Colette de Marneffe, Ph.D.
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215-645-2565

OUTPATIENT SERVICES CONTRACT

Welcome to my practice. The following information is intended to provide you with guidelines of my practice and to answer frequently asked questions. If you have any concerns about these policies, please discuss them with me.

PSYCHOLOGICAL SERVICES

Psychotherapy is not easily described in general statements. It varies depending on the particular problems you bring forward and individual qualities in the patient and psychologist. There are many different methods I may use to help you with the problems that you wish to address. 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 difficulties and goals we discuss both during our sessions and at home.

Psychotherapy 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. On the other hand, psychotherapy has also been shown to have benefits for people who go through it. Therapy often leads to improved relationships, solutions to specific problems, and significant reductions in feelings of distress. However, there are no guarantees of what you will experience.

Our first session(s) 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 preliminary treatment plan. You should evaluate this information along with your own opinions of whether you feel comfortable working with me. If you have questions about my procedures or approach, we should discuss them whenever they arise. If your doubts persist, I will be happy to help you arrange a meeting with another mental health professional for a second opinion.

It is often not possible to predict the duration of treatment at the outset. However, I will discuss this with you and give you my professional judgment about the possible/likely length of treatment.

FEES

Initial Evaluation (90 minutes) --$380.00
Individual, couple or family therapy (50 minutes) -- $200.00
Individual, couple or family therapy (60 minutes) -- $240.00

PAYMENT

Payment is expected at the time of service, unless other arrangements are made in advance. You may pay by check, cash or credit card (Visa, MasterCard, Discover or American Express). You will be given an invoice (monthly, or more frequently as requested) that includes all information required for insurance claim submission.

INSURANCE

With the exception of Medicare and Tricare, I am not a network provider for any insurance plans. Your private health insurance plan may provide out-of-network benefits and it is your responsibility to determine your benefits and to submit insurance claims.

CANCELLATIONS

It is important to keep all scheduled appointments in order to maintain the continuity of treatment. In the event that you need to cancel an appointment, please provide at least 24 hours notice. If you do not provide 24 hours notice and you cancel for any reason other than a true emergency or inclement weather, you will be charged the full session fee. If I am able to schedule another appointment at the time of your canceled session, you will not be charged for the missed appointment. In addition, if we are able to reschedule the appointment the same week, I will waive the fee for the missed session. If you have Medicare, your insurance will not pay for a missed session. Consequently, you will be responsible for paying the full allowable fee.

CONFIDENTIALITY

Maryland law recognizes that patient-therapist communication is privileged, and, as such, any information concerning your treatment can only be released with your written consent. There are several exceptions to this privilege, as follows:

- The law requires that a psychologist report any suspicion of possible abuse of a child, elderly or disabled person.

- The law requires a psychologist to take appropriate action when a patient threatens serious physical harm to self or others. Such action can include informing family members, other professionals, law enforcement officers, or potential victims of the harmful intent, or seeking hospitalization for the patient.

- When court ordered, confidential information may be released.

PRIVACY

I am required to give you information about the Health Insurance Portability and Accountability Act of 1996 (HIPAA), which informs you about the required management of private health care information. I will give you a copy of the form, or if you prefer, you can read it on my website

(www.drcdemarneffe.com). Your signature on this form attests to your having been given access to HIPAA policies, as they concern your treatment with me.

MINORS

If you are under 18 years of age, it is important for you to know that the law provides your parents with the right to have access to information about your treatment. Since privacy is often needed in order for therapy to be helpful, I ask parents to waive their right to specific information about our conversations. If they agree to this, I will provide them with general information about our work together, and I will discuss with you any conversations I have with your parents. In the event that I believe you are at risk of behavior that could seriously harm you or another person, I will notify your parents of my concern, and I will also tell you that I am sharing this information.

TERMINATION OF TREATMENT

You may elect to discontinue treatment at any time, and you will be responsible for paying for all services rendered. The decision to stop therapy can be difficult and I encourage you to raise for discussion with me your inclination and/or thoughts about bringing therapy to a close. On rare occasion, if we do not agree about the treatment method or goals, or if I deem therapy to be a risk to your wellbeing, I may recommend the discontinuation of treatment. In this situation, I will thoroughly discuss this with you and will recommend other mental health professionals.

RECORDS REVIEW AND RETENTION

If I request records of prior evaluations or treatments, I will ask that you give me non-original copies. For adults, I will retain clinical records for five years after the last session. In the case of minors, I will retain records for five years, or until your 21st birthday, whichever is later. If your insurance is Medicare, I will retain your records for six years after our last session.

CONTACTING ME

I am usually not immediately available by telephone. When I am unavailable, your call will go to a voice mailbox that I monitor several times daily. I will make every effort to return your call on the same or next business day.

In the event of an emergency, if you are unable to reach me and cannot safely wait for me to return your call, please contact your primary care physician, call 911 or 988, or go to the nearest emergency room.

If I am unavailable for an extended period of time, I will provide you with the name of a colleague to contact if necessary.

EMAIL AND TEXT MESSAGES

I prefer to use email and text messaging only to arrange or modify appointments. Please do not email or text me information related to your therapy sessions as they are not completely secure or confidential. If you choose to communicate with me via email or text message, please be aware that all emails are retained in the logs of your and my internet and cell phone service providers.

COVID-19

I am currently conducting in-person sessions, with masks optional, as the risk of developing serious illness from Covid-19 has diminished. We will discuss your masking preference prior to meeting. We agree to inform one another if either of us has been exposed to Covid-19, shows symptoms, or tests positive for Covid-19. In the event of cancellation due to Covid-19, there will be no charge for the canceled session. If you wish to meet virtually due to Covid-19 concerns, please discuss this with me.

INFORMED CONSENT

I certify that Dr. Colette de Marneffe has answered any questions I have about the information contained in this contract. I have read, understand, and accept the terms of this contract.

Signature: _____ Date: _____

Co-Signature (if applicable): _____ Date: _____