Arlene C. Gerson, PhD
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9650 Santiago Road, Suite 3
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CLINICAL SERVICES AGREEMENT & INFORMED CONSENT

By signing this agreement you are giving consent for your son/daughter to receive assessment and therapy services from Dr. Arlene Gerson. I will meet with you and your child for an intake evaluation to determine the initial treatment plan and the frequency of appointments. The treatment plan is dependent on the nature of the presenting problems. The methods used in therapy will vary given the goals of treatment. Therapy is a collaborative process between the therapist and the patient and parents. It requires active effort on the part of you and your child. Sustainable change is best accomplished if your child has the encouragement and assistance to try out skills and strategies in the interim between appointments. A standard therapy session is usually 45 to 60 minutes in duration. Time is billed on a "per session" basis and is collected at the time of service.

Confidentiality. All information pertaining to your child's treatment will remain confidential unless you sign a release to a specific person or organization. The primary exceptions to this are (a) if I determine that the patient poses a direct threat to the health or safety of any individual, including himself/herself I am required to take actions. These actions may include notifying the potential victim, contacting the police, or seeking hospitalization for the patient, (b) by court order or subpoena; (c) information discussed in professional consultations; (d) if there is the possibility that your child has been or is being sexually abused or neglected or (e) if a government agency requests information for health oversight activities.

Insurance Disclosures. If you choose to use insurance benefits to pay for a portion of treatment, I may be required to submit clinical information, such as diagnostic codes and treatment plans to insurance industry data banks. If I am required to submit otherwise confidential information about you to an insurance provider I can no longer promise that such information will remain confidential once it leaves my office. You have the right to pay for your treatment yourself if you do not want any clinical information released to insurance companies.

Telephone Contact. Messages should be left on my confidential voice mail (443-827-3175) and I will return your call as soon as possible. I prioritize urgent calls and I make every effort to return non-urgent calls within 24 hours. Telephone calls over 10 minutes may be charged a prorated session fee.

Emergencies. If a mental health related emergency occurs, do not wait for me to return your call. Rather, you are advised to go to call 911 or go to an emergency room, as you would do with any other health emergency.

Cancellations or Missed Appointments. Requests to cancel or reschedule an appointment must be made 24 hours in advance. Cancellations less than 24-hours may be billed directly to you. Missed appointments may be charged full fee. Cancelations or requests to reschedule can be made by email or by calling me. If I am not able to answer your phone call you may leave a message on my confidential voice mail. Most insurance companies will not reimburse you for cancelled or missed appointment charges.

Financial Polices and HIPAA Notice of Privacy Practices are addressed separately.

Your signature below indicates that you have read this agreement and agree to its terms. Your signature grants permission to Arlene C. Gerson, PhD to perform such evaluations and therapeutic procedures as are professionally deemed necessary or advisable for your child's diagnosis, treatment, and healthcare operations.

_____ _____

Parent Signature & Date Parent Signature(s) & Date

Patient Name:_____

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