Dr. Sumer Ledet
PSYCHOLOGICAL SERVICES

PSYCHOLOGIST-CLIENT CONTRACT

Please read this document carefully and write down any questions you have. Do not sign the document until all of your questions have been answered. When you sign this document, it represents an agreement between us.

NEW PATIENT PAPERWORK
You are asked to fill out several forms in advance of your first appointment. They provide me with initial information about your reason for seeking services. The information you provide is voluntary. If you do not wish to complete any part of the form, you do not need to do so. However, the more information you provide, the more it will aid me in assisting you.

PSYCHOLOGICAL SERVICES
Psychotherapy is an interactive process. Sometimes, therapy is emotionally intense and, at other times, very fulfilling. You are expected to contribute to all decisions regarding goals and methods. You have the right to refuse any discussed method. While there can never be a guarantee that any approach will be successful, the methods I use are shown in research to have a low risk of harm and a significant likelihood of effectiveness. The potential risks and benefits of not engaging in treatment should also be weighed.

The first 1 to 2 sessions involve an evaluation of your needs. At the end of the evaluation, I can offer you my recommendations on how best to proceed. Therapy involves a large commitment of time, money, and energy, so consider your options carefully. If you have questions about my procedures, ask as they arise. I will be happy to provide you with a diagnosis and treatment rationale or refer you to another mental health professional for a second opinion if you desire. I will respect your values, feelings, and decisions about how and if you would like to proceed. My goal in treatment is to get you the assistance you are looking for, whether that is with me or with another professional. You may withdraw from a session or from treatment at any time.

MEETINGS/APPOINTMENTS
The initial evaluation will last up to 120 minutes. Any follow up appointments will last up to 55 minutes. Often, appointments are scheduled weekly for 8 to 16 weeks, but this varies based on individual needs.

COURT RELATED APPREARANCES OR DEPOSITIONS
I am not a legal service and do not involve myself in legal proceedings. Should my services be required (even if by a third party), you will be required to pay for my professional time and any fees I incur. Because of the difficulty of legal involvement, my rate is $400.00/hour, and travel time and expenses, phone consultation, letter compilation, communication with attorneys, record(s) review, and testifying in court will be included in total cost. All fees are due at least 10 business days in advance of services rendered. Legal participation could potentially harm our therapeutic relationship. These issues will be discussed, and a referral to another appropriate mental health professional may be made for continuity of services.

FORENSIC FEE SCHEDULE
Depositions - $1200 includes two hours deposition and one hour preparation. Deposition fees must be paid at least 10 days in advance of services rendered.
Court Appearances - $3600 includes one-day court appearance plus one hour preparation. Court appearance fees must be paid at least 3 days in advance of services rendered.
*If additional time is required, it will be billed at $400/hour.
*48 hours cancellation notice is required. Payments are non-refundable if given less than 48-hour notice

REQUESTS FOR DOCUMENTATION
Requests for completing documentation will be considered on a case-by-case basis. If agreed to, documentation will be completed during session. If documentation must be completed outside regular session time, client will be charged $25 for every 15 minutes required.

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BILLING AND PAYMENTS

If your account has not been paid for more than 60 days and arrangements for payment have not been agreed upon, I have the option of charging the credit card that is on file with our office or using legal means to secure the payment. This may involve hiring a collection agency or going through small claims court. If such legal action is necessary, its costs will be included in the claim.

INSURANCE REIMBURSEMENT

In order for us to set realistic treatment goals and priorities, it is important to evaluate what resources you have available to pay for treatment. **It is important that you find out exactly what mental health services your insurance policy covers, as you are responsible for the payment of fees.** Private payment for services is an option. My assistant will check your benefits during your initial phone consultation, as a courtesy. **If your insurance rejects a claim or does not pay what you anticipated, you are responsible for payment of services rendered. It is your responsibility to notify us if you have insurance coverage through more than one policy.** Once we have all of the information about your insurance coverage, we will discuss what we can expect to accomplish with the benefits that are available and what will happen if services run out prior to the completion of treatment.

MINORS/TEENAGERS

If you are under 18 years of age, please note that the law provides your parents the right to examine your treatment records. I request from parents an agreement of limited access to treatment related information. If they agree, this means that I will provide them with only general information about our work together, unless I feel there is a high risk that you will harm yourself or someone else. In this case, I will notify them of my concern without your permission.

