**Nicole K. Albertson, Psy.D., LLC**
124 North Court Street, Frederick, MD 21701
301-663-3350

# Client Information Agreement

## Client:

I, Nicole K. Albertson, Psy.D., LLC, am dedicated to providing psychological services to children, adolescents, adults, couples and families regardless of age, race, sex, or religious affiliations. The practice of psychology is regulated by the Maryland State Department of Health and Mental Hygiene. I am committed to the client's right to information regarding office policy, non-discrimination, confidentiality, consent, and competent service.

**Policies and Procedures:**

1. Your therapy is confidential, and information will not be shared with others unless you sign a release form. However, confidentiality is limited by state law, and I am mandated to report child/elder abuse or suicidal or homicidal intentions.

2. You may call me at any time to leave me a confidential voicemail, **301-663-3350**, and I will respond as soon as I am able. In an emergency, please call **911** or go to your nearest emergency center. In crisis, you may also call my Google Voice number, **240-285-9137**, which will notify my cell phone that you have called. Again, I will respond to your call as soon as I am able to, but if you need immediate attention, please call 911.

3. I may have an authorized, trained office administrator who may have access to your demographic information for the purpose of maintaining patient accounts and contacting insurance for benefits and claims. This administrator has been informed of and committed to adhere to Maryland's Psychological Ethics Laws and Regulations regarding confidentiality, as well as HIPAA Standards. This administrator will not have access to your psychotherapy notes unless a specified release has been given by you.

4. Records will be kept for seven years past termination of treatment. I hold to my profession's ethical and legal regulations of record keeping.

5. If you agree to have your records subpoenaed for Court, you then waive the right to confidentiality of such records. If you become involved in a legal proceeding that require my participation, you will be expected to pay for my professional time even if I am called to testify by another party.

6. In the unforeseen event that I am unable to perform services, your records will be available to you via Tracy Blood, Ph.D. She can be reached at 301-593-1315.

_____(initial) I understand that the state of Maryland requires that records of my treatment must be kept and that Nicole K. Albertson, Psy.D., LLC will keep such records in accordance with all legal and ethical requirements for confidentiality.

_____(initial) I understand that Dr. Albertson will discuss with me a potential course of treatment in order for me to give fully informed consent for my treatment. I may ask for a written treatment plan after the third session.

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**Fee, Payment & Insurance:**

1. Payment is due at the time of service unless other arrangements are made in advance.

2. Sessions missed or canceled with **less than 24 hours advance** notice **will be charged at FULL** fee. Charges for late cancellations or missed appointments will be solely the responsibility of the client. Insurance will not cover such expenses.

3. Insurance coverage will be discussed with your therapist. If you are using insurance, please be aware that most insurance companies require a clinical diagnosis be provided for payment. Sometimes, additional information such as treatment plans or summaries are also required. This information will become part of the insurance company files and will probably be stored in a computer. Though all insurance companies claim to keep their records confidential, I have no control over what they do with them.

4. Charges shown by statements are agreed to be correct and reasonable unless protested in writing within 30 days of billing date.

5. Patient balances will be limited to no more than $250.

6. Treatment may cease if payment is not made in a timely manner.

7. Clients are responsible to pay for services rendered, including reasonable attorney fees and costs of collections in the event of default.

8. Psychological evaluation and therapy, testing, report preparation, and records review will be billed at the rate listed.

Initial Session: $180/hour
Ongoing Sessions: $140/45 minutes
$175/60 minutes
Testing, Evaluation, Report Preparation, Records review, legal proceedings: $140/hour
Extended Time: $45/15 minutes
(Extended Time = 15 minutes or greater beyond the scheduled session or 15 minutes or greater phone calls.)

**I understand and agree to the above policies: _____**

**Date: _____**

**Authorization by Parent/Legal Guardian for treatment of Minors:**

I certify that I/We have the legal right to do so and hereby authorize treatment for

_____ and agree to pay for all fees and charges for such treatment.

Signature(s) of Parent(s) or Legal Guardian(s): _____

**Date: _____**