SWANSON PSYCHOLOGY, INC.
A Psychological Corporation

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OUTPATIENT SERVICES CONTRACT

Informed Consent for Psychological Services

This document contains important information about my professional services and business policies. Please read it carefully and note any questions you might have so we can discuss them at our first meeting. When you sign this document, it will represent a binding agreement between us. Please feel free to ask questions about anything in this document before signing.

PSYCHOLOGICAL SERVICES

Psychotherapy is not easily described in general terms. It varies depending on the personalities of the psychologist and client, and the particular concerns you bring forward. There are many different methods I may use to address the problems you hope to resolve. Psychotherapy is not like a medical doctor visit; it calls for a very active effort on your part. In order for therapy to be most successful, you will need to work on things we discuss both during our sessions and between them.

Psychotherapy can have both benefits and risks. Since therapy often involves discussing unpleasant aspects of your life, you may experience uncomfortable feelings such as sadness, guilt, anger, frustration, loneliness, and helplessness. Changes made in therapy can also affect your relationships. While therapy often leads to improved communication and deeper connections, the personal growth and changes that result from therapy can sometimes be unsettling to those close to you, and may temporarily disrupt existing relationship dynamics. On the other hand, psychotherapy has been shown to have significant benefits for many people, including better relationships, solutions to specific problems, and meaningful reductions in distress. However, there are no guarantees regarding what you will experience.

Our first few sessions will involve an evaluation of your needs. By the end of that evaluation, I will be able to offer you some initial impressions of what our work together will include, along with a treatment plan, if you decide to continue. You should evaluate this information along with your own sense of whether you feel comfortable working with me. Therapy involves a significant commitment of time, money, and energy, so it is important to feel confident in the therapist you select. If you have questions about my procedures at any point, please bring them up. If your concerns persist, I will be happy to assist you in arranging a consultation with another mental health professional for a second opinion.

MEETINGS

I normally conduct an initial evaluation lasting two to four sessions. During this time, we can both assess whether I am the best person to provide the services you need to meet your treatment goals. If psychotherapy is begun, I will typically schedule one 50-minute session per week at a mutually agreed-upon time, although some sessions may be longer or more frequent.

Once an appointment is scheduled, you will be expected to pay for it unless you provide at least 24 hours' advance notice of cancellation, or unless we both agree that you were unable to attend due to circumstances beyond your control. When possible, I will try to find another time to reschedule.

PROFESSIONAL FEES

My hourly fee is $300.00. In addition to weekly appointments, I charge this hourly rate (prorated for time less than one hour) for other professional services you may need. These include report writing, telephone conversations lasting longer than fifteen minutes, attendance at meetings with other professionals you have authorized, preparation of records or treatment summaries, and time spent performing any other service you may request. If a telephone call or other service is likely to result in a charge, I will endeavor to let you know in advance so there are no surprises.

If you become involved in legal proceedings that require my participation, you will be expected to pay for my professional time even if I am called to testify by another party. Legal work is billed at my standard hourly rate.

BILLING AND PAYMENTS

Payment is due at the time of each session. Payment arrangements for other professional services will be agreed upon when those services are requested. In cases of unusual financial hardship, I may be willing to negotiate a fee adjustment or payment installment plan.

If your account carries an outstanding balance for more than 30 days, I will issue a statement to you. If your balance remains unpaid beyond 60 days and no payment arrangement has been agreed upon, I reserve the option of using legal means to collect payment. This may include engaging a collection agency or filing a small claims court action. Any associated costs will be included in the claim. In most collection situations, the only information released regarding a client's treatment is their name, the nature of services provided, and the amount owed.

INSURANCE REIMBURSEMENT

In order to set realistic treatment goals and priorities, it is important to evaluate what resources you have available to pay for your treatment. If you have health insurance, it will often provide some coverage for mental health services. I will assist you in completing forms and will provide whatever help I can in obtaining the benefits to which you are entitled; however, you, not your insurance company, are ultimately responsible for full payment of my fees.