COUPLES/FAMILY PSYCHOTHERAPY

At the outset of therapy, we will discuss and identify who the client will be. In cases where more than one person is the client (e.g., a couple), only one record will be kept. If records are requested, it will be necessary to release only the portion involving the party covered in the release. In cases where we identify more than one person as the client, I do not keep secrets for any party involved. All shared in individual and group conversations is open to be discussed in the therapy process.

SUBSTANCE USE POLICY

If a client arrives to session under the influence of alcohol or drugs, he/she will be asked to leave and will be billed for the session. If the person is unsafe to drive or walk from the appointment, emergency contacts or appropriate authorities will be notified for assistance.

If during treatment it becomes concerning that substance use may be interfering in your mental health, you may be required to comply with urine drug screens, at your expense, in order to proceed with treatment. I can provide referrals for the screenings. Should you refuse to comply with screens, an appropriate mental health referral will be made. This policy is to ensure safe and appropriate intervention.

SECURITY

A security camera is installed in the waiting area as a safety measure for all clients and staff. The camera allows providers to monitor the entrance and lobby area from our offices.

COMMUNICATION POLICY

Email: Email is available at info@sumerledet.com or click "Contact Me" on the left column of my website at www.sumerledet.com, as a method to engage in appointment scheduling and cancelling and to provide a forum for general inquiries about my services. **Email is not to be used for therapy purposes. Email cannot be guaranteed to be confidential,** and liability for any breach of confidentiality is hereby waived.

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Our office offers automated email and text message appointment reminders for appointments. You will be given the option to receive these when you schedule your appointment and/or at the time of your first appointment. Please let our office know if you would like these reminders stopped at any point or if you would like the reminders sent to a different telephone number or email address.

For privacy, our office sends password protected emails. These can be opened with your 8 digit date of birth.

Neither my email nor office phone is an emergency access point. Should you find yourself in crisis, please call 9-1-1 or present to your nearest emergency room. I also have a list of crisis hotlines; please inquire if interested.

CLIENT RESPONSIBILITIES AND EXPECTATIONS

It is your responsibility to **notify me if you are currently in another therapy relationship**. This is an issue that we need to discuss and handle in a way that provides you with the best, most appropriate, level of care.

Please help to ensure a comfortable environment by remaining quiet in the waiting area. Remember, other sessions are in progress. **Put your cell phone on silent or vibrate,** and take phone calls quietly or step outside. During session, phones should be kept on silent or powered off, unless extenuating circumstances exist. Disruptive persons will be asked to exit the building in order to maintain a serene, confidential environment.

If a follow up appointment is not made at the close of a session, it is your responsibility to initiate rescheduling.

CONFIDENTIALITY

For your confidentiality, any treatment related information will be encrypted and password protected if sent via email. The encryption question will be, "What is your Date of Birth?" The answer will be all numbers in the following format (mmddyyyy).
In general, the privacy of all communications between a client and a psychologist is protected by law, and I can only release information about our work to others with your written permission. However, there are some situations in which I am legally obligated to take action, even if I have to reveal some information about treatment. For example, **if I believe that a child, disabled person, or elderly person is being abused, I am required to file a report with the appropriate state agency. Child abuse includes verbal, emotional, physical, and sexual abuse. Child abuse includes neglect. Child abuse includes any instance of individuals under 18 witnessing domestic violence. If I believe that a client is threatening serious bodily harm to another, I am required to take protective actions.** These actions may include notifying the potential victim, contacting the police, notifying family members, or seeking hospitalization for the individual threatening harm. **If a client has a plan or intention to seriously harm or kill him/herself, I am obligated to seek protective measures** which may include contacting family members or emergency personnel or seeking hospitalization. In most legal proceedings, you have the right to prevent me from providing any information about your treatment. In some cases, **a judge may ORDER my testimony, in which case I must comply. I am required to report admitted prenatal exposure to controlled substances that are potentially harmful. Parents or guardians of non-emancipated minors have the right to access the clients' records. Insurance companies and third party payers are given information they request regarding services. In the case of threatening outbursts in the office, authorities will be contacted.**

PROFESSIONAL RECORDS

The laws and standards of the profession of psychology require that I keep treatment records. They are stored in a locked file cabinet. Electronic records are password protected and stored in a secure database. You are entitled to a copy of your records unless I believe seeing them would be emotionally damaging; alternately, I can prepare a summary for you or I can send them to a mental health professional of your choice. If you wish to see your records, I ask that we meet to review them in person. Time spent responding to record requests are subject to regular session fees. However, summary review of records taking 15 minutes or less will be provided free of charge.

