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Agreement for Psychological Services

This Agreement contains important information about my professional services and business policies. Along with this document, you will find a document titled, HIPPA Notification of Privacy Practices, a federal law that provides privacy protections and patient rights with regard to the use and disclosure of your Protected Health Information (PHI). The law requires that I obtain your signature acknowledging that you have received the privacy notice. You also have the right to a "Good Faith Estimate."

Please read carefully and note any questions you have.

PSYCHOTHERAPY

Psychotherapy is not easily described in general statements. It varies based on the personalities of the psychologist and patient, as well as the concerns brought to treatment. I may use different methods at different times to address your goals and needs.

Psychotherapy can involve both benefits and risks. Because therapy often includes discussing difficult or painful experiences, you may experience emotions such as sadness, guilt, anger, frustration, loneliness, or helplessness. These reactions are normal when exploring issues that matter. At the same time, psychotherapy has been shown to offer many benefits, including improved relationships, increased self-understanding, symptom reduction, and more effective coping. However, no specific outcome can be guaranteed.

Effective therapy requires a willingness to reflect honestly on your internal experiences—your emotions, beliefs, conflicts, expectations, and relational patterns. This often includes becoming curious about how your own thoughts, behaviors, or coping strategies may contribute to recurring difficulties. My role is not to judge these patterns but to help you understand them with compassion, clarity, and psychological insight.

You are always free to disagree with any of my comments, interpretations, or suggestions. Your honest reactions are essential to our work. If something feels confusing, uncomfortable, or not quite right, I strongly encourage you to share this openly. Therapy works best when we can reflect on these experiences together.

MEETINGS / EVALUATION PROCESS

Our first few sessions will involve a psychological evaluation of your history, concerns, strengths, and goals. By the end of this evaluation period, I will provide my initial impressions and recommendations for treatment. You should consider this information alongside your own sense of whether you feel understood, comfortable, and supported in our work together. Therapy often involves a significant investment of time, emotional energy, and financial resources, so it is important that you feel confident in choosing a psychologist who is a good fit for you.

If at any point you have questions about the process, my recommendations, or how therapy is unfolding, please feel free to ask.

If I do not hear from you for two weeks, I will assume you are choosing to end treatment and will close your file. You are welcome to contact me in the future to resume treatment, space permitting.

FEES, PAYMENT, AND BILLING

Private-pay fee: My out-of-pocket fee is $150 per 50-minute individual psychotherapy session as well as for evaluations, testing, report-writing, or any legal procedures.

Insurance: I am contracted with a limited number of insurance companies. If we use your insurance benefits, the session fee is determined by the specific rate I have negotiated with your insurance plan, which I do not know usually because they change every so often. You are responsible for all copayments, coinsurance, and any portion of the deductible required by your policy.

Because insurance plans vary widely, it is your responsibility to confirm your mental-health benefits before our first appointment, including:

- Whether I am in-network with your plan
- Your copay or coinsurance amount
- Whether your deductible applies
- Any visit limits or prior authorization requirements

I strongly encourage you to contact your insurance provider to fully understand your financial responsibility before beginning treatment.

Payment is due at the time of service unless other arrangements are made in advance. I accept most forms of payment, credit cards, HSA, check, etc.

If insurance denies coverage, retroactively or otherwise, you are responsible for the full session fee.

CANCELLATION & LATE POLICY: Your appointment time is reserved exclusively for you.

- You may cancel or reschedule without charge if you provide at least 24 hours' notice, unless there is an emergency.
- Cancellations within 24 hours or no-shows are charged a $50 fee.

My reciprocal commitment to you: If I fail to keep your scheduled appointment (barring emergencies such as illness, power outages, or weather-related closures), I will pay you a $50 missed-appointment fee, equal to your own late-cancel/no-show charge.

This ensures mutual respect for time and fairness in the therapeutic relationship.

CONTACT & COMMUNICATION

Email and texting are appropriate for scheduling matters only. Please do not include clinical or sensitive information in electronic communications. I do not provide crisis intervention through text or email.

Phone messages are checked periodically Monday–Friday during business hours. I will return calls as soon as I am reasonably able.

AFTER-HOURS & EMERGENCIES. I do not provide 24-hour emergency services.

If you are experiencing a crisis or emergency:

- Call 911
- Go to the nearest emergency room
- Contact the Washtenaw County Crisis Line: 734-544-3050
- Or the National Suicide & Crisis Lifeline: 988

You may leave me a voicemail after stabilizing the emergency.

CONFIDENTIALITY & ITS LIMITS

The privacy of your information is protected by law. In general, I may not disclose information about your treatment without your written permission.

However, the law requires or permits disclosure in certain circumstances, including:

1. Risk of harm to yourself or others
2. Suspected child abuse, elder abuse, or abuse of a dependent adult
3. Court orders or subpoenas
4. Collection of unpaid fees (minimum necessary information only)
5. Medical emergencies

I will discuss any potential need for disclosure with you whenever possible.

TELEHEALTH

Telehealth services are provided using secure video platforms. The benefits include greater flexibility and accessibility; risks include potential technological interruptions, reduced non-verbal communication cues, and privacy considerations in your environment. By participating in telehealth, you agree to:

- Ensure that you are in a private, quiet location
- Not engage in telehealth sessions while driving or in distracting settings
- Use a secure internet connection whenever possible

Telehealth is billed at the same rate as in-person sessions.

RECORDS & PRIVACY (HIPAA)

I maintain records as required by law and professional standards. These records are confidential and stored securely. You may request access to your records in writing; I may recommend reviewing records together in session to protect clarity and reduce risk of misunderstanding.

I comply with all applicable HIPAA regulations regarding use, storage, and disclosure of protected health information.

SOCIAL MEDIA & BOUNDARIES

To protect your confidentiality and maintain appropriate therapeutic boundaries:

- I do not accept friend requests or follow patients on social media.
- I do not communicate through social media messaging platforms.

RISKS OF THERAPY

In addition to the emotional discomfort sometimes experienced, other risks may include:

- Temporary increases in distress as deeper issues emerge
- Changes in significant relationships
- Disappointment if progress is slower than expected

These risks are part of the therapeutic process and often precede meaningful growth.

Should you ever feel stuck or discouraged, please share this with me—we will address it together.

ENDING TREATMENT

You have the right to end therapy at any time. Ideally, we will discuss this in advance so we can process the ending and ensure continuity of care. If I believe that you need a different kind of treatment or a higher level of care, I will discuss this with you and provide appropriate referrals.

CONSENT

By signing below, you acknowledge:

- You have read and understood the information above.
- You have had the opportunity to ask questions.
- You consent to treatment under these terms.
- You agree to the cancellation policy.
- Have received the HIPPA Notice of Privacy Practices (in a separate document)

Patient Name: _____

Signature: _____ Date: _____

Clinician: Shasha M. Camaj, PhD

Signature: _____ Date: _____