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OUTPATIENT SERVICES CONTRACT This document contains important information about my professional services and business policies. Please read it carefully and jot down any questions you might have so that we can discuss them at our initial session. When you sign this document, it will represent an agreement between us.

PSYCHOLOGICAL SERVICES We will work together to address your needs, concerns, and goals. It is my belief that every human has strengths and resources that can be developed to manage and cope with life's challenges and to enhance life's pleasures. Therapy, which is a personal journey, can be a rewarding process of self-discovery. It does, however, call for a very active effort on your part. In order for therapy to be most successful, it will be important to remain mindful of the topics discussed while in session, as well as, during the time outside the sessions. Our first few sessions will involve an evaluation of your needs. I will share with you my impressions and together we will develop a treatment plan and treatment goals. I welcome your feedback and invite you to share any questions or comments you may have along the way. If, at any time, you feel that our collaboration is not helpful to you, please feel free to discuss any concerns with me.

Frequently Asked Questions: 1) What are the benefits of therapy? The potential benefits of treatment include improved mental health, improved relationships, and improved ability to cope with life's stressors. 2) What are risks of therapy? The risks of treatment include disappointment over expectations of treatment being unmet and failure to experience any improvements related to treatment. Since therapy often involves discussing unpleasant aspects of your life, you may experience uncomfortable feelings like sadness, guilt, anger, frustration, loneliness, and helplessness. 3) What are some alternatives to therapy? Alternatives to treatment include self-help books, self-help groups, spiritual activities, dance, music, exercise, or any activities that improve mental health functioning. 4) What is the "therapy hour"? The "therapy hour" lasts 45-50 minutes. I typically try to spend the last 5 minutes reviewing the progress we made during the session, discussing homework, and scheduling our next appointment. Please keep in mind that late afternoon appointment slots are highly desirable, especially for children and adolescents. If your schedule allows for earlier appointment times, your flexibility will be greatly appreciated. If you are the parent or guardian of a minor in session, please remain in the area until the appointment has ended. Appointments are often scheduled on the hour and I will be unavailable to monitor your minor before and after the therapy hour. 5) What information will be shared with the insurance company? When I bill your insurance company, I am required to provide them with a clinical diagnosis. I will explain to you the nature of any diagnosis that I give you. Some insurance companies may also require additional information about you, and some insurers may require a treatment plan. I will inform you if such a request occurs. 6) What can I expect during the initial visit? You will be asked to arrive early to complete initial paperwork unless you have had the paperwork mailed to you ahead of time. Please ensure that you arrive on time to allow sufficient time for the evaluation. The initial visit with me is expected to last 45 – 90 minute and is designed to provide a comprehensive diagnostic evaluation, not treatment services. At the end of the office visit, a tentative diagnosis will be shared with you and a proposed treatment care pathway will be offered. Since there is a lot of information to cover

and different perspectives, I will structure the evaluation to ensure sufficient time to meet with child and caregivers together as well as separately. 7)What information should I be prepared to share? I will want to know what concerns you have about your (1) health & safety, (2) thoughts, feelings or behavior, (3) social relationships, (5) family, (6) school performance and (7) any other concerns that you have. Also, it will be helpful if you can provide your thoughts about why you are experiencing difficulties at this time and if there are any transitions or challenges that are occurring for you. 8)What will I be expected to do? You will be asked to actively participate in your treatment. This will include reading informational packets provided, becoming familiar with community agencies and resources, become knowledgeable in your illness, complete assignments, and practice learned skills at home. Your health is truly dependent on how much time & effort you invest.

Minors: The process of therapy with minors can be challenging when the minor suspects that information shared in session will eventually be shared with parent/guardian. To maintain a safe space for the minor to process their concerns, needs, and fears, information will usually be shared if it is necessary to maintain the minor's health and safety. Please be respectful of the therapeutic relationship between the provider and the minor. Please be prepared with documentation indicating current custody agreement if one exists when you arrive for your initial appointment.

Couples: If I am seeing you as a couple, please understand that the therapeutic space is meant to be a safe space to explore some of the most painful and vulnerable emotions. Respecting one another in session is a must and physical nor emotional violence will be tolerated. If you are being see as a couple and feel that you or your partner are unable to maintain a level of respect and safety in session I may consider seeing you individually until intensity of emotions decrease and you and your partner feel they can be managed safely together in session.

Groups: The group therapy process is unique in that information is shared with multiple people within the group. Please be mindful that confidentiality rules apply to all members of the group outside of therapy as well. You may disclose your comfort level with individual group members on contact outside of group since the group process can also be means for building a social support system in the community. However, please respect your group members preferences and privacy if they express the desire to maintain their privacy outside group sessions.

Availability: Office hours are typically Monday Through Friday between 8 am and 3 PM. I am generally unavailable between sessions. If you have a need to contact me between sessions, I will make every effort to return your call on the same day, except for weekends and holidays. If you are experiencing a crisis or emergency, please indicate that in your message. If you are feeling suicidal, homicidal or otherwise in need of immediate assistance, call 911 or present directly to an emergency room.

PAYMENTS AND FEES Payment is collected at the end of each session. If services are to be billed to your insurance company, please be advised that you are financially responsible for the co-payment and tax that is not covered by your insurance plan or for the entire payment if services are not covered by your insurance plan. While some insurance plans pay the excise tax on medical services, most do not. If your plan does not cover the tax, you are responsible for paying the tax on the eligible charge, not just the tax on the co-payment. My professional fees for services not covered by an insurance company or for services provided when I am not participating with the client's insurance company are as follows.

Individual therapy: \$200 Family/couples therapy: \$250 Cash, checks, or credit card are accepted as forms of payment.

