WELCOME TO THOMPSON AND ASSOCIATES

We are pleased to have the opportunity to serve you. Please read the items below carefully. They will give you information about our practice and answer many of your initial questions.

Staff: Thompson and Associates is a psychological and counseling practice dedicated to professional excellence and caring involvement. We have clinicians with education and expertise in a wide range of mental health areas. Dr. Thomas S. Thompson is the clinical director of the practice and he will have access to any information regarding your treatment. As professionals certified and licensed by the State of Ohio, we make every effort to protect your welfare and to abide by the ethical standards of our professions. All therapists in this office are directly supervised as required by Ohio law.

Confidentiality: Issues discussed during the course of therapy with a psychologist or counselor are confidential, meaning that the information revealed will not be discussed with others without your consent. You may decide that it would be useful for your therapist to discuss your situation with someone else (for example, a prior therapist). You will simply need to sign a release of information form before this can occur. Also, if you come with someone to therapy (e.g., marital counseling), you are thereby releasing your confidentiality in order that all matters can be discussed openly among involved parties. In addition, therapists share clinical information received in counseling with other therapists at Thompson and Associates as a means of receiving peer supervision to provide you with the highest quality of care possible.

You do need to be aware of several unusual circumstances where there are exceptions to confidentiality. In situations of potential harm to oneself (suicide), or others (homicide), suspected child abuse or neglect, and in situations where the court may subpoena records (most often in contested divorce cases), the release of confidential materials may be required by law.

Privacy Practices: We use health information about you for treatment purposes, to obtain payment for treatment, for administrative purposes, and to evaluate the quality of care you receive. In most cases you have the right to look at or get a copy of health information about you. If you believe that any information in your record is incorrect, you have the right to request that we correct the existing information. If we deny your request for amendment, you have the right to file a statement of disagreement with us, and your medical record will note the disputed information. We are required by law to protect the privacy of your information, provide this notice about our information practices, follow these information practices, and seek your acknowledgment of these notices. If you believe that we have violated your privacy rights, you may contact the Privacy Officer, our office manager. You also may send a written complaint to the U.S. Department of Health and Human Services.

Appointments: Appointments are typically scheduled for 45-minute sessions. Couples and family therapy can be scheduled for longer sessions as needed. Since therapy is a negotiated process, both you and your therapist will need to evaluate the progress of therapy periodically and determine the need for ongoing appointments. Length of treatment is determined by the nature and number of problems that exist.
Fees: Financial arrangements are determined during the initial session and are based upon the standard cost of services of $140.00 per session. Any other fees for services rendered are based upon the amount of time your therapist spends on your behalf. This includes administration, scoring, and reporting diagnostic testing; consultations with other professionals at your request; and any time spent with you or on your behalf (for example, phone calls or requested correspondence).

Cancellations and Missed Appointments: If you find it necessary to cancel a scheduled appointment, a 24-hour notice in advance is required to avoid a full charge for the session missed. A full charge for session time will be applied if you do not show up for a scheduled appointment or do not give the required 24-hour notice of cancellation.

Payment for Professional Services Rendered: Payment at the time of each visit is preferred. If you are expecting insurance to cover some of the fee, we ask that you pay one-half of the standard fee upon your first visit and the known co-payment at each subsequent visit. If your insurance will only pay you, the member, we ask that you continue to pay one-half the fee at the time of your visit.

Insurance: If you have health insurance, part of your expenses for therapy may be covered. You have the responsibility to understand your insurance coverage and the requirements and limits of their reimbursement for services rendered. For example, you may need to call for pre-authorization for services or provide us with forms that your insurance specifically requires for service authorization. Please note that your insurance company may pay less or not at all if you do not meet these requirements and the result will be that your overall expense for therapy will be higher.

Please initial that you understand the following:

____ I understand that if I use insurance to help cover the costs of therapy, it is my responsibility to understand my coverage and to provide my therapist with any information needed for the filing of insurance or for the authorization of services.

____ I understand that if using insurance, I will need to pay one-half at the time of first visit and will continue to do so if I have an insurance that will pay only me.

____ I understand that fees for services are rendered based upon time involved and that time spent with me or on my behalf (per my request) is billed based upon my established hourly fee.

____ I understand that if I cancel a scheduled appointment without 24 hours notice or do not show up for an appointment, I am subject to a full charge for the session.

RECEIVED AND READ

_________________________________     ___________________
Signature                                      Date

_________________________________     ___________________
Spouse Signature (if applicable)                Date