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PUTTING FIRST RESPONDERS AND THEIR FAMILIES FIRST

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OUTPATIENT SERVICES CONTRACT **Revised June 1, 2026**

Welcome to my practice. I am a licensed psychologist in the state of California. I provide assessment and psychotherapy services to individuals, couples, and families.

This document (the Agreement) contains important information about my professional services and business policies. It also contains summary information about the Health Insurance Portability and Accountability Act (HIPAA), a federal law that provides new privacy protections and new client rights with regard to the use and disclosure of your Protected Health Information (PHI) used for the purpose of treatment, payment, and health care operations. When you sign this document, it will represent an agreement between us. You may revoke this Agreement in writing at any time. That revocation will be binding unless I have taken action in reliance on it; if there are obligations imposed on me by your health insurer in order to process or substantiate claims made under your policy; or if you have not satisfied any financial obligations you have incurred.

Psychological Services

I want you to know that I am completely independent in providing you with clinical services and I alone am fully responsible for those services. I do not provide fitness for duty statements or custody recommendations.

Psychotherapy varies depending on the personalities of the psychologist and client, and the particular problems you are experiencing.

Psychotherapy has benefits and risks. Therapy often involves discussing unpleasant aspects of life and you may experience feelings of sadness, guilt, anger, frustration, loneliness, and helplessness. It can be uncomfortable to talk about the circumstances that you find yourself in or that have led up to your troubles. On the other hand, psychotherapy has been shown to be beneficial for many people and can lead to significant reductions in distress, better relationships, and solutions to specific problems. There are no guarantees of what you will experience.

Therapy involves a large commitment of time, money and energy. In taking this step to help yourself, it is important that you feel comfortable with the psychologist you choose. Our first one to two sessions will involve an evaluation of your needs. If I feel that I am not the best person to assist you, I will refer you to your insurance or a professional or an agency to better serve your needs. Please remember that you are the consumer. You have a right to ask questions about treatment or to refuse to participate in anything you deem inappropriate. I am open to discussing my treatment approach with you and encourage you to bring questions and concerns to my attention so we may discuss them, whenever they arise.

Initial _____

Professional Fees

My fees for individual therapy are \$210 for a 50 minute session, and \$300 for a 90 minute session. Additionally a session of EMDR may be beneficial which costs \$310. My fees for couples therapy are \$230 for a 50 minute session and \$330 for a 90 minute session. I will usually schedule one appointment session of 50 minutes duration per week at a time that we agree on, although some sessions may be longer or more or less frequent. In addition to weekly appointments, I charge \$145 per hour for other professional services you may need including preparation of a treatment summary that may go along with a records request. Some services include report writing, telephone conversations lasting more than ten minutes, attendance at meetings with other professionals you have authorized, preparation of records or treatment summaries. If you become involved in legal proceedings that require my participation you will be expected to pay for all of my professional time, including preparation and transportation costs, even if I am called to testify by another party. Because of the complexity of legal involvement, I charge \$325 per hour for preparation, travel time, and attendance at any legal proceeding. In addition, this fee will need to be paid in advance.

Initial _____

I require 24 hour advanced notice for any cancellation of a scheduled appointment. It is possible to call and leave a message 24 hours a day at (510) 797-4911. You will be charged \$100 for any cancellation made with less than 24 hours notice. **Late cancellations will be charged directly to you and not your insurance company**, unless prohibited by the insurance company. If our *first* appointment is canceled with less than 24 hour notice it will not be rescheduled and treatment will not begin.

Initial _____

There will be a \$30 surcharge for checks returned due to non-sufficient funds. Unless paying by cash or check, fees may apply if using an online payment system. This fee goes directly to the payment provider and not to me. Proof of electronic payment is expected at time of service.

Initial _____

Billing, Payments, and Insurance Reimbursement

You are expected to pay for each session at the time it is held, unless we agree otherwise or unless I have a contract with your managed care insurance company. If I have a contract with your managed care company, the billing procedures of that company will be followed. If I am covered by your insurance plan, but do not have a contract with your insurance plan, or if I am not covered by your insurance plan, you will be responsible for paying for my services at the time they are provided. I will be happy to provide you with a receipt for you to submit to your insurance company; however, you (and not your insurance company) are responsible for full payment of my fees.

