Georgann Norton, Psy.D.
Licensed Psychologist 239-261-1514

TREATMENT CONTRACT

Welcome to my practice. I would like to take this opportunity to thank you for choosing me for your professional services.

This document contains important information about my professional services and business policies. Please read it carefully and jot down any questions you might have so that we can discuss them when we meet. When you sign this document, it will represent an agreement between us.

Professional Services
I deliver outpatient mental health services. Treatment is confidential and designed to meet the therapy needs of adults. Services may also include psychological testing, assessment and therapy with other family members as deemed important by you. My services are provided via Telemental Health which includes video conferencing and telephone therapy.

You and I will develop a plan which will be modified regularly depending on the needs and progress of your treatment. There is a small risk that your condition may worsen during treatment. If at any point you are unhappy about your progress, the process or the outcome of your treatment, please discuss this with me so that together we can attempt to resolve any difficulties to better meet your needs. Therapy requires a commitment and consistent effort on your part to secure the best results. Open and honest communication between us will be necessary for our success.

As part of your treatment, I may recommend a referral to your physician or another professional for evaluation/management of medication or additional treatment options. Your first several sessions with me will include information gathering on my part in an effort to get to know you and better understand your situation and background. During sessions please silence your phones so we can have uninterrupted time together.

I will be available to you through my 24-hour voicemail service. Due to my work schedule, I am often not immediately available. I am generally in session and unable to answer the telephone. I will attempt to return telephone calls to my office within 24 hours during the work week, if not sooner. I am in Eastern Standard time zone. Weekend calls will be returned by the next weekday. If you ever have a clinical emergency, please call 911 or go directly to the nearest emergency room for help.

You may discontinue therapy at any time. My clients who have not had a session with me in over 30 days (or after that time without a mutually agreed upon appointment) will be considered inactive and no longer under my professional care. It is always preferable to have a final session before ending your therapy in order to evaluate and review progress and any remaining issues. Be assured that if you wish to return to active therapy, you may do so by making a new appointment with me to resume therapy.

Telemental Health:

Telemental health is the practice of delivering clinical health care services via technology assisted media or other electronic means between a practitioner and a client who are located in two different locations. This form of communication allows for greater convenience and availability for my clients. The telehealth videoconferencing platform I use is Doxy.me.com, a secure, encrypted website. Please understand the following with respect to your telemental health:

1. I understand that I have the right to withdraw consent at anytime.
2. I understand that there are risks and consequences associated with telemental health, including but not limited to, disruptions of transmission by technology failures, possible interruption and/or breaches of confidentiality by unauthorized persons, and/or my limited ability to respond to emergencies.
3. I understand that there will be no recording of any kind of the online sessions by either party. All information disclosed within sessions and written records pertaining to those sessions are confidential and may not be disclosed to anyone without written authorization, except where the disclosure is permitted and /or required by law.
4. I understand that confidentiality is very important and that I will be in a private room with the door closed or area where I am alone and free to talk without interruption. I will announce anyone who is in the room or who enters the room. I will turn off any digital apps in the room such as Siri, Alexa, Google Now, etc.
5. I understand that the privacy laws that protect the confidentiality of my protected health information also apply to telemental health unless an exception to confidentiality applies.by law.
6. I understand that if I am having suicidal or homicidal thoughts, actively experiencing psychotic symptoms or experiencing a mental health crisis that cannot be resolved remotely, it may be determined that telemental health services are not appropriate and a higher level of care is required.
7. I understand that during a telemental health session, we could encounter technical difficulties resulting in service interruptions. If this occurs, you can end and refresh the session. If we are unable to reconnect within five minutes, please call me at 239/261-1514 to continue our session.
8. I understand that all other terms in this treatment contract such as but not limited to HIPAA, payment, insurance, confidentiality, etc., apply to our telehealth sessions.

Emergency Protocols:

I understand and agree to provide my location in case of emergency to Dr. Norton. I also give her permission to call 911 or contact the person below in a life-threatening emergency to assist me or take me to the hospital. If I am in danger of hurting my self or someone else I will call 911 or go to the nearest emergency room immediately.

Contact Person:_____

Cell Number:_____

Home/Office Number:_____

Relationship to You:_____

Nearest Hospital Name: _____, City: _____, Tel. No. _____

Nearest Local Police Tel. No. (not 911) _____

Appointments and Cancellations:
My sessions are 53 minutes in length and are by appointment only. If you chose to reschedule or cancel an appointment, you must provide a minimum of 24 hours advance notice. If you do not provide proper advance notification, you will be charged the full fee for late cancellations or missed appointments.

If you happen to arrive late for an appointment I cannot extent our time as this would interrupt other appointments. The number and frequency of our sessions are determined on your and my availability. Please understand that regular and consistent sessions are necessary for effective therapy.