Please review the mental health benefits section of your insurance policy carefully. If you have questions about your coverage, contact your plan administrator. I am happy to assist you in understanding any information you receive from your insurer.

Due to the rising costs of health care, insurance benefits have become increasingly complex. "Managed Health Care" plans such as Health Maintenance Organizations (HMOs) and Preferred Provider Organizations (PPOs) often require prior authorization before reimbursing for mental health services, and they may limit coverage to short-term, problem-focused treatment. It may be necessary to seek approval for additional sessions after an initial authorized period. While much can be accomplished in short-term therapy, some clients find they need continued services after insurance benefits are exhausted. Some managed-care plans may not allow me to continue providing services to you once your benefits end. If that occurs, I will do my best to refer you to a provider who can support your continued care.

You should also be aware that most insurance companies require me to provide a clinical diagnosis to process claims. In some cases, additional clinical information, such as treatment plans, summaries, or records, may also be required. Once submitted, this information becomes part of the insurance company's files and may be stored electronically or shared with a national medical information database. I have no control over how insurers handle this information once it leaves my office. I will provide you with a copy of any report I submit upon request.

As part of our early work together, we will discuss what can realistically be accomplished within your available benefits and what options exist should those benefits run out before you are ready to end treatment. You always have the right to pay for my services out of pocket to avoid the issues described above, unless prohibited by contract.

CONTACTING ME

I am often unavailable by telephone during the day. When I cannot be reached directly, my telephone is answered by a confidential office voicemail that I monitor frequently. I will make every effort to return your call the same day you place it, with the exception of weekends and holidays. If you are difficult to reach, please let me know times when you are generally available.

Please be aware that standard email and text messaging are not fully secure or confidential forms of communication. I ask that you use these channels only for scheduling and administrative matters, not for discussing clinical content or crisis situations. By providing your email address or mobile number, you consent to receiving routine communications through these channels.

For urgent after-hours concerns that are not life-threatening, please leave a message on my office voicemail and I will respond as soon as reasonably possible. In the event of a psychiatric emergency, please call 911 or go to your nearest emergency room immediately. You may also contact the 988 Suicide and Crisis Lifeline by calling or texting 988. If I will be unavailable for an extended period, I will provide you with the name of a qualified colleague to contact in my absence.

SOCIAL MEDIA POLICY

To protect your privacy and maintain appropriate professional boundaries, I do not accept friend or follow requests from current or former clients on any social media platform. This policy is not a reflection of my regard for you; it is a professional boundary that protects the integrity of our therapeutic relationship and your confidentiality. If you have questions or concerns about this policy, please raise them during a session.

TERMINATION OF SERVICES

Either of us may choose to end our work together at any time. If you wish to discontinue therapy, I ask that you discuss this with me so we can address any concerns and plan an appropriate ending. You are never obligated to continue services you do not wish to receive.

I reserve the right to end or transition our therapeutic relationship under certain circumstances, including but not limited to: non-payment of fees, your needs exceeding the scope of my practice or training, a determination that treatment is no longer clinically indicated, or safety concerns. Should this occur, I will provide you with reasonable advance notice and will assist you in identifying suitable referrals so that your care is not interrupted.

PROFESSIONAL RECORDS

The laws and standards of my profession require that I maintain treatment records. In California, adult treatment records are retained for a minimum of seven years from the date of the last service. For minor clients, records are retained until the client reaches age 25, or for seven years from the date of last service, whichever is longer.

You are entitled to receive a copy of your records unless I determine that doing so could cause emotional harm, in which case I will be happy to forward them to a mental health professional of your choice. Because professional records contain clinical language that may be misinterpreted by those without training, I recommend reviewing them with me so we can discuss the contents together. I am sometimes willing to conduct a records review meeting without charge. A reasonable fee will be charged for time spent preparing and copying records in response to requests.