WHAT TO EXPECT FROM OUR RELATIONSHIP

I follow the ethical standards of the American Psychological Association (APA). The APA puts limits on the relationship between the therapist and client. These limits are to protect your confidentiality. First, **I cannot offer you professional consultation in any area except psychology** – not law, medicine, or finance. Second, **if we meet socially, I may not say hello. My behavior will not be a personal reaction, but a way to maintain your confidentiality.** Third, I can only be your therapist. **I cannot have any other role in your life such as friend or business partner. I cannot be a therapist to someone who is already a friend. I can never have a romantic relationship with any client, during or after therapy.**

CONSULTATION

I consult with professionals about providing best treatment to clients. I do not use names in these consultations. I make every effort to avoid details that would reveal the identity of any client. The consultant is also legally bound to keep the information confidential. If there was a case where your identity needed to be revealed for consultative purposes, I would request your written permission in advance to do so.

TELEPSYCHOLOGY SERVICES

I offer telepsychology services to existing, established clients. This includes audio-video media communications through a HIPAA-compliant application called Vsee. Participants will download the VSee application to their selected media. Our office will send an email invitation to connect electronically. At the time of the scheduled appointment, our office will initiate electronic contact.

At the start of the interaction, your name, date of birth, and location/address will be verified for security, safety, and billing purposes.

Please have headphones or earbuds available in case of technical difficulty.

Vsee is a HIPAA-compliant service. Skype or FaceTime may be utilized if needed; however, these services are NOT HIPAA-compliant and are NOT reimbursable by insurance. Therefore, private pay rates would apply. Additionally, telephone conversations may be utilized in the case of technical difficulty, but are NOT reimbursable by insurance. Should technical difficulty arise, each client has the option of using another media source for which you are responsible for the fees or rescheduling the appointment.

Privacy and confidentiality is of utmost importance in therapy. This applies to teletherapy services as well. Please ensure privacy at the time of our session. Please do not use a public place such as a coffee shop or a library to participate in teletherapy. Please find a private room where our conversation will not be interrupted or overheard.

In the case of emergency, a patient support person will be identified. Additionally, local emergency personnel will be identified including the closest emergency room. Any contact with outside persons will be with the consent of the client, with the exception of the threat of imminent harm to self or others. In this case, standard emergency procedures will be followed.

FOLLOW UP

To help me continue my development as a clinician, I send a brief survey to clients after they have ended treatment with me. Completing this form is optional and anonymous. Please choose one of the following:

___ Please email me the link to the form.

___ Please opt me out of receiving this form. I do not wish to receive it.

SIGNATURES

Your signature below indicates that you agree to abide by the terms of this document during our professional relationship.

_____

Signature/Date of Client

_____

Signature/Date of Responsible Party (if different from above)

_____

Provider Signature/Date at time of review

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GENERAL COMMUNICATION PERMISSIONS

This document is to assist me in understanding who you would like me to have permission to communicate with regarding your treatment. This may include family, friends, past therapists, or current physicians. This may include individuals who will call to schedule or cancel your appointments or join you in session.

In the boxes below, please list individuals you would like to give me permission to communicate with.

NAME	RELATIONSHIP	CONTACT PHONE #	TO DISCUSS WHAT

Please insert the corresponding number(s) in the column above named "TO DISCUSS WHAT" indicating to me what I am allowed to discuss with the named individual.
Enter a #1 for: In case of emergency only
Enter a #2 for: Appointment scheduling and/or cancellation
Enter a #3 for: Treatment attendance
Enter a #4 for: Any and all therapy related information

_____ _____

Client signature and Date, indicating consent
Consent may be revoked at any time.

Provider signature and date

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ELECTRONIC COMMUNICATION POLICY

In order to maintain clarity regarding our use of electronic modes of communication during your treatment, I have prepared the following policy. This is because the use of various types of electronic communications is common in our society, and many individuals believe this is the preferred method of communication with others, whether their relationships are social or professional. Many of these common modes of communication, however, put your privacy at risk and can be inconsistent with the law and with the standards of my profession. Consequently, this policy has been prepared to assure the security and confidentiality of your treatment and to assure that it is consistent with ethics and the law. If you have any questions about this policy, please feel free to discuss this with me.

