Katie M. McCall, PhD
Licensed Clinical Psychologist
120 Hickory Street, Suite A
Missoula, Montana 59801
Phone: (206) 619-7088
www.katiemccallphd.com

Service Agreement and Consent to Treatment Form

Welcome:
I appreciate the opportunity to work with you. I am a licensed clinical psychologist in both Montana and Washington state.

This document answers some questions clients often have when entering therapy. Since therapy is a relationship that works in part due to clear definition of rights and responsibilities held by each person, it is important to me that you know how we will work together. If you have any questions prior to your first appointment, feel free to call 206-619-7088.

The Therapeutic Relationship:
Like any important relationship, finding the right match between therapist and client is essential for therapy to be successful. During our first few sessions, I encourage you to notice how emotionally safe and comfortable you feel with me, how confident you feel in our work, and if we are in agreement on common goals for therapy. These are the qualities that make for a strong foundation of a therapeutic relationship. If you feel uncertain about any aspects of our work, please let me know and we can work on addressing the issue or I can help you find someone who will be a better match for you. Likewise, during our first few sessions, I will also be evaluating to make sure my skill sets and therapeutic style is a good match for your needs. I will let you know if I think someone else would be a better fit.

Consent to Treatment:
Psychotherapy has both risks and benefits. Usually people find psychotherapy helpful, but sometimes it can cause disappointing, unexpected, or negative results. If you have concerns about your progress or any aspects of treatment, please feel free to discuss these with me. You are free to stop therapy at any time; however, it is recommended that we discuss this prior to stopping. If you choose to discontinue therapy, I am happy to provide referrals to other providers.

Our First Session:
Our initial consultation is scheduled for 60 minutes and typically involves us talking about what brings you into therapy and a discussion of potential treatment options. If we decide to work together, the next session or two typically continues the consultation and results in our developing an initial treatment plan.

Confidentiality:
Discussions that take place as part of your therapy, as well as your record, are kept confidential. Information is never released to anyone, including your spouse/partner or family, without your

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written consent, except as required by law or ethical code of conduct as described in the NOTICE OF PRIVACY PRACTICES.

Legal issues:
Psychotherapy is for the improvement of your psychological functioning and not intended to be used for the purposes of current or future legal proceedings (e.g., custody, divorce, civil proceedings). Consequently, please inform Dr. McCall immediately of any current or future legal proceedings.

Access to Records:
All records are kept for a minimum of seven years. In the event of your death, the privilege to access your record passes to your estate. If you request access to your records, we will discuss the best way to facilitate this.

Fees:
My current fees for psychotherapy are as follows:

- Initial diagnostic intake session: $225
- Individual therapy session, 45 minutes: $150
- Individual therapy session, 60 minutes: $175
- Individual therapy session, 90 minutes: $220
- Telephone Consultation: $150 an hour over 5 minutes. No charge for calls about appointments or similar business.

Please pay for each session at the time of service. I accept cash or check. There is a $25 charge for all dishonored checks.

Insurance:
I am currently an in-network provider with Allegiance, Blue Cross/Blue Shield, Cigna, First Choice Health, Aetna, PacificSource, and Missoula County.

I am out-of-network with other insurance plans. If you have an insurance plan that includes therapy as part of your benefit, then a portion of my fee should be covered as an out-of-network provider. After we meet, I will provide you with a bill that you can submit to your insurance company for reimbursement. However, you are responsible for payment in full at the time of service.

If you would like to use insurance to cover therapy services, I encourage you to contact your insurance company and ask them if you have outpatient mental health benefits, the number of visits per year that are covered, and what portion of these services would be covered.

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Appointment Cancellation:
I will reserve a regular appointment time for you. I will also do this for my other clients. Therefore, I am rarely able to fill a cancelled session unless I have a week's notice. If you are unable to keep an appointment, please give me at least 24 hours notice although more notice is much appreciated. You will be billed $100 for an appointment that you do not cancel within 24 hours of the appointment time.

I request a credit card authorization to bill for missed appointments. The reason for this is that attempting to collect large unpaid balances does not make for a strong therapeutic relationship. If you would prefer not to sign a credit card authorization form, please talk to me about your concerns so that we can develop an alternative plan that is workable for both of us.

Agreement to Participate in Services:
Disclosure laws require Dr. McCall obtain your signature acknowledging that she has provided you with this information. Your signature below indicates that you have read the information in this Service Agreement and Consent to Treatment Form as well as the attached handouts, that you understand it and agree to abide by its terms during your professional relationship with Dr. Katie McCall. It also serves as an acknowledgement that you have been provided with copy of this Service Agreement and Consent to Treatment Form. If you have any questions, please feel free to discuss them with Dr. McCall prior to signing this form.

I hereby authorize Katie M. McCall, Ph.D. to provide psychotherapeutic services to

[Print your name] _____.

This agreement constitutes informed consent without exception.

_____ _____
Client Name Signature Date

_____ _____
Provider Name Signature Date