Mark Goldstein, Ph.D
CLINICAL PSYCHOLOGY
psychotherapy • assessment • consultation

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Patient Contract

I would like to take this opportunity to welcome you and to introduce you to my office practice and procedures. Please take a moment to read this information and sign at the bottom of the page indicating that you understand and agree with these policies. If you have any question, please feel free to talk to me directly.

CONFIDENTIALITY:

All information discussed in the therapy setting is held confidential. It will not be shared without your written permission (or, if under age 18, the permission of a parent/Guardian) **EXCEPT** under the following conditions:

1. The patient presents a danger to self.
2. The patient presents a danger to others.
3. Child or elder abuse or neglect, past or present is suspected.

In the latter two cases, I am required by law to inform potential victims and legal authorities so that protective measures can be taken.

FINANCIAL TERMS:

My fee is **$ _____** per session. Our sessions are 50 minutes in length. You are responsible for the payment of the fees at the time the service is rendered. I will provide you with a copy of your paid statement to submit to your insurance company for reimbursement at the end of each month. I also will be glad to send a claim directly to your insurance company for the paid services provided.

CANCELED AND MISSED APPOINTMENTS:

A scheduled appointment means that time is reserved for you. If an appointment is missed or canceled with less than 48 hours' notice, you will be charged for the hour.

CONSENT FOR TREATMENT:

I authorize and request that **Mark Goldstein, Ph.D.** carry out psychological examinations, treatment and/or diagnostic procedures, which now or during the course of my care or the care of my minor child as a patient, are advisable. I understand that the purpose of these procedures will be explained to me upon my request and is subject to my agreement. I also understand that while the course of therapy is designed to be helpful, it may at times, be difficult and uncomfortable.

RELEASE OF INFORMATION:

I authorize the release of information for the processing of insurance claims to my health plan. (Release of information to other providers, family, etc. requires separate forms.)

I understand and agree to all of the above terms.

_____	_____
Patient(Parent/Guardian) ***signature***	Witness
_____	_____
Patient (Parent/Guardian) ***print name***	Date