NANCY GRAY, MED, LMFT

MARRIAGE, FAMILY AND CHILD THERAPIST

1111 Triton Drive, Suite 203
Foster City, CA. 94404

650-444-0433 tel

MFT # 28199

OUTPATIENT SERVICES CONTRACT

Welcome to my practice. This document contains important information about my professional services and business policies. When you sign this document, it will represent an agreement between us.

PSYCHOLOGICAL SERVICES

Psychotherapy can have benefits and risks. Since therapy often involves discussing difficult aspects of your life, you may experience uncomfortable feelings such as sadness, guilt, anger, frustration, loneliness and helplessness. On the other hand, psychotherapy has been shown to also have benefits. 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.

MEETINGS

Psychotherapy sessions usually run 50 minutes in length. Once an appointment is scheduled, you will be expected to pay for it unless you provide 24 hours notice in writing of cancellation.

PROFESSIONAL FEES

My hourly fee is $ _200___ for each 50 minute psychotherapy session. I also charge this hourly fee for additional requested tasks such as report writing, emails, and phone appointments with you or other members of your therapy treatment team.

Should I be required to prepare records for court purposes, or to speak with attorneys, or to collaborate with other professionals working on your legal case, or to testify in court on your case, I will charge $_400__ per 50 minute block of time. This is an hourly rate of two times my psychotherapy rate and will be charged in increments of 50 minutes, plus travel time.

BILLING AND PAYMENTS

You will be expected to pay for each session at the time it is held. For cases which involve mediation or court involvement with other parties, a retainer will be requested.

INSURANCE REIMBURSEMENT

If you wish to use your insurance, please notify me at the outset of treatment. My policy is to have you pay me directly at the time of service. Upon request, I will provide you with a statement which you can in turn use to seek reimbursement from your insurance carrier.

CONTACTING ME

Please feel free to text me at (650) 444-0433 or email me at meade7447@gmail.com. Please note that I do not work on weekends or late evenings. I will usually return your email within 48 hours during the week, or by Monday if you email me over a weekend period. I do not work on holidays. If you experience a psychiatric emergency, please dial 911 and proceed to your nearest emergency room.

PROFESSIONAL RECORDS

I am required by law and ethical standards to keep treatment records.

CONFIDENTiALITY

In general, the privacy of all communication between a patient and a psychotherapist is protected by law. There are a few exceptions:

1. If I suspect that a child, elderly person or disabled person is being abused, I must file a report with the appropriate state agency.

2. If I believe a patient is threatening serious bodily harm to an identifiable victim, then I must take action to protect the parties.

3. If I believe you may be a danger to yourself or to others, or be gravely disabled and at risk of harm, then I must take action to ensure your safety.

Your signature below indicates you have read the information in this document and agree to abide by its terms during our professional relationship.

Print Name: Patient/Parent of Minor Signature: Date

Nancy Gray, MED, LMFT

1111 Triton Drive, Suite 203.
Foster City, CA. 94404.
MFT 28199

Please fill out this intake form prior to your first appointment and email to:

meade7447@gmail.com

PATIENT NAME: ____

ADDRESS:____

DATE OF BIRTH:____

Cell:_______________________ Home:___________________________

Email:_______________________________________

Insurance:___________________________________

Patient ID Number:___________________________

Group Number:______________________________

Name of employer:___________________________

Insurance Phone Number:_____________________

Insurance Claims Address:____

Reason for therapy?____

Previous therapist (if any): ____

If paying by credit card:

Type of card. Number. Expiration Date. Billing Zipcode

____