Psychoanalysis Kansas City
www.psykc.com

Fees are an important issue to anyone receiving professional services.

Fee rate: There is no fee for an initial consultation. The fee for psychoanalytic therapy will be mutually decided upon the initial consultation. Upon mutual collaboration with the patient, we may jointly discuss raising this fee during the course of treatment. ***All fees are due and payable at the time of service. Payments can be made by cash or by check.***

Statements: Statements are available upon request.

Missed appointments: If you are unable to keep an appointment, please notify me at (913) 636-9650. ***If an appointment is cancelled or missed without 24 hours prior notice, you will be billed for the session.***

As of the last contact day of the month, you can be provided with an invoice which you are welcome to submit to a cafeteria/flexplan or third party of your choosing, but I cannot guarantee that you will be reimbursed for my services.

Responsibility: The patient (or referring parent in the case of minors) is considered responsible for the payment of my professional fees. When I am requested to bill a third party, such as a divorced spouse, relative, or person/institution/organization of your choosing, and that third party fails to make timely payments, payment is expected from the patient (or referring parent of minors).

I am appreciative of the opportunity to be of service to you. If you have any questions, concerns, or suggestions regarding any aspect of my practice, please discuss them with me. I am eager to receive your comments, and will gladly answer your questions.

I have read the above and understand my financial responsibilities. I agree to pay all fees due on a current basis. I also provide consent for Ryan Allison, to release the information, if it is required and requested by the patient, to bill any third party payer of my designation _____yes _____no

I understand that I have the right NOT to authorize this disclosure as well as the right to revoke consent at any time _____yes _____no

I understand that once information has been disclosed, it may be subject to redisclosure _____yes _____

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Patient Intake Date: _____

Name of Patient: _____ Birthdate: _____
SSN# _____

Address:
_____

_____
_____

Home Phone: _____ Work Phone:
_____

(If applicable, please provide contact information for parent or guardian)

Name: _____ Relationship:
_____

Medical Treatment information:

Have you ever been in therapy before? _____ If so, when?
_____

Have you ever been hospitalized? _____

For medical reasons? (when/what?)
_____

_____
_____

Are you currently being treated by a physician? If yes, by whom and for what?
_____

_____

Are you currently taking medications (prescription or over the counter, including herbal treatments)? If yes, what?

Consent for Treatment:

I provide consent for Ryan Allison to evaluate and treat me:

Signature: Date:

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Authorization for Release of Confidential Information:
(fill out only if you wish information to be shared with a designation below)

I, _____
(name of patient; parent/guardian must also include name of minor)

born on, _____, hereby grant my consent to Ryan Allison, Psychoanalyst., to exchange information with
_____
.

Information to be disclosed includes: (specify nature of information to be disclosed by marking an X for each that applies).
_____ Name and date(s) of service
_____Summary of Assessment
_____Summary of Treatment
_____Treatment summary and recommendations
_____Other
(specify):_____

The purpose of this disclosure is:
_____fulfill requirements of referring agency or clinician
_____fulfill request from attorney
_____referral
_____consultation with psychiatrist/physician/or mental health worker working conjointly with you.

I understand that I have the right not to authorize this disclosure as well as the right to revoke this consent at any time. I understand also that once information has been disclosed it may be subject to redisclosure.

_____
(Signature of Patient) Date: _____

_____
(Signature of Parent/Guardian)

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Informed Consent and Agreement for Psychotherapy

As we begin psychotherapy, I would like to inform you about the type of work I expect we will be doing together. There are many different forms of psychotherapy. I utilize a practice called 'Modern Psychoanalysis', which draws from a variety of procedures that have been effective in helping people deal with their emotional and social life.

While benefits can be expected from this treatment, no particular outcome can be guaranteed. We will work together to establish goals for therapy. In the course of our work, the goals may change and I will assist you in further redefining them. The psychotherapeutic process can sometimes lead to the emergence of upsetting feelings and, on occasion, a patient may feel worse before feeling better. I will ask you to participate in a periodic review of your progress.

As your therapist, I place a high value on the confidentiality of the information you share with me. State law and professional ethics also require therapists to maintain confidentiality and not to release information about you without your written consent. Most of the provisions explaining when the law requires were described to you in the Notice of Privacy Practices that you received with this form. However, there are a few possible exceptions to this confidentiality agreement.

1. As your therapist I am required by law to report any suspected child abuse or neglect. This law is designed to protect children from harm.
2. In the event that I learn information that could result in danger, injury or harm to you or to your property or to others or to their property, then I have a duty to notify some other person or official that in my judgement can reduce that risk of danger.
3. If you are currently involved in litigation or become so involved, the court may request a report, an evaluation of your entire mental health record. If you are requested to sign a release for psychotherapy records, you should consult with your attorney
4. I may have occasion to consult with professional colleagues about our work together. However, your name and other identifying information would not be revealed without your express authorization.
5. If I am away or unavailable, and another therapist is covering my practice, it may be necessary to share some information about our work together in order for the covering therapist to help you in an emergency situation.

In all of the circumstances described above, I will try to discuss the situation with you before any confidential information is disclosed and will reveal the least amount of information necessary.

The fee for therapeutic services will be agreed upon in the first treatment session. The psychotherapy session will be 45 minutes in length. Should we agree to have a longer or shorter session then those will be pro-rated at a similar rate.

Generally, there will not be a charge for short telephone conversations. However, telephone contact with you or others about your treatment, which is of significant length,

may be billed. Such telephone contacts may not be covered by your health insurance. Likewise, meetings outside the office related to your treatment will be billed and if travel time is significant, it may also be billed.

You are making the choice to begin psychotherapy. You have the right to end your treatment at anytime. If you decide to leave the treatment, you are encouraged to speak with me before doing so, so that we can end our work together appropriately and I can assist you with making plans for future treatment if necessary.

It is understood that I am engaged to provide psychotherapeutic treatment, not 'expert testimony' for court. As my patient, you agree not to require me to provide 'expert testimony' in any litigation. Should I be subpoenaed or be required by a court to participate in a deposition, give testimony or other services, you agree to pay me for time spent at a rate of $250 per hour.

By signing below, you indicate that you have read and understood this agreement and give consent for treatment.

Patient's name(Print and Sign):

_____

Date:

_____