USE OF AI TECHNOLOGY FOR SESSION DOCUMENTATION

To support the quality of your care and allow me to remain fully present during our sessions, I use an artificial intelligence (AI)-assisted platform to help generate progress notes and other clinical documentation. As part of this process, our sessions may be recorded (via audio only) and that recording is processed by the platform's software for the purpose of drafting session notes. I review and finalize all notes; the AI assists only with the initial draft.

The AI documentation platform I use is a HIPAA-compliant service provider. I have executed a Business Associate Agreement (BAA) with this provider, which legally requires them to protect your health information in accordance with HIPAA's Privacy Rule and Security Rule. Under these regulations, the provider implements appropriate administrative, physical, and technical safeguards to ensure the confidentiality, integrity, and security of your electronic protected health information. Your information is not used to train AI models or shared for any commercial purpose.

You have the right to decline the use of this technology. If you prefer that your sessions not be recorded or processed through an AI documentation platform, please inform me before our first session or at any point during our work together, and I will make alternative documentation arrangements. Declining will have no effect on the quality of your care.

MINORS

If you are under eighteen years of age, please be aware that California law may grant your parents or guardians the right to review your treatment records. It is my policy to request that parents agree in advance to limit their access to records. If they agree, I will share only general information about our work together unless I have significant concern that you may seriously harm yourself or another person. In such a case, I will notify them of my concern. I will also provide them with a summary of your treatment upon its conclusion. Whenever possible, I will discuss any required disclosures with you beforehand and consider any objections you may have.

HIPAA NOTICE OF PRIVACY PRACTICES

As required by the Health Insurance Portability and Accountability Act (HIPAA), I have prepared a separate Notice of Privacy Practices that describes how I may use and disclose your protected health information, as well as your rights regarding that information. Please review that document carefully. By signing this contract, you acknowledge that you have received a copy of my Notice of Privacy Practices.

CONFIDENTIALITY

In general, the privacy of all communications between a client and a psychologist is protected by law. I may only release information about our work to others with your written permission. However, there are important legal exceptions to this protection, which are described below.

It is important to understand that the psychotherapist-patient privilege belongs to you, the client, not to me. This means that only you have the right to waive this privilege and authorize the release of confidential information. I cannot waive it on your behalf.

In most legal proceedings, you have the right to prevent me from disclosing any information about your treatment. In certain proceedings, such as child custody disputes or cases in which your emotional condition is a central issue, a judge may order my testimony if the court determines the information is essential to the case.

There are situations in which I am legally required to take action to protect others from harm, even if doing so involves disclosing limited information about your treatment. For example, if I have reasonable suspicion that a child, elderly person, or dependent adult is being abused or neglected, I am mandated by California law to file a report with the appropriate state agency.

If I believe that a client is threatening serious bodily harm to another person, I may be required to take protective action. This may include notifying the potential victim, contacting law enforcement, or seeking hospitalization for the client. If a client threatens harm to themselves, I may be obligated to seek an emergency hold or contact family members or other individuals who can assist in providing safety.

These situations have rarely arisen in my practice. If a similar situation were to occur, I would make every reasonable effort to discuss it with you before taking any action.

I may occasionally consult with other licensed mental health professionals about a case. During consultations, I do not disclose identifying information. Consultants are also legally and ethically bound to maintain

confidentiality. Unless I determine that it is clinically significant to our work, I will not routinely inform you of these consultations.

This summary of exceptions to confidentiality is intended to keep you informed; it is not a complete legal analysis. I encourage you to raise any questions or concerns at our next meeting. If you require formal legal advice regarding confidentiality, please consult an attorney, as I am not acting in a legal capacity in our relationship.

ACKNOWLEDGMENT AND AGREEMENT

Your signature below confirms that you have read this document in its entirety, that you have had the opportunity to ask questions and have them answered to your satisfaction, and that you voluntarily agree to the terms set forth above. This document constitutes a binding agreement governing our professional relationship.

Client's Printed Name: _____

Client's Signature: _____ Date: _____

If client is a minor, a parent or guardian must also sign:

Parent/Guardian's Printed Name: _____

Parent/Guardian's Signature: _____ Date: _____

Relationship to Patient: _____