Fees:
My fees are set within the usual and customary range for this community. My fee per session is two hundred twenty-five dollars ($225) for the first clinical interview and two hundred five dollars ($205) per session thereafter. Payment is required at the time of service.

By agreeing to participate in treatment provided by me, you agree to pay for these services according to the above fee schedule. Any unpaid balance will be charged to your credit card on file with me. Any insurance claim filing will be your responsibility to send into your insurance company if you choose.

Additional Fees:
If you request that I write reports or attend meetings on your behalf to schools, to agencies or with other professionals, I will charge my hourly fee for time incurred in these activities including travel time. These charges are payable at the time of service.

A pro-rated hourly fee will be charged for telephone consultations which are fifteen (15) minutes in length or longer to you or on your behalf to other professionals.

If you become involved in legal proceedings that require my participation, you will be expected to pay for my professional time and services even if I am called to testify by another party. Due to the difficulty of legal involvement, I charge three hundred dollars ($300) per hour for all preparation and attendance at any legal proceedings, including travel time, which must be paid prior to my participation or attendance in this process. It is my strong advice to keep my involvement out of these proceedings to protect your privacy, information and due to the high financial and emotional cost of these issues.

Unpaid Balances:
If financial difficulties arise, a payment schedule may be discussed with me. If for any reason unpaid balances are incurred, the balance will be paid from the credit card you have on file with my office. If the balance is not satisfied within three (3) months, a collection agency may be contracted. The collection agency fees, court costs and attorneys' fees will be added to the unpaid balance. I reserve the right to terminate the doctor-patient relationship for non-payment.

Insurance:
Be aware that I am a self-pay provider; which means I do not accept insurance. For those clients who wish to obtain reimbursement from their insurance after payment I will complete an insurance form for you to send into your insurance company. Some insurance companies do cover psychotherapy but limit the number of sessions for which they will pay. Some insurance companies will not cover psychotherapy services. You should check with your insurance company for details.

It is also important to note that insurance companies require a written or verbal clinical diagnosis from me. They may also require progress reports, treatment goals, a prognosis and other clinical information from me before they reimburse for these services. These requirements mean that therapy is not confidential, and that this information will become part of your insurance company's files. It is important to remember that when you pay directly for these services you avoid experiencing any limits to your confidentiality.

Confidentiality:
The confidentiality of communication between a client and a psychologist is very important and is protected by the ethical practices of the psychologist as well as state and federal law. I may occasionally find it helpful to consult with another professional about a case. During a consultation, I make every effort to avoid revealing the identity of my patient. The consultant is also legally bound to keep the information confidential.

Reports and other information are not sent outside of my practice without written consent by you to do so. After you approve my releasing a report/information, I cannot be responsible for the confidential information once it leaves my office.

Exceptions to Confidentiality:
There are exceptions to confidentiality by federal and state law. Information about a crime committed by a client, an emergency situation or information about a person who might be a danger to him/herself, or who might be a danger to another person is not protected by client confidentiality per federal regulations. Information about suspected child or elder abuse or neglect is also not protected by confidentiality by way of legal regulations.

If you become involved in certain types of court proceeding wherein you have placed your mental health as an issue in your claims or defenses, your records and information may be subject to disclosure in this matter. Please see the HIPAA Notice of Privacy Practices which is in your packet of information.

Exceptions to Confidentiality with Minors:
If you are under eighteen (18) years of age, please be aware that the law may provide your parents the right to receive general information on your treatment, especially if the information concerns your safety. It is my policy to request a consent from parents that they agree to give up access to information discussed in therapy by you, the minor, unless I feel there is a high risk that you will seriously harm yourself or someone else.

Contact Information:
Sometimes it is necessary to contact you outside of the session to return your telephone call, reschedule appointments, or send you information. Due to confidentiality, I would like to know how I may contact you.

Do I have your permission to call you and leave a message if necessary:

On your cell phone number #_____

On your office number #_____

Email (in case of emergency): _____

Mail billing information, etc. to your home address: _____
_____
_____

Social Media:
For your protection, I do not use text messaging, email, Facetime, Facebook, LinkedIn or other social media sites for client communication as these modes of communication are not confidential. I cannot protect your privacy through these means therefore, I do not use them. Whenever you would like to contact me to discuss any non-emergency issue or make/cancel an appointment, please call me at my confidential office number at: 239-261-1514 and I would be happy to speak with you.

Agreement:
I have read the above information on all 5 (five) pages of this Treatment Contract and I understand and agree to its contents. My signature indicates my consent to receive treatment by Georgann Norton, Psy.D.

