PSYCHOLOGICAL RESOURCE ASSOCIATES

Welcome to our practice. We appreciate your trust and the opportunity to be of help to you. We want you to know about your rights and responsibilities as a Psychological Resource Associate (PRA) client. For that reason we are asking you to read and sign the following information. If you have any questions please feel free to ask your therapist. Thank you.

AUTHORIZATION FOR TREATMENT:
I authorize _____(therapist) to provide _____(client) psychological services which may include psychotherapy, assessment and referral.

CONFIDENTIALITY:
- I understand that all communication between a client and the therapist is both privileged and confidential. the therapist cannot discuss my care orally or in writing unless I have signed a release of information form. By law, the California courts have upheld the following exceptions.
- If a client intends to take harmful or dangerous action against another individual it is the therapist's duty to warn that person or the family of that person. Alternatively, an appropriate public safety officer may be notified.
- The therapist will take reasonable preventive action for clients who may have suicidal intent with a specific plan.
- The therapist is required to inform an appropriate authority if there is reasonable suspicion that a child, dependent adult or elderly person has been abused.
- If a client files a worker's compensation claim or other legal action involving psychological distress, the therapist may be required to turn over records of treatment if ordered to do so by a court of law.
- Should the client default on his/her bill sufficient information regarding name, address and dates of service will be released to assist an attorney or collection agency to recover those unpaid fees.

FINANCIAL AGREEMENT AND TERMS FOR PAYMENT:
I agree to pay PRA $_____ or $_____co-pay per session. Payment will be made at each session unless other payment arrangements are agreed upon in writing. Payment will be made with cash, check, Visa or Mastercard. I understand that if authorization has been denied or if I am ineligible for insurance benefits I agree to pay all appropriate charges.

I assign all insurance benefits that I am entitled from my HMO, Medi-Cal, Medicare, or private insurance to PRA. This assignment will allow the payment of benefits to go directly to the clinician. I understand that in assigning benefits I am financially responsible for all charges not paid by any insurance, unless another agreement is specified by my HMO, PPO, or EAP contract.

I authorize PRA to release any information necessary to secure payment. This assignment shall remain in effect until I revoke it in writing.

I understand that my scheduled appointment is a time that is specifically reserved for me. I agree to pay for all appointments which I fail or cancel with less that twenty-four hours' notice. If I am covered by an Employee Assistance Program, I understand that a failed appointment or a late cancellation will be counted against the number of sessions I am allowed.

AGREEMENT:
I have read the above and understand my obligations according to it. I understand that I will receive a copy of the contract.

_____ _____
responsible party's signature date

_____ _____
clinician's signature date