Sophia Kong, Ph.D.

Clinical Psychologist
PSY #25298

960 E. Green St.
Suite L-11
Pasadena, CA 91106

(323) 702-3936
sywkong@gmail.com

PSYCHOTHERAPY SERVICES AND POLICIES

This document contains important information about my professional services and business policies. Please read it carefully and ask me any questions that arise. When you sign this document, it represents an agreement between us.

PSYCHOLOGICAL SERVICES

Psychotherapy varies depending on the particular problems you and/or your child bring and the approach of the therapist. It is important to select a therapist that fits your style and goals. By the end of the intake evaluation, I will be able to offer you my recommendation of whether you and/or your child can benefit from my services. If not, I will try to refer you to a more appropriate therapist/therapy group. Therapy involves a commitment of time, money, and energy, so you should make sure you feel comfortable working with me. If you have questions about our work together, we should discuss them whenever they arise. If your doubts persist, I will be happy to provide a referral to another mental health professional.

Should you decide to move forward with individual therapy or one of the therapy groups that are offered, it is because the treatment goals that you identified for yourself or your child are in line with those set with me for individual therapy and/or are covered by the group's curriculum. Group curriculums are designed to meet the needs of the majority. Fortunately, my group sizes are small, allowing for some individual work to occur within the group. However, it is important for you to accept the stated curriculum as the major focus of the treatment. In individual therapy the focus is specifically on you and/or your child and is tailored to fit your and/or your child's needs. Referrals for additional services will be provided as needed and upon request. It is also important to remember that the results of therapy cannot be guaranteed.

CONFIDENTIALITY

Your discussions with a licensed psychologist are considered *confidential,* which means these discussions are protected by law. I may not disclose confidential information about you or your child without your formal consent. There are situations, however, in which I am required to break confidentiality. These include the following circumstances: if you or your child are in danger of harming yourself or another person; if you are unable to care for yourself; if there is suspected abuse or neglect of a child, older adult (65 or older), or dependent adult; if I am court-ordered to release information as part of a legal proceeding; or as otherwise required by law.

PROFESSIONAL FEES, BILLING, AND PAYMENTS

Payments are to be made at the beginning of each individual appointment, program, or service. ***Cash or checks only.*** The intake fee is non-refundable should you choose not to continue with me in individual or group therapy. The intake fee is also non-refundable should you choose not to have your child participate in individual therapy or the group for whatever reason (e.g., have decided to pursue alternate services) or if your child is not a match for the group. When you or your child is participating in a group, half of the group fee is required before a spot in the group will be held for you or your child, with a portion of this fee being non-refundable. The balance is due on the first session.

No refunds will be given for sessions missed for any reason, including illness, childcare difficulties, vacation, traffic, or inclement weather. Should you decide to drop from the program, you will not be refunded money for the remaining sessions. In extenuating circumstances, a limited payment schedule may be arranged.

Individual Sessions: My 50-minute session fee is $150. There will be no charge for ***brief*** telephone calls and ***quick*** e-mail exchanges (i.e., limited to updates and scheduling).

Other services include telephone consultations, report writing, in-home visits, comprehensive school consultations, team meetings, or other services you may request of me at my regular rate of $175/hour, including travel time. I do not charge for typical consultations with other professionals involved in your child's care (i.e., updates). If you become involved in legal proceedings that require my participation, you will be expected to pay for the professional time I spend preparing records or treatment summaries. You will also be expected to pay for my time spent testifying, even if I am called to testify by another party. There is typically a small increase in fees each year.

Cancellation Policy: There is a 24-hour cancellation policy for individual appointments and other individually scheduled services (e.g., school visits). Should you cancel or no-show with less than a 24-hour notice *for any reason,* you will be charged the full session fee. Please note insurance companies do not reimburse or pay for missed sessions, therefore, if you are seeing me as an "in-network" provider, you will be responsible to pay your full session fee.

