James A. Purvis, Ph.D.
Psychotherapy Services Agreement

PSYCHOLOGICAL SERVICES

Our first few sessions will involve an evaluation of your needs. By the end of the evaluation, I will be able to offer you some first impressions of what our work will include and a treatment plan to follow. You should evaluate this information along with your own opinions of whether you feel comfortable working with me.

Psychotherapy has been shown to have many benefits. It often leads to better relationships, solutions to specific problems, and a significant reduction in feelings of distress. On the other hand, since therapy often involves discussing unpleasant aspects of your life, you may experience uncomfortable feelings along the way, like sadness, guilt, anger, and frustration.

The course of your therapy will vary depending on the particular problems you are experiencing and challenges that you are facing. There are many different methods that I may use to deal with the issues that you hope to address. Psychotherapy is not like a medical doctor visit. Instead, it calls for a very active effort on your part. In order for your therapy to be most successful, you will have to work on things that we talk about both during our sessions and at home. Psychotherapy involves a large commitment of your time, money, and energy, so you should be very careful about the therapist you select. If you have any questions about my approach to your therapy, feel free to discuss them with me as they arise.

SESSIONS

Psychotherapy sessions last 45 minutes, unless otherwise arranged. Once an appointment hour is scheduled, you will be expected to pay for it ***unless you provide 24 hours advance notice of cancellation***. It is important to note that insurance companies ***do not*** reimbursement for cancelled sessions, so the full $200.00 fee will be your responsibility.

PROFESSIONAL FEES

The following information pertains to my financial policy. I hope this will answer any questions that you may have, but if you do have any questions or special concerns, please do not hesitate to discuss them with me **at the first session.** If you would like a copy of this form for your records, I will be happy to provide one for you.

My fee is **$200.00** for individual sessions and **$225.00** for couples or family therapy sessions, **paid at the end of each session**. Please expect that my fee will increase from $5.00 to $10.00 per year each January. The fee for the initial diagnostic session is **$250.00**. Charges for services outside the usual therapy hour will be determined on an individual basis. These services might include report writing, telephone conversations (lasting longer than **10** minutes), consulting with other professionals with your permission, and the preparation of records or treatment summaries.

If you become involved in legal proceedings that require my participation, you will be expected to pay for my professional time, including preparation, transportation, and waiting costs, even if I am called to testify by another party. Because of the difficulty of legal involvement, I charge **$200.00** per hour for preparation and **$350.00** per hour for attendance at any legal proceeding.

BILLING AND PAYMENTS

Checks, credit/debit cards and HSA cards are accepted for your convenience. An insurance receipt is available should you wish to submit your insurance claims personally. If you are a member of a managed care company in which I participate, I am required to file
insurance claims for you. However, you, **NOT your insurance company**, are responsible for the full payment of my fees. For that reason, it is very important that you find out **personally** what mental health services your insurance policy specifically covers. If your insurance company declines to pay for a service, please be aware that you may receive a future bill for services if sessions are declined by the company,

*** **NOTE**: Since your appointment time is reserved solely for you, please notify me as soon as possible if you find that you must cancel an appointment. Appointments not cancelled with at least **24-hours notice** will be billed at the usual fee of $200.00. **Missed appointments cannot be billed to the insurance company.** You may leave a message on my confidential voicemail after hours and on weekends if you need to cancel an appointment.

Occasionally, patients will ask why I charge for missed appointments not cancelled with 24-hours notice. Your appointment time is reserved solely for you. When you are unable to keep it without at least 24-hours advanced notice, I am often unable to fill that time with another patient. Unlike other types of providers, who may be able to schedule multiple patients per hour, and even double book appointments, I schedule only one patient each hour, so that I can take the proper time and give proper attention to the quality care that you deserve. If you do not keep your appointment, I have no other way to offset the expenses that I remain responsible for during that lost time.

CONTACTING ME

Due to my work schedule, I am often not immediately available by telephone. When I am unavailable, my telephone is answered by my assistant or by my confidential voicemail (470-508-8955). I will make every effort to return your call within 24 hours. If you are difficult to reach, please inform me of some times when you will be available. In the event of a life-threatening emergency, please go to your nearest emergency room, or call 911.

STATEMENT OF CONFIDENTIALITY

Under Georgia law communications between patients and psychologists are confidential, and under ordinary circumstances **only the patient** can waive this privilege. However, there are three clear exceptions in which a psychologist is legally and ethically

bound to break confidentiality: (1) the patient is imminently dangerous to him or herself, (2) the patient is imminently dangerous to others and/or has made a specific threat to harm an identifiable third person, or (3) there may exist actual or suspected incidents of child abuse or elder abuse. Although legally and ethically bound to break confidentiality under the aforementioned circumstances, I generally will not do so without attempting to discuss it with you.

CONSENT TO PAY FOR TREATMENT

I acknowledge responsibility for all fees incurred and, if it is necessary, I consent to have my account collected through an attorney or collection agency. I also agree that I will be responsible for all costs of litigation, including attorney's fees. I have read and understand the above policies.