Email Communications

I use email communication only with your permission and only for administrative purposes unless we have made another agreement. That means that email exchanges with my office should be limited to things like setting and changing appointments, billing matters and other related issues. Please do not email me about clinical matters because email is not a secure way to contact me. If you need to discuss a clinical matter with me, please feel free to call the office so we can set up at time to discuss it on the phone or wait so we can discuss it during your therapy session. The telephone or face-to-face context simply is much more secure as a mode of communication.

Text Messaging

Because text messaging is an unsecure and impersonal mode of communication, I only text message in the event that an appointment must be unexpectedly cancelled or if there is an urgent matter that must be discussed and you cannot be otherwise reached. Please do not text message me unless we have made other arrangements.

Social Media

I do not communicate with, or contact, any of my clients through social media platforms like Twitter and Facebook. In addition, if I discover that I have accidentally established an online relationship with you, I will cancel that relationship. This is because these types of casual social contacts can create significant security risks for you. I believe that any communications with clients online have a high potential to compromise the professional relationship. In addition, please do not try to contact me in this way.

Websites

I have a website that you are free to access. I use it for professional reasons to provide information to others about me and my practice. You are welcome to access and review the information that I have on my website and, if you have questions about it, we should discuss this during your therapy sessions.

Web Searches

Recently it has become fashionable for clients to review their health care provider on various websites. Unfortunately, mental health professionals cannot respond to such comments and related errors because of confidentiality restrictions. If you encounter such reviews of me or any professional with whom you are working, please share it with me so we can discuss it and its potential impact on your therapy.

_____ _____

Signature Date

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Consent to Use and Disclose Your Health Information

This form is an agreement between Dr. Ledet and her client(s).

When we examine, test, diagnose, treat, or refer you, we will be collecting what the law calls "protected health information" (PHI) about you. We need to use this information in our office to decide on what treatment is best for you and to provide treatment to you. We may also share this information with others to arrange payment for your treatment, to help carry out certain business or government functions, or to help provide other treatment to you. By signing this form, you are agreeing to let us use your PHI and to send it to others for the purposes described above. Your signature below acknowledges that you have read or heard our notice of privacy practices, which explains in more detail what your rights are and how we can use and share your information.

If you do not sign this form agreeing to our privacy practices, we cannot treat you. In the future, we may change how we use and share your information, and so we may change our notice of privacy practices. If we do change it, you can get a copy from our website, www.sumerledet.com, or by calling Dr. Ledet at 225-323-5087.

If you are concerned about your PHI, you have the right to ask us not to use or share some of it for treatment, payment, or administrative purposes. You will have to tell us what you want in writing. Although we will try to respect your wishes, we are not required to accept these limitations. After you have signed this consent, you have the right to revoke it by writing to our privacy officer. We will then stop using or sharing your PHI, but we may already have used or shared some of it, and we cannot change that.

_____ _____
Signature of client or his or her personal representative Date

_____ _____
Printed name of client or personal representative Relationship to the client (if applicable)

_____
Description of personal representative's authority

_____
Signature of authorized representative of this office or practice

Date of NPP: _____

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AGREEMENT TO PAY FOR PROFESSIONAL SERVICES

I request that Dr. Ledet provide professional services to me and/or a person I am legally responsible for. I agree to pay the fees outlined on her website. **I understand that the payment of services rendered is my responsibility, should my insurance not cover services due to unforeseen circumstances (e.g., preexisting conditions, expiration of coverage, diagnostic exclusions, misinformation from carrier, etc).**

Charges for missed appointments are not covered by insurance and are my sole responsibility**. I understand that the credit card I placed on file with Dr. Sumer Ledet, Psychological Services, LLC will be automatically charged if I fail to show or cancel less than 24 hours in advance of a scheduled appointment, I** issue a check for services and the check is returned NSF, or if my account balance is not paid within 60 days and a payment plan has not been agreed upon. I will be charged $100 for 90 minute missed appointments and $50 for 45 minute missed appointments.

I understand that all unpaid fees will be charged to the credit card I placed on file with Dr. Sumer Ledet, Psychological Services, LLC after 60 days delinquent.

I understand and agree with the stated policy regarding placing my credit card information on file and I hereby authorize Dr. Sumer Ledet, Psychological Services, LLC to charge my credit card accordingly as outlined above.

_____

Signature of client (or person acting for client) Date

_____

Printed name

I, Dr. Ledet, have discussed the issues above with the client (and/or the person acting for the client). My observations of the person's behavior and responses give me no reason to believe that this person is not fully competent to give informed and willing consent.

_____

Signature of psychologist Date