Late Fees: There is a $15 fee for returned checks. A late fee will be added for any charges past due by 30 days, with additional charges accruing monthly. If your account has not been paid for more than 60 days, I may use legal means to secure the payment and include its costs in the claim.

INSURANCE REIMBURSEMENT

Certain health insurance policies will provide some coverage for "out-of-network" mental health treatment, however, you (not your insurance company) are responsible for full payment of my fees. You will be provided with superbills that contain information your insurance company may require, however, it will be your responsibility to complete insurance forms and obtain reimbursement. It is very important that you find out exactly what mental health services your insurance policy covers and the status of your deductible. Of note, insurance companies typically do not reimburse for missed sessions. If you have an HMO, please ask me about pursuing a single case agreement for insurance coverage.

If I am an "in-network" provider with your insurance carrier, you are responsible for submitting your co-payment to me on the day of each session via ***cash or check only***. You are also responsible for contacting your insurance carrier to determine the limits of your deductible and your co-payment amount.

CONTACTING ME

My preferred method of communication is via telephone at (323) 702-3936 for the most rapid response. You may also contact me via email: sywkong@gmail.com. If you are unable to reach me and feel that you cannot wait for me to return your call, contact your family physician, your psychiatrist, or the nearest emergency room. It is important to note that I do not provide crisis services and am not available 24 hours a day. Should your child become a danger to him/herself or someone else, you should take him/her to the nearest emergency room for care or dial 911 for assistance. Should you feel that you have become a danger to yourself or others, you should go to the nearest emergency room for care or dial 911 for assistance.

It is important to note that although the internet provides a fast and convenient method of communication, confidentiality cannot be guaranteed through electronic mail, as e-mails can sometimes be intercepted. Similarly, it is possible for wireless phone conversations to be overheard. Please inform me in advance if you have concerns about privacy through e-mail or wireless phone use.

ENDING THERAPY

You may end therapy at any time. A final individual session is important so that you and/or your child have closure with me as your or his/her therapist. The groups have a natural cycle with closure built in. If you end a group early, it is important to give yourself and/or your child a chance to say goodbye in a final session.

Please Note: This policy is subject to change at any time; current clients will be kept updated.

I have read and understand this document and I have had my questions answered to my satisfaction. I accept, understand, and agree to abide by the contents and terms of this agreement. Please initial the statements below to indicate your agreement and sign below to indicate your consent for treatment:

_____(initial) I understand that cell phone and e-mail correspondence can potentially be intercepted and is therefore not guaranteed to be confidential.

_____(initial) I understand that individual therapy and consultation appointments must be cancelled within 24 hours of the appointment to avoid paying the full fee. I further understand that once an appointment is scheduled, it is my responsibility to record the date and time. Reminders are not given.

_____(initial) I understand that I will be charged for phone calls beyond 15 minutes and for lengthy e-mail exchanges. I will be warned of a charge beforehand.

_____(initial) I understand that if my child is seeing Dr. Kong as an "out-of-network" provider she will provide me with a "superbill" to submit to a PPO insurance company periodically for past sessions. Insurance does not reimburse for missed sessions. All receipts or invoices will be e-mailed unless otherwise indicated.

_____(initial) I understand that my or my child's spot in group therapy may be given away unless the non-refundable deposit payment is made by the deadline.

_____(initial) I understand that there is no reimbursement for missed group therapy sessions for any reason, even if I decide to drop out of the group.

_____(initial) I pledge to uphold the confidentiality of all group members when participating in group therapy. This means keeping personal information about group members to myself. It also means describing the social skills group as a "study group" to people who may know both my child and another child in the group.

_____(initial) I agree to refrain from arranging get-togethers with other group members until one or both of the children have ended their participation in the group.

_____(initial) I certify that a copy of Dr. Kong's Notice of Privacy Practices detailing the provisions of HIPAA and my/my child's privacy rights was made available to me.

_____ _____

Name of Patient/Child (please print) Signature of Patient (18 years or older) Date

_____ _____

Name of Parent/Legal Guardian (please print) Signature of Legal Guardian Date

Relationship to Child:_____