TIMOTHY M. LANE, PH.D., PLLC, PSYCHOLOGIST
209 TRAVIS ST., #101, ROANOKE, TX 76262, PHONE 940-395-1670

CONSENT AND AGREEMENT FOR PSYCHOLOGICAL SERVICES

I, _____, agree to participate with Dr. Lane in my individual,
Printed name of client
couple or family psychotherapy. I will initial beside each of the following points indicating I am aware of and agree to the following:

☐ I acknowledge that I received and understood *the Informed Consent, Treatment Agreement for Psychological Services, and Office Policy* handout for Clients (available online and at the office)..

☐ I realize that I am fully responsible for paying the agreed upon session fees per the fee schedule (e.g. $140 per 50 minute session) whether I submit an insurance claim or not. I recognize that Dr. Lane is out-of-network for insurance unless otherwise stated.

☐ **Medicare is not accepted** by Dr. Lane so I agree to not submit any claim to Medicare regarding my treatment with Dr. Lane. A form agreeing to this must be signed before therapy begins, if you have Medicare. (This is a Medicare requirement.)

☐ I understand that payment is due *at each session* and that sessions begin and end at the scheduled times. I understand that all payment balances must be paid up to date.

☐ If I utilize my insurance, I understand that Dr. Lane may provide my insurance company with all the information they request from my clinical record and that if my insurance denies coverage for Dr. Lane's services for any reason, I am responsible for paying for such services in full.

☐ If I fail to attend a scheduled session without giving 24 hours notice, I will be charged $100 for the session. I realize that insurance does not pay for missed or cancelled sessions making me responsible for this fee.

☐ I understand that email is not a secure or confidential form of communication and that I should not send private, personal, emergency, and/or time sensitive information via email.

☐ I understand that if I do not contact Dr. Lane for 30 days (e.g., I do not call to reschedule), my file will be closed and I will no longer be under his care. After 30 days, I understand I may call to discuss with Dr. Lane the possibility of reestablishing a therapeutic contract.

☐ I understand that no specific promises have been made to me by Dr. Lane about the results of treatment, the effectiveness of the procedures used by him, or the number of sessions necessary for therapy to be effective. It does, however, constitute an offer on my part to pay Dr. Lane for access to his resources as a psychologist and his willingness to apply those resources in good faith.

☐ I understand that Dr. Lane may terminate the therapy relationship for any reason, i.e. failure to follow treatment guidelines or safety plans, excessive absences, progress is unlikely or continuing may be detrimental to me/us, that he decides to make a referral to a professional(s) better suited to my needs, and he will discuss this with me/us in person or attempt to notify me of this decision.

□ I understand that Dr. Lane is not available at all times and cannot provide 24-hour crisis counseling. If he is unavailable and I am experiencing an emergency, I will do one of the following to ensure my safety: (1) call 9-1-1 or (2) go to the nearest emergency room if I can safely drive myself or have someone else drive me.

□ Dr. Lane will respect my right to confidentiality within the limits imposed by current law and will not share information about me unless I provide written authorization or unless it is necessary for him to do so as discussed in the Information for *Informed Consent, Treatment Agreement for Psychological Services, and Office Policy* handout for Clients and the *Notice of Privacy Practices.*

I understand that I have the right not to sign this form (thus not agreeing to treatment) and are encouraged to discuss any related concerns with Dr. Lane before therapy begins. I understand that after therapy begins I have the right to withdraw my consent to therapy and terminate treatment at any time, for any reason. If at any time during the treatment I have questions about any of the subjects discussed in this agreement, I can talk with Dr. Lane about them. I agree to act according to the points covered in this agreement, and to cooperate fully and to the best of my ability.

_____ _____
Signature of Client Date

_____
Printed Name of Client

I, Dr. Tim Lane, have informed this client of the points raised in this agreement. I have responded to all of his or her questions. I believe this person fully understands the Information for Clients handout and this agreement, and I find no reason to believe this person is not fully competent to give voluntary, informed consent to treatment. __ Copy accepted by client __ Copy kept by psychologist

_____ _____
Signature of Psychologist Date

Timothy M. Lane, Ph.D.
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