Client Signature _____ Date: _____

Minor's Signature: _____ Date: _____
(If Client is over 12 years old)

Therapist's Signature: _____ Date: _____

Georgann Norton, Psy.D.
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PATIENT INFORMATION FORM

Client Name: _____

Date of Birth_____ Gender: _____

Social Security #: _____Marital Status S M W D

Address: _____

City: _____ State: _____Zip: _____

Permanent Address if different from above: _____

City: _____ State: _____Zip: _____

Home Tel No: _____ok to call? _____

Cell No: _____ok to call? _____

Work Tel No: _____ok to call? _____

Employer Name: _____City: _____

Referred by: _____

Please read the information below then sign and date this page.

All new clients, please include a copy of your Driver's License or State I.D.

I understand that I am responsible for any unpaid balances from session appointments, cancellation fees and missed appointments that I may incur. I understand that I am required to give a 24-hour cancellation notice for an appointment cancellation and that I will be charged a full session fee for this or a missed appointment. My credit card will be used to pay for these fees.

Signature: _____Date: _____

Print Name: _____

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CLINICAL INFORMATION

In order to have as full an understanding of your history as possible, please complete the following questions thoroughly. Thank you for your help.

Name: _____ Date: _____

Date of Birth: _____ Referral Source: _____

History of Presenting Problem:

Chief Complaints:

_____

_____

Mood:

How would describe your mood over the past 4 weeks: _____Difficulty concentrating: _____ Hopeless/Helplessness: _____ Fatigue: _____Crying: _____

Anxiety: _____Other Symptoms: _____

When did these problems first start: _____

Have you experienced these symptoms before: _____When: _____

How long do these symptoms last: _____

How would you rate these symptoms on a 1 -10 scale, with 10 being the worst: _____

Have you been in therapy previously: _____ When: _____

For how long: _____

Sleep:
Do you have sleep issues: _____ How many hours of sleep do you get at night: _____

Do you have problems falling asleep or staying asleep at night: _____

Appetite:
Have you had recent weight gain or weight loss: _____

Have you had appetite changes or dietary changes recently: _____

Have you had any bariatric surgery in past: _____

Do you consider yourself to be underweight or overweight: _____

Any history of an eating disorder: _____

Risk Factors:
Have you had suicide/homicidal thoughts in the past 4 weeks: _____ Have you had these thoughts in the past: _____ Do you have a plan:_____ Attempt: _____ Please explain

_____

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Psychiatric History:
Have you ever had psychiatric hospitalizations: _____Diagnosis: _____

Have you had hallucinations: _____Delusions: _____

Victim of violence: _____ Victim of bullying: _____ Victim of Sexual Abuse: _____ Please explain: _____

Domestic Violence:
Do you feel safe with your current partner: _____ Have you been hit_____ pushed _____shoved_____ spit upon_____ slapped_____ strangled_____ threatened_____ raped_____ or fear for your life: _____ Please explain: _____

Substance Abuse History:

Do you drink alcohol: _____ Number of drinks on weekdays: _____ On weekends:_____ Do you use recreational drugs: _____ Which drugs:_____ Do you use prescription painkillers, narcotics, or opioids: _____Which type: _____ Do you use medical marijuana: _____ Have you had any arrests or DUI's:_____ Do you drink caffeine: _____ How many cups per day: _____ Do you smoke cigarettes/vape: _____ How many packs per day: _____

Medical History:
Physicians Name: _____ Address: _____

Telephone Number: _____ May I contact your physician about your physician regarding your symptoms, treatment, diagnosis and treatment plan: _____

Current Medical Issues:

_____

_____

Previous medical issues:

_____

_____

Do you have any pain issues: _____ Please explain: _____

Previous surgeries: _____

Allergies: _____

Current Medications:

Name	Dosage	Times Per Day	Purpose of Medications

Current History:

Any legal involvement with DUI's, lawsuits, custody issues: _____ Please explain: _____
Hobbies_____

Groups and Organizations to which you belong: _____

Previous Social History:

Where were you born: _____ Where did you grow up:
_____Have you lived in any other states: _____

What is your educational level: (GED, HS, AA Degree, BA, MA, Doctorate, Vocational School):
_____ Current Occupation: _____

Previous Position: _____ Are you retired now: _____

Military Experience: _____Rank: _____ Did
you see combat: _____

Describe your childhood years:

_____

_____

_____

_____

Describe your adolescent years:

_____

_____

_____

_____

Mother's History:

Is your mother living: _____If not, when did she die: _____ Her age at death: _____

Cause of death: _____Did she have any anxiety: _____ Any depression: _____Any alcohol
abuse or addiction: _____ Any drug use: _____ Treatment for any of these issues: _____

Highest level of education: _____ Occupation: _____ How would you describe your mother:

_____

_____

_____

_____

How would you describe your relationship with your mother:

