

Old Town Professional Psychology, LLC

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CLIENT INFORMED CONSENT TO TREATMENT

Welcome to my office. I would like to briefly describe my services and office policies. Please feel free to ask me any questions, at any time.

Initial Sessions and Therapy Process: Our first few sessions will involve gathering information about your presenting concerns and history and formulating your treatment options. The therapy process is a collaborative agreement to observe, explore, define and remedy or resolve your presenting difficulties. As we work, material may be discussed which brings up uncomfortable feelings. Please feel free to discuss your feelings about the treatment process as this is a valuable part of the treatment. There is no guarantee that a specific result will emerge from the therapy process. Therapy usually ends after mutual agreement about readiness and goal completion. There is usually a sense of a beginning, middle, and end to treatment. However, either one of us may raise the issue of ending treatment at any time.

I do not provide custody evaluations recommendations, medication or prescription recommendations, or legal/financial advice, as these activities do not fall within my scope of practice.

Confidentiality: The information you provide will be treated confidentially and will not be made available to individuals or agencies without your written consent. If you are less than 18 years of age, a parent or guardian must provide written consent. There are instances in which confidential information must be released without your consent. These instances include:

- 1) If you pose a serious danger to yourself or others.
- 2) If neglect or abuse of a child or an incapacitated adult is suspected.
- 3) If a court issues a subpoena concerning your records.
- 4) If you file a worker's compensation claim.
- 5) If I become the focus of a Virginia Board of Psychology inquiry and the Board subpoenas the records.

In cases in which information must be released without your consent, I will attempt to notify you in advance. Please read the HIPAA Notification Form for more information on your rights and privacy.

Fees and Payments: All individual, couples, and family sessions are 45 minutes long. The fee for each session is \$120.00 per session. Unless other arrangements have been

mutually agreed upon in advance, payment is due at the time of service for the first three sessions. After that, you will receive a bill at the end of the month with the expectation that payment is received by the 15th of the following month. I will provide you with a copy of your billing statement, which you can then submit to your insurance company for reimbursement if I am out-of-network. Please note that Marital or Couples counseling is not reimbursable by insurance. If your account is overdue (unpaid) and there is no written agreement on a payment plan, I may use legal or other means (court, collection agencies, etc.) to obtain payment. Extended and/or unscheduled telephone contacts or preparation of written reports will be billed on a prorated basis.

Services may be covered in full or in part by your health insurance or employee benefit plan. Please check your coverage carefully by asking the following questions:

- Do I have mental health insurance benefits?
- What is my deductible and has it been met?
- How many sessions per year does my health insurance cover?
- What is the coverage amount per therapy session?
- Is approval required from my primary care physician?
- How much does my insurance pay for an out-of-network provider?

You will be responsible for any charges not covered by your insurance company. While, I usually do not need to be involved with your insurance company, I will help you when necessary. At your request, I will review with you any information you ask me to send to your insurance company.

Scheduling and Cancellations: Upon deciding to work together, we will set time to meet for one or more sessions weekly. If you need to miss a session, please give as much advance notice as possible. If you miss an appointment, you will be charged for that session. Please note that your insurance company may not be billed for missed appointments. In the event that I can give your time to someone else, you will not be charged. I will make a conscientious effort to notify you well in advance of planned absences.

Emergency Procedures: If there is an emergency during our work together, or if I become concerned about your personal safety, I may contact the person whose name you have provided on the client intake form. This includes the possibility of you injuring someone else. My action of using your emergency contact would be for the sole purpose of ensuring that you receive proper psychiatric care, to prevent you from injuring yourself or others and to ensure that you receive the proper medical care. I would abide by the limits of the law for disclosure of information about you in such a situation. When possible, I will make every effort to make you aware of the possibility of such a situation and would inform you if an emergency release of information occurred, even after termination.

Emergencies: If you are in crisis between sessions and you need to talk to someone right away call:

Crisis link: (suicide and crisis hotline) for the Washington Metropolitan Area (202) 527-4077
Access Help Line: (24/7 DC Mental Health including mobile psychiatric response units) (888) 793-4357
Arlington County Mental Health: (703) 288-1550
Police: 911

Emails, Computers, and Faxes: If you communicate with me via e-mail, I will assume that you have made an informed decision, and will view it as your agreement to take the risk that such communication is subject to third party interception. Unless you indicate otherwise I may use the email address you provide to communicate with you about appointments or invoices.

Consultation: I consult regularly with other professionals regarding my clients; however, client's confidentiality is fully maintained in accordance to the law.

Litigation Limitations: Due to the nature of the therapeutic process and the fact that it often involves making a full disclosure with regard to many matters, which may be of a confidential nature, it is agreed that should there be legal proceedings (such as, but not limited to divorce and custody disputes, injuries, lawsuits, etc.), neither you nor your attorney, nor anyone else acting on your behalf will call me to testify in court or at any other proceeding, nor will a disclosure of the psychotherapy records be requested unless otherwise agreed upon. If agreed upon additional fees will apply for Dr. Cook to testify in a legal proceeding.

Telephone Contact, Coverage, and Emergencies: Telephone messages are checked regularly and routine telephone calls are returned within a 24-hour period. Generally, I do not provide emergency services. If a situation requires immediate attention, and you can not await my return call, please call 911 or go directly to your nearest emergency room. Please notify me of the emergency as soon as possible so that I may assist you with follow-up. Coverage by a colleague will be provided during vacations and absences.

I have read the above information and fully understand and consent to the policies described above. I have received the attached HIPAA notification form.

Signature of Client/Parent

Date

Sundar J. Cook, Psy.D.

Date