VALEÑA & ASSOCIATES
CELEBRATING 30 YEARS
CHILD, ADOLESCENT & ADULT PSYCHIATRY

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Welcome to our practice. We are pleased to have the opportunity to work with you and hope that this handout will provide information helpful in making an informed decision concerning our services and your treatment. Please feel free to ask questions you may have at any time.

Appointments:

While our services are available by appointment only, we make every effort to address emergencies as quickly as possible. Appointments for psychotherapy are scheduled for 50 minutes while appointments for medication checks and psychological testing will vary upon needs. Please be aware that testing fees include face to face contact as well as test scoring, interpretation, and report generation. Because this time is reserved for you, it is necessary to charge for appointments which are not cancelled 24 hours in advance. However, we will credit your account for the first missed appointment if your next one is kept. All other missed appointments will be billed ($40.00 for 30 minute appointments and $75.00 for 50 minute appointments) unless we agree that an emergency has occurred to create the need for the late cancellation. If three appointments are missed with no cancellation notice, our professional relationship will be terminated and a referral may be made to another mental health provider as needed.

Treatment:

We encourage you to become an informed consumer of the procedures, goals, rationale, and possible side effects of medications and psychotherapy used in your treatment. Both methods of treatment can be highly beneficial, although they are not completely free from risk. Potential side effects from medications vary greatly and will be discussed in detail with you prior to their prescription. For psychotherapy, the risks may include the experience of intense and unwanted feelings (e.g., anger, fear, guilt, or anxiety), recalling of unpleasant life events, or facing unpleasant thoughts and beliefs. It is important to remember that these feelings are often natural and normal and are an important part of the therapy process and should be discussed in your sessions.

Therapy is essentially a relationship between the patient and the therapist. The initial focus of therapy is to understand the thoughts, feelings, and life situations that concern you. Therapy can offer support, the development of specific skills such as communication, parenting, problem solving, and self-control, and guidance to facilitate your desired goals. However, as the patient you have the responsibility to decide your ultimate course of action. Formal and informal assessments, readings, journal writing, and other "homework" are often suggested to enhance your therapy experience.

Patient's Rights:

At any time, our patients may question and/or refuse therapeutic, medication, or diagnostic procedures, or gain whatever information they wish to know about the process and course of treatment. You also have the right to seek a second opinion from another clinician. Patients are assured of confidentiality, which is protected by professional ethical standards and by Indiana State Law. This law also applies to adolescents. While the parent/guardian is entitled to information regarding their child's progress, we have found that it is most helpful if the teenager is not pushed to disclose everything they discuss with their clinician. There are some exceptions to confidentiality that are legally mandated. These include: 1) if in our best professional judgment a patient has an intention to harm him/herself, someone else, or is gravely disabled to the point of being unable to take care of his/her basic needs; 2) if there is any reason for us to suspect child abuse, neglect, or molestation; 3) if there is any reason for us to suspect elder abuse; 4) if there is a legal action in which we or our records are subpoenaed or if we are ordered by a judge to release our records. In the above cases, we will make an effort to discuss the release of this information with you before it is sent, but we are under no obligation to do so. If there is a need to release information from your records for other circumstances (e.g., to talk with a child's teacher, primary care physician, etc.), it will be discussed with you and you must sign a "Release of Information" form, even if the release is at your request. Finally, in cases of divorce, Indiana law allows non-custodial parents to have equal access to the custodial parent with respect to all medical (including mental health) and school records.

Termination:

Termination from treatment may occur at any time and may be initiated by either the patient or our staff. If a decision is made to terminate, there may be a minimum of one session notice so that the reason(s) for termination can be explored. If any referral is warranted, it will be made at that time.

Charges:

The charges for our services are based on the usual, reasonable, and customary fee profiles of this area. Our charges vary by clinical service and will be discussed with you in advance. The fee includes our time in session as well as our time on your behalf that involves record keeping, session preparation, and telephone calls for the purpose of scheduling, clarifying billing information, or consultation with other professionals who may be involved with you (e.g., primary care physician). Our patients are expected to pay for services when they are provided, which includes co-pays, deductibles, and balances. Any balance not paid after 60 days could result in collection agency fees being added to your account balance and indefinite termination from our practice for all family members.

Insurance:

If you have a health insurance plan, a portion of the cost of your treatment may be reimbursed. While we will be happy to file your claims, you are responsible for knowing the terms of your policy and the extent of your coverage. Insurance balances that remain after 60 days may become patient responsibility. If we do not participate in your plan, payment is expected in full at the time of service before a claim will be filed on your behalf. Often insurance companies require diagnostic and treatment information before reimbursing us. We will release this information to them as needed so your claims can be paid promptly. While this is sensitive information and is generally treated as such by insurance companies, we cannot guarantee how any particular insurance company respects this information. If you prefer that we do not release this information to your insurance company for reimbursement purposes, you will be responsible for the entire fee for your services.

CONSENT FOR MENTAL HEALTH SERVICES

I, the undersigned, agree and consent to participate in the mental health services provided by Valena and Associates as defined in Indiana State law. This consent applies to my child or ward if they are the identified patient.

I understand that I am consenting and agreeing only to those mental health services that my provider is qualified to provide within the scope of his/her license and training.

I understand that this agreement does not guarantee that we will attain my goals; however, I agree that I will pay for access to Valena and Associates' resources as mental health providers and their willingness to apply their skills and resources in good faith.

I stipulate that this agreement will become part of my medical record which is accessible to myself and Valena and Associates, but to no other person without my written consent, with the exceptions as stated above. My provider may discuss my progress with my physician(s) or physician group _____.

To the extent necessary to determine liability for payment and to obtain reimbursement, I authorize the release of any information regarding service rendered and allow a photocopy of my signature to be used to file insurance. I direct my insurance to issue payment for all medical/mental health benefits due me directly to my provider. This assignment and authorization will remain in effect until revoked by me in writing. I understand that I am responsible for the fees for all services rendered and that I may be charged for refilling lost prescriptions.

My signature indicates that I have read the above presented in this disclosure statement. I understand the information and agree with the conditions of treatment stated or implied here. I have received a copy of this office's policies and a notice of privacy practices.

_____ _____

Client Signature Date

_____ _____

Parent/Guardian Signature Date

_____ _____

Valena & Associates Staff Signature Date