_____

_____

_____

Mother's ethnic or cultural background: _____

Father's History:

Is your father living: _____If not, when did he die: _____ His age at death: _____

Cause of death: _____Did he have any anxiety: _____ Any depression: _____Any alcohol abuse or addiction: _____ Any drug use: _____ Treatment for any of these issues: _____

Highest level of education: _____ Occupation: _____ How would you describe your father:

_____

_____

_____

_____

How would you describe your relationship with your father: _____

_____

_____

_____

_____

Father's ethnic or cultural background:

_____

Family:

Describe the relationship between your parents:

_____

_____

_____

_____

Siblings Names Ages

_____

_____

_____

_____

_____

_____

Relationship Status:

Are you married, single, coupled, separated, widowed or divorced:_____

Have you been married previously: _____ How long were you married/coupled: _____

If married, coupled or widowed, name of your spouse: _____

How would you describe your relationship with your spouse/significant. other:

_____

_____

_____

Spouse/Significant Other's occupation: _____

Do you currently own or rent: _____

Children:

Children's Names	Ages	Occupation	Relationship Status (Married, Single, Coupled, Divorced)

Your Goals in Therapy:

_____

_____

_____

_____

Patient Signature: _____ Date: _____

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HIPAA NOTICE OF PRIVACY PRACTICES

I acknowledge receipt of Dr. Norton's HIPAA Privacy Notice

Patient Name: _____ Date:_____Signature: _____

Patient Name: _____ Date: _____Signature: _____

Please sign the above and return to Dr. Norton. Thank you.

Georgann Norton, Psy.D.
Licensed Psychologist 239-261-1514

Credit/Debit Card Payment Consent Form

Patient Name _____
Print: First Name Middle Last Name

Name on Card if different than above _____
Print: First Name Middle Last Name

I authorize Georgann Norton, Psy.D. and ProfessionalCharges.com to charge my Card for professional services as follows:

_____ All visits beginning with _____/_____/_____ not to exceed $225.00 per visit.
(Initial here) I also agree to allow Dr. Georgann Norton to charge my Card for the balance of fees not paid by me or my insurance company within 60 days.

Type of Card: _____Visa _____MasterCard _____Discover

Card Number: _____ - _____ - _____ - _____

Expiration Date: _____/_____ DVV Number: _____
(On back of Card)

Card holder's billing address associated with this Card:

_____

_____
Street City State Zip Code

Charges will appear on your Card statement as ProfessionalCharges.com or some abbreviated form of this title. If you have any questions about any of your charges you should contact Dr. Norton. I agree that if any of my actions yield a chargeback for any reason to Dr. Norton, the charges and all penalties will be paid by me the Cardholder.

Card Holder Signature _____ Date _____

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GOOD FAITH ESTIMATE OF SERVICES

Date _____

Name_____

Address _____

_____

Date of Birth_____ Diagnosis Code _____

Primary Service Provided: Individual Psychotherapy (90791, 90837) Office Location: Telehealth
The "No Surprises Act" was enacted by Congress to reduce the likelihood that patients would receive a surprise medical bill by their medical providers. The Act requires providers to inform patients of expected charges for the services they will receive.

The following are the expected charges associated with my services. My individual session fee is $225.00 for the initial session and $205.00 for every session thereafter. My session fees are also in your Treatment Contract and on my website, NortonTherapy.com. As an example of your cost, accounting for only some of the vacations, holidays, sickness and any late-cancellation fees that you may encounter, it means that if you attend approximately:

- One session every other week, or approximately 24 sessions per 12-month period, your cost could be $4,940.00 per year ($225.00 for the initial session plus $205.00 x 23 for 23 additional sessions)

The information provided above is a good faith estimate and only an estimate for your treatment. But I believe it gives you a range of costs that is likely for your care for a 12-month period. The actual charges will differ depending on the actual number of sessions that you decide to schedule. Depending on how your treatment progresses, more or fewer sessions may be desired. There may also be additional services that I may recommend as part of your treatment which are not included in the above estimate and at your discretion to attend. This estimate does not include any unknown or unexpected costs that may arise during treatment including but not limited to a new diagnosis or additional crisis sessions.

You have the right to initiate a patient-provider dispute resolution process if you feel your charges unexpectedly exceed the good faith estimate above. If you have any questions regarding my services or charges, please do not hesitate to contact me immediately. You may also contact cms.gov/nosurprises for more information. Any questions that you have will in no way impact the quality of your health care treatment provided by me. This letter is a good faith estimate and not a contract and does not require you to maintain a certain number of sessions or obtain the above services from me.

Let's talk if you have any questions. I look forward to speaking with you again soon.

Sincerely,

Georgann Norton, Psy.D.
NPI 1518035674