If you have insurance, it is very important that you find out exactly what mental health services your insurance policy covers. 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 based on my experience. My rate for discussing payment matters with your insurance company may vary.

If you will not be using any insurance or EAP benefits, please initial here.

Initial _____

Do you want a receipt for psychological services?

Yes _____ **No** _____

Due to the rising costs of health care, insurance benefits have increasingly become more complex. It is sometimes difficult to determine exactly how much mental health coverage is available. “Managed Health Care” plans such as HMOs and PPOs often require authorization before they provide reimbursement for mental

health services. These plans are often limited to short-term treatment approaches designed to work out specific problems that interfere with a person's usual level of functioning. It may be necessary to seek approval for more therapy after a certain number of sessions. While much can be accomplished in short-term therapy, some clients feel that they need more services after insurance benefits end. Some managed-care plans will not allow me to provide services to you once your benefits end.

You should also be aware that your contract with your health insurance company requires that I provide it with information relevant to the services that I provide to you. I am required to provide a clinical diagnosis. Sometimes I am required to provide additional clinical information such as treatment plans or summaries, or copies of your entire Clinical Record. In such situations, I will make every effort to release only the minimum information about you and/or your child that is necessary for the purpose requested. This information will become part of the insurance company files and will probably be stored in a computer. Though all insurance companies claim to keep such information confidential, I have no control over what they do with it once it is in their hands. By signing this Agreement, you agree that I can provide requested information to your carrier.

It is important to remember that you always have the right to pay for my services yourself to avoid the problems described above [unless prohibited by contract].

Initial _____

If a reduced fee, delayed of fee or other entity will be paying your fee, this is pertinent information to note in our contract. Please outline the specific details below:

Initial _____

Contacting Me

Generally, I am in the office between 10:00 am and 3:00 pm. I am often not immediately available by telephone and not available typically on weekends and holidays. I will also not answer the phone when I am with a client. Calling me at **(510) 797-4911** is the easiest way to reach me or leave me a private, confidential voice mail message. Email response time is generally slower than phone response time. If you are unable to reach me and feel that you cannot wait for me to return your call, contact your family physician, the nearest emergency room, or call 911. If I will be unavailable for an extended time, I will provide you with the number of a local crisis hotline.

Initial _____

Limits on Confidentiality

The law protects the privacy of all communications between a client and a psychologist. In most situations, I can only release information about your treatment to others if you sign a written Authorization form that meets certain legal requirements imposed by HIPAA. There are other situations that require only that you provide written, advance consent. **Your signature on this Agreement provides consent for those activities, as follows:**

- I may occasionally find it helpful to consult other health and mental health professionals about a case. During a consultation, I make every effort to avoid revealing the identity of my client. The other professionals are also legally bound to keep the information confidential. If you don't object, I will not tell you about these consultations unless I feel that it is important to our work together.
- I may employ administrative staff. In most cases, I need to share protected information with these individuals for both clinical and administrative purposes, such as scheduling, billing and quality

assurance. All staff members have agreed not to release any information outside of the practice without the permission of a professional staff member.

- As required by HIPAA, I have a formal business associate contract with certain business(es), in which it/they promise to maintain the confidentiality of this data except as specifically allowed in the contract or otherwise required by law.
- In the event of my incapacitation or death, I have arranged for a clinician from the company TheraClosure to notify you promptly, assist you with referrals to other qualified mental health professionals if needed, secure your records and, at your direction, transfer your records to another therapist to ensure continuity of care. Please be assured that TheraClosure clinicians are bound by the same ethical and legal standards of confidentiality as I am.
- Disclosures required by health insurers or to collect overdue fees are discussed elsewhere in this Agreement.
- If a client threatens to harm himself/herself, I may be obligated to seek hospitalization for him/her, or to contact family members or others who can help provide protection.

