Q Counseling Services

Michael D. Peck, MA, MSW, PhD
602.570.2373

301 E Bethany Home Rd, Suite C-296
Phoenix, AZ 85012

OUTPATIENT SERVICES CONTRACT

Welcome to my practice. I am Dr. Michael Peck, a Licensed Clinical Social Worker (LCSW) and Psychotherapist. Feel free to call me Dr. Peck or Michael, whichever makes you comfortable.

There are various methods and techniques that I use to empower you and to help you deal with your presented concerns. However, unlike visiting a medical doctor, this work requires an active effort from you. For therapy to be most successful, you work on the solutions discussed with me. Much of this work is done during the time between our sessions.

Therapy can have benefits and risks. Since therapy often involves discussing unpleasant aspects of your life, you may experience uncomfortable feelings such as sadness, guilt, anger, frustration, loneliness, and helplessness. Psychotherapy also has benefits and often leads to solutions to specific problems, better relationships, and significant reductions in feelings of distress. But, there are no guarantees of what you will experience.

The first sessions will involve an evaluation of your needs. By the end of the evaluation, I will offer my initial impressions of what the work will include. In subsequent sessions we will develop and implement a treatment plan. If you have questions, I always am happy to discuss them with you.

OUR MEETINGS

Initial evaluations will typically last from 45 minutes to 1 hour and 15 minutes. Afterwards, our meetings typically will last 45-50 minutes. Once an appointment is scheduled, you will be expected to pay for it unless you provide 48 hours advance notice of cancellation (unless you and your clinician agree that you were unable to attend due to circumstances beyond your control). If you do not show for a scheduled appointment, or cancel within the 48 hour notice, you will be charged a no show fee of $75.00. If you are on an Arizona Health Care Cost Containment System plan and no show for the initial appointment, or have 2 consecutive no shows to scheduled appointments, services will be terminated.

PROFESSIONAL FEES

The initial evaluation fee is $195 for individual adults, couples, and families. The hourly fee for regularly scheduled individual sessions is $130. If these fees are a significant economic burden to you or your family, I am willing to operate under a sliding-scale fee. Other services include report writing, telephone conversations lasting longer than 15 minutes, attendance at meetings with other professionals you have authorized, preparation of records or treatment summaries, and the time spent performing any other service you may request of your clinician. If you become involved in legal proceedings that require your clinician's participation, you will be expected to pay for the professional time even if your clinician is called to testify by another party. Because of the difficulty of legal involvement, I charge $200 per hour for preparation and attendance at any legal proceeding.

INSURANCE REIMBURSEMENT

If your insurance carrier will be billed, I typically can do that. At the time of service, you are responsible for any applicable deductibles and co-payments. If you are not eligible at the time services are rendered, you are responsible for payment in full. It is very important that you find out exactly what mental health services your insurance policy covers.

However, if you are seeing me out-of-plan, meaning I am not affiliated with your insurance provider, you will be responsible for billing your insurance carrier and all fees will be paid to me at the time of service; your insurance carrier will reimburse you directly for the insurance portion.

You should carefully read the section in your insurance coverage booklet that describes mental health services. If you have questions about the coverage, call your plan administrator. I will provide you with whatever information I can and will be happy to help you in understanding the information you receive from your insurance company.

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CONTACTING ME

My telephone line is open 24 hours per day; however, I am not able to answer calls at all times. Please leave a message and every effort will be made to return your call in a timely manner. If you are unable to reach me and believe that you cannot wait for a return call, please contact your family physician, primary care provider (PCP), primary medical doctor (PMD), your insurance company's crisis line, or call 911. You also can contact or go to the nearest emergency room.

SOCIAL NETWORKING AND WEBSITES

It is my policy that I do not engage in a relationship via social networking websites, such as Facebook, My Space, Twitter, etc. Ethical guidelines and legal statues of licensing boards have strict guidelines with regards to dual relationships, confidentiality, and professional boundaries.

PROFESSIONAL RECORDS

The laws and standards of the profession require that I keep treatment records. You are entitled to receive a copy of the records unless, in my professional opinion, I believe that seeing them would be emotionally damaging; in this case, I will be happy to send your records to a mental health professional of your choice. Because these are professional records, they can be misinterpreted and upsetting to untrained readers. If you want to review your records, I recommend that you do so with me so that we can discuss the contents. Patients will be charged an appropriate fee for any time spent in preparing information requests.

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.

CONFIDENTIALITY

In general, the privacy of all communications between a patient and a licensed clinician is protected by law. I only can release information to others with your written permission. But, there are a few exceptions.

In most legal proceedings, you have the right to prevent your clinician 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 the judge determines that the issues demand this information.

There are some situations in which I am obligated legally to take action to protect others from harm, even if I have to reveal some information about a patient's treatment. Circumstances in which disclosure is required by law include the following: when there is a reasonable suspicion of child, dependent, or elder abuse or neglect; and when a client presents a danger to self, to others, to property, or is gravely disabled. If I have reasonable suspicion that these situations have occurred, I must file a report with the appropriate state agency.

If I believe that you are threatening serious bodily harm to another, I am required to take protective actions. These actions may include notifying the potential victim, contacting the police, or seeking hospitalization for the patient. If you threaten to harm yourself, I may be obligated to seek hospitalization for you or to contact family members or others who can help provide protection.

In general these situations during which I am required to break confidentiality rarely have occurred. If a similar situation occurs, I will make every effort to discuss fully the situation with you prior to taking any action.

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Consent for Treatment

Your signature below indicates your consent to treatment. By signing you acknowledge that you have received and read the Outpatient Services Contract and agree to abide by its terms during the professional relationship.

Signature: _____ Date: _____

Assignment of Benefits

By signing below:

I certify that I, or my responsible party, have insurance coverage as indicated above. I assign directly to Q Counseling Services, LLC and Dr. Michael Peck all insurance benefits payable to me for services rendered. I understand that I am financially responsible for all charges, whether or not paid for by my insurance. I hereby authorize Q Counseling Services, LLC and Dr. Michael Peck to release information as necessary and sufficient to secure payment for benefits. I authorize the use of my signature below on all claims submitted on my behalf.

Signature: _____ Date: _____