amend – You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. We may deny your request. On your request, we will discuss with you the details of the amendment process.

Right to an Accounting – You generally have the right to receive an accounting of disclosures of PHI. On your request, we will discuss with you the details of the accounting process.

Right to a Paper Copy – You have the right to obtain a paper copy of the notice from us upon request, even if you have agreed to receive the notice electronically.

Psychologist's Duties:

We are required by law to maintain the privacy of PHI and to provide you with a notice of our legal duties and privacy practices with respect to PHI. We reserve the right to change the privacy policies and practices described in this notice. Unless we notify you of such changes, however, we are required to abide by the terms currently in effect. If we revise our policies and procedures, we will provide you with a revised notice either in person or by mail.

V. Complaints

If you are concerned that a psychologist or member of our practice has violated your privacy rights, or you disagree with a decision we made about access to your records, you may contact:

Michael G. Selders, Ph.D., Owner
The Psychology Practice of Michael G. Selders, PLLC
2602 Martin Luther King Jr. Blvd, Dallas, TX 75215

You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services. The person listed above can provide you with the appropriate address upon request.

VI. Effective Date, Restrictions, and Changes to Privacy Policy

This notice will go into effect on October 1, 2014.

We reserve the right to change the terms of this notice and to make the new notice provisions effective for all PHI that we maintain. We will provide you with a revised notice by U.S. mail or in person.

CONSENT

As the client, parent of a minor, legal representative, or power of attorney, I have read and understand the aforementioned information regarding the professional psychological services provided by Dr. Michael G. Selders, and HIPAA Notice of Privacy Practices provided of The Psychology Practice of Michael G. Selders, Ph.D., PLLC, and request and authorize him to provide psychological treatment to me (or the person named) or my child/ren. I request and authorize the Psychology Practice's billing service to file and/or forward claims to applicable healthcare payers, on my behalf (or the person named) for services provided. I also fully understand that if I must cancel my (or my child's) appointment for any reason, I must do so at least 24 hours in advance of the scheduled appointment. I also understand that if I fail to cancel the scheduled appointment at least 24 hours in advance, I will be responsible for paying the full amount for the scheduled service prior to Dr. Selders scheduling the next appointment for me (or my child). My signature below indicates my understanding of and full agreement with all the aforementioned terms.

Signature of the Client (or Personal Representative)

Date

Printed Name of the Client (or Personal Representative)

Signature of the Spouse

Date

Printed Name of the Spouse

Signature of the Parent

Date

Printed Name of the Parent

Printed Name of the Minor