There are some situations where I am permitted or required to disclose information without either your consent or authorization:

- If you are involved in a court proceeding and a request is made for information concerning the professional services I provided you, such information is protected by the psychologist-client privilege law. I cannot provide any information without your or your legal representative's written authorization, or a court order. If you are involved in or contemplating litigation, you should consult with your attorney to determine whether a court would be likely to order me to disclose information.
- If a government agency is requesting the information for health oversight activities, I may be required to provide it for them.
- If a client files a complaint or lawsuit against me, I may disclose relevant information regarding that client in order to defend myself.
- If a client files a worker's compensation claim, and I am providing services related to that claim, I must, upon appropriate request, provide appropriate reports to the Workers Compensation Commission or the insurer.

Initial _____

There are some situations in which I am legally obligated to take actions, which I believe are necessary to attempt to protect others from harm and I may have to reveal some information about a client's treatment. These situations are unusual in my practice.

- If I have reason to believe that a child under 18 is or has been the victim of injury, sexual abuse, neglect or deprivation of necessary medical treatment or is involved in child pornography, the law requires that I file a report with the appropriate government agency, usually the Office of Child Protective Services. Once such a report is filed, I may be required to provide additional information.
- If I have reason to believe that any adult client who is either vulnerable and/or incapacitated and who has been the victim of abuse, neglect or financial exploitation, the law requires that I file a report with the appropriate state official, usually a protective services worker. Once such a report is filed, I may be required to provide additional information.

- If a client communicates an explicit threat of imminent serious physical harm to a clearly identified or identifiable victim, and I believe that the client has the intent and ability to carry out such threat, I must take protective actions that may include notifying the potential victim, contacting the police, or seeking hospitalization for the client.

While this written summary of exceptions to confidentiality should prove helpful in informing you about potential problems, it is important that we discuss any questions or concerns that you may have now or in the future. The laws governing confidentiality can be quite complex, and I am not an attorney. In situations where specific advice is required, formal legal advice may be needed.

Initial _____

Professional Records

The laws and standards of my profession require that I keep Protected Health Information (PHI) about you in your Clinical Record. Except in unusual circumstances that involve danger to yourself or others or where information has been supplied to me confidentially by others, you may examine and/or receive a copy of your records if you request it in writing. Because these are professional records, they can be misinterpreted and/or upsetting to untrained readers. For this reason, I recommend that you initially review them in my presence or have them forwarded to another mental health professional so you can discuss the contents. Fees for PHI may include \$20 per 30-minutes of assembly and \$0.25 per page copied plus a minimum \$10 postage fee if mailed. If I refuse your request for access to your records, you have a right of review, which I will discuss with you upon request. You will be charged an appropriate fee for any professional time spent in responding to information requests, although I am sometimes willing to conduct a review meeting without charge. I do not use electronic health care records. You will have a paper chart only. Emails you send can be printed out and included in your chart. Email is not confidential.

Initial _____

If you are seeing me as a member of a couple or family, the couple or family *as a whole* is my client. I will not release records without the written consent of *all* applicable parties.

Initial _____

Client Rights

With my signature, I acknowledge that I have read the above information, or it has been read to me. I acknowledge that I have received answers to my questions I may have had and that I understand the content of the information above and agree to abide by its terms during our professional relationship. I hereby authorize the release of any medical information necessary to process medical claims on my behalf. I also authorize the payment of any governmental or private insurance benefits directly to Anne Bisek, Psy.D. I acknowledge that I am responsible for all services rendered to me, my child and/or members of my family. I also understand that I am obligated to pay for all services should my insurance eligibility be denied.

YOUR SIGNATURE BELOW INDICATES THAT YOU HAVE READ THIS AGREEMENT AND AGREE TO ITS TERMS AND ALSO SERVES AS AN ACKNOWLEDGEMENT THAT YOU HAVE RECEIVED THE HIPAA NOTICE FORM DESCRIBED ABOVE.

Printed Name of Adult Client(s):

Signature of client _____

Date _____

Signature of client _____

Date _____

Anne Bisek, Psy.D.

Date