______________________________ _______________________
Patient Signature Date

James A. Purvis, Ph.D.
Psychotherapy Services Agreement

Patient Information:

NAME: ____

ADDRESS: ____

____

PHONE Home: _____________ Cell: ______________ Work: ____________

Can a message be left at Home? Yes ___ No ____

Work? Yes ___ No ___ Cell? Yes ___ No ____

Email address: ____

Last 4 digits of your SSN: _________________ SEX: Male ____ Female ____

MARITAL STATUS: __________ DATE OF BIRTH: _________ AGE: _____

EMPLOYER: ____

POSITION: _________________________________

REFERRED BY: ____________________________

May I contact this person? Yes ____ No ____

Have you been in therapy before? Yes _____ No ____

For your current issue? Yes _____ No _____

If yes, with Whom? ____

Where? _________________________________ When? ______________

Next of Kin not living with you: ______________________________________

Phone #: ________________________

Address: ____

____

James A. Purvis, Ph.D.
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Responsible Party/Spouse/Parent Information:

Name: ____________________________________

Date of Birth: _______________ Last 4 digits of SSN: ________________

PHONE Home: ____________ Cell: _____________ Work: ___________

Primary Insurance:

Name of Carrier:
____

Name of Insured: ____

Phone #: ____

ID#:____

Group #: ____

Insurance Patients: Please read and sign the following assignment of benefits if you would like us to file your insurance for you

Release of Authorization/Assignment of Benefits

I authorize the release of any medical/psychological information necessary to process my insurance claims. I authorize and request payment of medical benefits directly to my psychologist, **Dr. James A. Purvis**, for services rendered. I agree that a photocopy of this form may be used in place of the original. All professional services rendered are charged to the patient. I understand that I am financially responsible for all charges, including those determined to be "not medically necessary" by my insurance carrier

Signature: ______________________________

Date: _______________________

INSURANCE WAIVER

IF YOU ELECT **NOT TO UTILIZE** YOUR INSURANCE BENEFITS, YOU HEREBY ACKNOWLEDGE THAT YOU ARE WAIVING THE RIGHT TO FILE FOR ANY SERVICES FROM THIS POINT FORWARD AND THAT **NO CLAIMS WILL BE FILED RETROACTIVELY**.

YOU DO RETAIN THE RIGHT TO CHANGE YOUR DECISION AT ANY TIME AND BEGIN TO USE YOUR BENEFIT. HOWEVER, CLAIMS WILL **ONLY BE FILED GOING FORWARD** FROM THE POINT THAT YOU DECIDE TO UTILIZE YOUR INSURANCE BENEFITS.

My signature below indicates that I have read and understand the notification above:

____
Printed Name

__________________________ ____________
Signature Date

James A. Purvis, Ph.D.
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Primary Care Physician Information

Name: ____

Address:

____

____

Phone: _________________________

How long have you been a patient of this physician?

____

For purposes of continuity of care, may we contact your physician to let him/her know of your visit today?

Yes ________ No ________

If yes,

I, _________________________________, give permission to Dr. James A. Purvis to send a general statement notifying my primary care physician of my visit today. The information sent will be used for coordination of care, and will be limited to a brief description of the problem area and/or diagnosis, and a general outline of treatment.

____

Patient Signature

____

Date

Confidential Patient Information

Please list any current medical conditions, past major surgeries, illnesses, or injuries:

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____

____

Please list all current medications and dosages (medical and psychiatric):

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____

____

Please list all past psychiatric medications and dosages:

____

____

____

Family Psychological History (Please specify which relative for each condition):

__ Depression ______________________________________
__ Anxiety/ Panic Disorder ____________________________
__ Bipolar Disorder _________________________________
__ Alcoholism _____________________________________
__ Drug Abuse _____________________________________
__ Suicide ____
__ Other (specify) ___________________________________

Personal Substance Use History (specify past or current, amount and frequency):

__ Tobacco ____
__ Alcohol ____
__ Marijuana _______________________________________
__ Stimulants ______________________________________
__ Cocaine ____
__ Opiates ____
__ Other (specify) ___________________________________

Psychological Services Agreement for Electronic Communication

The benefits of using electronic communications and telephone are many, including being able to avoid contending with traffic to and from an in-person appointment, having to take less time away from work or using time off, the convenience and comfort of holding a session in your own home or office, or you may be briefly out of town and wish to continue to receive services while away.

I hereby give permission to James A. Purvis, Ph.D. to provide psychotherapy services to me electronically by telephone or video teleconferencing.

Further, I give permission for James A. Purvis, Ph.D. and his staff to leave messages regarding appointments on my designated voicemail and to send appointment reminders to me via the FullSlate scheduling platform.

Email may also be used to provide updates, invoices, account statements, and educational resources.

When providing services by telephone or electronic platforms, the same degree of confidentiality provided during an in-person session is not possible. One limitation includes the possibility of the interception of communications.

Dr. Purvis will make every effort to eliminate any interruptions during our video or telephone contacts and requests that you do the same. Please attend to the security of the devices that you will employ (phones, tablets, laptops, and desktop computers). Further, it is expected that you will secure a private area for your sessions, perhaps by locking your door and assuring yourself that you cannot be overheard.

Toward this end, you agree to make these efforts and further, **to advise Dr. Purvis immediately if someone enters the room in which you are communicating with Dr. Purvis, or comes within earshot of your conversation.** Please keep in mind that should you not take precautions, other individuals (such as those living in your home), may be able to access information, sensitive or otherwise, communicated electronically or by telephone.

Any communications provided by James A.Purvis, Ph.D., or by his administrative assistant are intended for you, **and not for others**, unless agreed to otherwise. **By signing this Informed Consent, you are confirming to him that you have taken reasonable steps to secure the electronic devices that you have in your home or designated private area. This includes having a confidential password and employing adequate protective firewalls for security.**

You further agree not to allow others (household members or non-household members) access to any communications sent to you from Dr. Purvis or his administrative assistant, unless agreement is reached in advance that a particular communication is appropriate to share with others.

James A. Purvis, Ph.D. <u>does not</u> consent to recording of electronic sessions by phone, tablet, laptop computer, desktop computer, or any other electronic device.

I have read, understand, and consent to the above policies.

______________________________ ________________

Patient Signature Date

____

Print Name