If you are covered by an insurance company with whom I am not participating and they allow for non-participating providers, an insurance form will be mailed to your insurance company on your behalf.

Employee Assistance Program (EAP) Referrals In the event that you are referred by your employee assistance program, your fees will most likely be covered by your employer for a pre-authorized amount of sessions. As a result, you will not be responsible for any payment during the pre-authorized sessions. You may also choose to continue treatment under your own insurance after the pre-authorized sessions have been utilized. If you are interested, previous paragraph on terms for payments and fees would apply.

CANCELLATION/ NO SHOWS/ MISSED SESSIONS POLICY Please give at least 24 hour notice if you need to cancel an appointment. If you are experiencing an emergency that necessitates canceling an appointment without 24 hour notice, please contact the office as soon as possible. If you do not show for an appointment or cancel with very little notice (unless there was an emergency), there will be a "first time" no-show or late cancellation fee of \$50.00. If there are follow up occurrences of late cancellations or no-shows you will be charged the amount I would have been paid for the session (i.e. If I would have been paid \$180 by the insurance company and \$20 by you, you would be charged \$200 for the No Show or late cancellation). If you no show for an appointment or there is a pattern of cancellations, services may be terminated. If you are referred by your EAP and no show or cancel with less than 24 hour notice, the same conditions may apply. Please keep in mind that insurance does not cover these no show/late cancellation fees so you will be responsible for all of these payments. Credit card information is collected at the beginning of treatment and your card will be charged if you do not make payment in cash or check within 5 business days.

CONFIDENTIALITY The therapeutic relationship is intended to be a confidential relationship that is built on trust between the client and the therapist. The confidentiality of this relationship and information disclosed during treatment is so sacred that it is actually protected by law. There are, however, several exceptions to confidentiality outlined below: 1. The therapist has an obligation to break confidentiality if the client is a danger to self or others. In those instances, the importance of protecting life outweighs the confidential relationship. Specifically, the therapist has an obligation to notify emergency personnel (i.e. police, hospital) that the client is in need of psychiatric hospitalization to protect self or others. In the case of danger to others, the therapist must always notify the police and any persons threatened to be harmed. 2. The therapist has an obligation to notify the Department of Human Services if a minor client is being physically abused, sexually abused, neglected, or if the client is abusing or neglecting a minor or an elder person. 3. The therapist has the right to notify the police if a client has committed a crime against the therapist. 4. The therapist must respond to a court order for client records. 5. The therapist must notify emergency medical personnel if, during care of the client, the client has a medical emergency that requires emergency medical treatment. 6. The health insurance provider that pays for your treatment has a right to know information about your mental health services. This information includes your diagnosis and dates of service. Some health insurance providers may require a treatment plan before they authorize services and/or during your treatment episode. 7. A therapist can release information with a signed consent from you. The nature of the information to be released is agreed upon before signing. In addition, the client has a right to revoke the release at any time. 8. **MINORS:**

Please keep in mind that parents/guardians have the right to information shared by minors in session; however, to promote a healthy therapeutic relationship between the provider and the minor it is recommended that the minor's privacy be respected and honored as much as possible. The minor's best interest will be greatly considered in determining what information is shared with parent/guardian and will always be discussed with the minor before disclosing information. In all cases, clinical discretion will be used to determine what should and will be disclosed.

Record Keeping: In compliance with state & federal laws and professional standards, I maintain a record on every client. The record consists of your intake documents and a note following each session. The notes contain general information such as: your name, date and time of session, diagnosis, progress update, treatment plan, etc. The records are kept in a locked file in my locked office and/or in an encrypted file on my computer. I am the only person who has access to these files.

Your signature below indicates that you have read the information in this document, consent to treatment, and agree to abide by its terms during our professional relationship.

Print Name	Signature	Date
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Print Name	Signature	Date
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Legal Guardian Print Name	Signature	Date
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Name: _____ Age: _____ Date of Birth: _____

Name: _____ Age: _____ Date of Birth: _____

Name: _____ Age: _____ Date of Birth: _____

*If coming in for couples/child/family therapy please list Parents/Spouse/Legal Guardian

Current Mailing Address: _____

Billing Address (If different from above): _____

Primary Phone Number: _____ Secondary Phone Number: _____

Text / Voicemail ? Y___ N___

Email Address: _____ 2nd Email: _____

Appointment Reminders through Email? Y___ N___

Insurance Carrier: _____ Subscriber Number: _____

Primary Insurance Holder Name and Date of Birth: _____

Primary Insurance Holder Address if different from above: _____

Credit Card Number: _____ (Visa/Master/Discover/American Express) Exp: _____

Name on Card: _____ CVC: _____

(Only in the event that a payment is not received in a timely manner will you card be charged)

Chief Complaint: _____

Are you currently experiencing thoughts of harming yourself? Yes___ No___

If you marked yes on previous question:

1) Do you have a plan? Yes___ No___

2) Do you have the intention of following through? Yes___ No___

*If you marked YES on numbers 1 and 2 please call 911 immediately or contact someone who can take you to the nearest emergency room.

3) Are you able to contract for safety? Yes___ No___

4) Do you have a history of suicide attempt? Yes___ No___

Current Employer: _____ Is this visit due to work stress? Yes ___ No ___

Were you referred by your EAP? If yes, please explain. _____

Is this visit requested by minors school? Y__ N__ For what reason? _____

School: _____ Grade: _____ Teacher: _____

Lives with: _____

Previous mental health diagnoses: _____

Previous medications taken for mental health diagnoses: _____

Medication(s) you/your minor are currently taking: _____

Substance use (type, frequency, quantity): _____

Medical conditions: _____

In case of emergency, please contact: _____ Phone: _____

Relationship to you: _____

Referred by: Psychology Today/ Reneebellistherapy.com/ PCP _____