William M. Boylin, Ph.D.

Individual, Marital and Family Psychotherapy

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Office Policies and Philosophy of Treatment

You have chosen to enter into a therapeutic relationship with myself. This notice is a summary of office practices and procedures and my personal philosophy of treatment. Kindly review it and sign the bottom to let me know that you understand it.

The therapeutic process can be one of tremendous personal, emotional growth. It involves an investment both on the part of the client and the therapist and a commitment to the process. There may be times during your course of treatment that you are faced with difficult emotions and/or painful memories. It is possible that this process will bring up resentment and uncomfortable feelings in the therapy room. It is important to talk about this with me an let me know what is going on for you through our meetings.

It is important to remember also that this process is *voluntary*. You may, at any time withdraw from the process. In addition, during your course of treatment, please provide me with feedback. If a client feels a lack of direction, it may become evident through a lack of progress or withdrawal in other ways, either missed appointments or termination. The only way I can tell if therapy is helpful is through your own voice.

Please respect the fact that I come to my office to see *you*. If you are unable to make an appointment, please give as much notice as possible by calling the office. I will make every effort to contact you within 24 hours of any phone call, to reschedule. Bear in mind that if you miss an appointment, I will generally not call you to reschedule, as this process involves a personal commitment on your part. Please note that co-pays are expected at the time of the service provided. If you consistently fail to pay your co-pay, I may suspend our meetings until you are current with payment. If you miss appointments, I cannot bill your insurance company. If missed appointments occur, unless in the case of personal or family emergency, without 24-hour notice, I will bill you directly, at your home, for the cost of the missed session. It is your responsibility to inform me of any changes in your insurance benefits as they occur.

I will make every effort to protect your privacy. Because my practice is in a small community, if I should see you outside the office, I will not approach you unless you let me know that is acceptable. Information regarding our therapeutic relationship will be shared only in certain circumstances, with your permission. For a more complete review of privacy guidelines, refer to HIPPA statement.

Lastly, because some of my work involves late afternoon and evening hours, please note that my office building is secure. I keep appointments promptly and will meet you at the door to let you in, at the time of our appointment.

Confidentiality / HIPPA Statement

There are federal and state laws that protect your right to confidentiality with regard to your treatment in my office. Without your permission, I cannot discuss any information you share with me with another person or agency. The following are circumstances in which I do not have to adhere to the above regulations:

* If you or your child report an intention to harm yourself or others
* If I learn that a child, elderly or physically challenged person has been abused or it is suspected they may be abused, and
* If I am required to provide records or information by court order.

In addition, with your permission I may provide Protected Health Information to your insurance carrier, HMO, or my billing officer to procure payment for services rendered.

Costs Outside of Customary Service Provided

Occasionally, clients may request written reports or treatment summaries to be provided to other professionals or providers. Treatment summaries are provided in lieu of releasing my clinical notes. Again, this will only be done with your written permission. Insurance carriers do not pay for such services and therefore, my charge for any services provided outside of the usual and customary is $ 300.00 per hour. If I am called to testify in court proceedings, my fee per hour is $ 300.00, which includes travel time.

I welcome the opportunity to work with you on a personal level. I consider it an honor to enter into a therapeutic relationship with you and look forward to hearing about the work that gets done outside the therapy office, between our sessions.

Should you have any questions, never hesitate to ask me directly.

My signature below indicates that I have reviewed and understand:

_____ **Office Policies and Philosophy of Treatment**

_____ **Confidentiality Statement**

_____ **Costs Outside of Customary Service Provided**

_____ **I consent to treatment with William Boylin, Ph.D. In the case that a minor child is receiving treatment; I consent for the child to obtain treatment.**

_____ _____

Name **Date**