OCD•ANXIETY PROGRAM
OF SOUTHERN CALIFORNIA

OUTPATIENT SERVICES CONTRACT

Welcome to the OCD & Anxiety Program. This document contains important information about our professional services and business policies. When you sign this document, it will represent an agreement between us.

PSYCHOLOGICAL SERVICES

Psychotherapy is not easily described in general statements. It varies depending on the personalities of the psychologist and patient, and the particular problems you bring forward. I primarily use a cognitive-behavioral therapy approach to treatment; however, I take a very individualized approach and will consult with you to determine what best suits your needs. Psychotherapy is not like a medical doctor visit. Instead, it calls for a very active effort on your part. In order for the therapy to be most successful, you will have to work on things we talk about both during our sessions and on your own as homework.

Psychotherapy can have benefits and risks. Since therapy often involves discussing unpleasant aspects of your life, you may experience uncomfortable feelings like sadness, guilt, anger, frustration, loneliness, and helplessness. More specifically, successful treatment of anxiety disorders often requires that the therapist assist the patient in tolerating anxiety, meaning the patient will be put in potentially anxiety producing situations and supported in tolerating the resultant anxiety. However, in our experience, patients that actively participate in treatment and are willing to face their fears have been successful in reducing their symptoms of anxiety and depression. Therapy often leads to better relationships, solutions to specific problems, and significant reductions in feelings of distress; but there are no guarantees of what you will experience.

Our first few meetings will involve an evaluation of your needs. By the end of the evaluation, I will be able to offer you some first impressions of what our work will include and a treatment plan to follow. You should evaluate this information as therapy involves a large commitment of time, money, and energy. If you have questions about our procedures, we should discuss them whenever they arise.

Initials

MEETINGS

I normally conduct an evaluation that will last from 2 to 4 sessions. During this time, we can both decide if I am the best person to provide the services you need in order to meet your treatment goals. If psychotherapy is begun, I will usually schedule one 50-minute session (one appointment hour of 50 minutes duration) per week at a time we agree on, although some sessions may be longer or more frequent. Once an appointment hour is scheduled, you will be expected to pay for it unless you provide 24-hours advance notice of cancellation [unless we both agree that you were unable to attend due to circumstances beyond your control]. [If it is possible, I will try to find another time to reschedule the appointment.]

Initials

CONTACTING ME

I am often not immediately available by telephone. While I am usually in my office between 9AM and 5 PM, I probably will not answer the phone when I am with a patient. When I am unavailable, my telephone is answered either by one of the program staff or by voice mail. I will make every

effort to return your call on the same day you make it, with the exception of weekends and holidays. If you are difficult to reach, please inform me of some times when you will be available. If you are unable to reach me and feel that you can't wait for me to return your call, contact your family physician or the nearest emergency room and ask for the psychologist [psychiatrist] on call. If I will be unavailable for an extended time, I will provide you with the name of a colleague to contact, if necessary.

_____ Initials

PROFESSIONAL RECORDS

The laws and standards of my profession require that I keep treatment records. You are entitled to receive a copy of your records, or I can prepare a summary for you instead, unless to do so would cause emotional damage, upset, etc. Because these are professional records, they can be misinterpreted and/or upsetting to untrained readers. If you wish to see your records, I recommend that you review them in my presence so that we can discuss the contents.

_____ Initials

MINORS

If you are under eighteen years of age, please be aware that the law may provide your parents the right to examine your treatment records. It is my policy to request an agreement from parents that they agree to give up access to your records. If they agree, I will provide them only with general information about our work together, unless I feel there is a high risk that you will seriously harm yourself or someone else. In this case, I will notify them of my concern. Before giving them any information, I will discuss the matter with you, if possible, and do my best to handle any objections you may have with what I am prepared to discuss.

_____ Initials

CONFIDENTIALITY

In general, the privacy of all communications between a patient and a psychologist is protected by law, and I can only release information about our work to others with your written permission. There are, however, a few exceptions.

In most legal proceedings, you have the right to prevent us from providing any information about your treatment. In some proceedings involving child custody and those in which your emotional condition is an important issue, a judge may order my testimony if he/she determines that the issues demand it. There are some situations in which I am legally obligated to take action to protect others from harm, even if I have to reveal some information about a patient's treatment. For example, if I believe that a child [elderly person, or disabled person] is being abused, I may be required to file a report with the appropriate state agency.

If I believe that a patient is threatening serious bodily harm to another, I may be required to take protective actions. These actions may include notifying the potential victim, contacting the police, or seeking hospitalization for the patient. If the patient threatens to harm himself/herself, I may be obligated to seek hospitalization for him/her or to contact family members or others who can help provide protection. These situations have rarely occurred in our practice. If a similar situation occurs, I will make every effort to fully discuss it with you before taking any action.

_____ Initials

Your signature below indicates that you have read the information in this document and agree to abide by its terms during our professional relationship. Your signature further indicates that you are willingly consenting to treatment. You retain the right to stop treatment at any time.

Patient Signature:_____

Date:_____

Parent Signature:_____

Date:_____

Staff Signature:_____

Date:_____