Anthony Fiore, Ph.D.

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PLEASE PRINT, INITIAL AND BRING WITH YOU AT FIRST SESSION

Outpatient Services Contract

Welcome to my practice. When you sign this document, it will represent an agreement between us.

Here are some important things you should know about my services: Please initial each point to indicate you understand and agree:

- **Psychotherapy can have benefits and risks.** Since 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 treatment.. 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. _____

- **Psychotherapy is not like a medical doctor visit.** Instead, it calls for a very active effort on your part, sometimes requiring your carrying out "home-work' and other assignments (such as reading a book relevant to your issues) that, in my opinion, will help you with your problem. _____

- You may decide the type of therapy I offer is not what you desire or need. You may also decide that the "chemistry" or "fit" isn't right between us for any number of reasons.. If so, please let me know and we will explore options, including possible referral to another therapist who may be more compatible with your needs or circumstances. _____

- **My Professional fee is $180 per session** for either an individual session (45-50 minutes) or couples (conjoint) (45-50 minutes) session. You will be expected to pay for each for each session at the time it is held, unless I have a contract with your insurance company. Co-pays with insurance are also due at the time of session. _____

- **48-hour notice of cancellation is required.** Simply call 714-745-1393 and leave a message. If you not call within the 48 hours, or you are a no-show, you agree to pay $180 cancellation fee._____

- **Limits on Privacy and Confidentiality.** The law protects the privacy of all communication between a patient and a psychologist. In most situations, I can only release information about your treatment to others if you sign a written authorization form. Please ask me if you have questions about this. There are some situations in which I am legally obligated to take actions without your permission such as situations involving elderly abuse, child abuse or sexual abuse, or if I feel I need to protect others from harm. _____

- You should also be aware that most insurance companies require you to authorize me to provide them with a **clinical diagnosis.** Sometimes I have to provide additional clinical information such a treatment plans or summaries. This information will become part of the insurance company files and will probably be stored in a computer. Though all insurance companies claim to keep such information confidential, I have no control over what they do with it once it is in their hands. If this a concern to you, you may elect to pay cash and not utilize your insurance company's benefits. _____

YOUR SIGNATURE BELOW INDICATES THAT YOU HAVE READ THIS AGREEMENT AND AGREE TO ITS TERMS.

_____ _____

Signature of patient Date

_____ _____

If patient is a minor child, signature of parent or guardian Date