



Contract

In order to avoid confusion, I have listed below certain procedures and guidelines, which will govern our working relationship together. Please read it, put your initials, sign it and date it. Thank you

Confidentiality: All sessions are confidential. As a result, Dr Portal will only release information to another professional or agency with your written consent. Only necessary or pertinent information will be shared. Dr Portal is required by law to report information with specific outside parties when actual or potentially dangerous behavior toward yourself or others is reported, especially child abuse, elderly abuse. _____

Appointments: Scheduled appointment times are reserved especially for you. If an appointment is changed, missed or canceled with less than **24 hours' notice**, you may be billed as a regular session fee. Repeated "NO SHOW" appointments could result in referring you back to the insurance company for reassignment to another practitioner. Your insurance company cannot be billed for fees associated with missed or canceled appointments. Therefore, you, the patient will be responsible to pay the missing appointments. Cancellation by E-mail is not a valid form to notify this office: _____

Rules & Policies: No disruptive behavior, disrespect, threats or violent behaviors are tolerated at this office. Any patient who come to his/her session under the influence of alcohol, illegal drugs or under abuse of prescribed medication will be terminated from his treatment and will be referred to another agencies or professionals. I you miss your session for more than 2 consecutive weeks your case will be closed at this office and we will refer you back to your insurance. If you case is terminated and you want a copy of your records you need to send a formal letter by regular mail (not E-mail) requesting them and after 10 business days we will delivery your records, an extra fee of .50 cents per page will charged to your account. _____

Fees: It is customary that payment be made at each appointment. The fee of \$ 250.00 dollars is for a regular session (45 minutes). Initial assessment (90 minutes) fees are \$300.00 dollars In case your insurance company do not pay the fees as agreed you the patient are responsible for the entire amount. Fees for other services (i.e. reports, evaluations, letters, etc.) will be discussed during your first session. If you are applying for disability or immigration issues and we need to complete some documents the regular fees will apply to the time invested in preparing your documentation in an hourly rate (45 minutes). If Dr. Portal-Queirolo needs to appear to the court our fees are \$1500 for the first three hours, regular fees will apply after that time (45 minutes /\$250.00). _____

Consent for treatment In accordance with existing law, I AGREE WITH: the nature and purpose of the proposed evaluation (which may include psychological testing) and psychotherapy, alternative therapies, other treatment methods including the alternative of no therapy, have been discussed and explained to me and I understand the risks involved. I consent to and authorize the following procedures necessary for my health and wellbeing: The assessment may include: Interview with client, adult, child or adolescent and interview with parent. Behavioral Observation. Consultation with other professionals such as Doctors, Lawyers, Teachers, Pastors, Priests, Para-professionals, Law Enforcement agencies, courts. Psychiatrist: Mental Health exam. Reviewed of available records. Consultation with previous providers. Psychological Testing. Written report with recommendation and other procedures or actions to implement your treatment plan_____

Use and Disclosure of Healthcare Information: the therapist is required by law to provide each patient with a notice of Use and Disclosure of Healthcare Information, which describes how their health information may be used and disclosed as well as the rights regarding their health information. The undersigned hereby knowledge's that they have received a copy of the Use and Disclosure of Healthcare Information Notice (HIPPA)_____

In case of an emergency I AGREE to call 911 or I will go to the nearest hospital _____

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose health information to authorized federal officials if required for lawful intelligence, or order national security activities_____.

To the best of my knowledge I had read and understood this document and I agree / consent with its terms and conditions .

Patient's Name DOB

Patient's Signature Date