Aliza Feldman, Psy.D.
New Jersey Licensed Clinical Psychologist #5978
1 Cattano Avenue, Morristown, NJ 07960 | P: (973) 306-4280 F: (973) 538-2302

Welcome to My Private Practice

This document contains information about my professional services and practice policies. Please review the following information carefully and do not hesitate to ask questions if any of the following information appears to be unclear. After signing this document, it will represent a professional agreement between us.

Psychological Services

Treatment typically consists of an initial consultation appointment and on-going psychotherapy sessions based on your individual needs and goals. The purpose of the initial consultation is for me to get a better understanding of your current concerns, relevant background information, and treatment goals. In addition, it is an opportunity for me to determine whether I am the best fit for your needs. If, for any reason, you feel that I am not the best fit for you, I will be happy to provide referrals to other providers who might better suit your needs. The purpose of on-going individual psychotherapy is to be able to work towards your goals and hopefully improve your symptoms and quality of life. Since therapy often involves discussing unpleasant aspects of your life, the process of therapy may cause you to experience uncomfortable and often difficult emotions (e.g., anger, sadness, loneliness). On the other hand, the potential benefits of participating in therapy might include improved relationships with others, reduced negative emotional states in your day-to-day life, an increased ability to manage stress and other life problems, and discovering new ways of thinking about yourself, others, and the environment. As such, therapy is a collaborative process and requires you to commit to working on your issues both in session and outside of session.

Attendance and Cancellation

Therapy sessions are typically 45 or 60 minutes in length and are normally scheduled on a weekly basis. Once you have scheduled an appointment, you will be expected to attend that session and assume responsibility for payment for that service.

I have a **24-hour cancellation policy**. You will be expected to pay for missed sessions *unless you provide at least 24 hour advanced notice that you need to cancel.*

Professional Fees

Payment is typically due at the time of service unless other arrangements have been arranged in advance. My initial consultation fee is $200. My hourly fee is $175. I accept cash or checks as forms of payment. In addition to weekly appointments, I charge this amount for other professional services that you may need, although I will break down the hourly cost if I work for periods of less than one hour. Other services may include, report writing, preparation of records or treatment summaries, and time spent on performing any other service that you request of me.

I am an in-network provider for **Horizon Blue Cross Blue Shield PPO**. Most insurance plans require you to pay at least a portion of your fee (e.g. copayment), and some plans

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require that you meet an initial deductible amount before they begin to reimburse. If you plan to use insurance, I strongly recommend that you reach out to your insurance company to get a better understanding of your benefits prior to our first session. I am considered an out-of-network provider for all other insurances, and I am happy to assist you with providing the necessary information for reimbursement. Please be advised that payment for services is ultimately your responsibility.

In cases when an account has been neglected by you and there has been no sign of good faith despite my repeated attempts toward resolution, I reserve the right to use legal means to secure the payment (e.g., hire a collection agency or go through small claims court). In most collection situations, the only information that I would release regarding your treatment would be your name, the nature of services provided, and the amount due. Finally, there is a charge for all returned checks.

Contacting Me

I am often not immediately available by telephone and it may take some time before I am able to return your call. Please leave me a message on my voicemail and I will make every effort to return your call within the same day (except weekends or holidays). On occasions when I plan to be unavailable for an extended period of time (e.g., away on vacation), I will provide you with the name and phone number of a colleague to contact.

Emergencies

As a private practice, my services do not include emergency treatment. If you are experiencing a crisis, please call 911 or proceed to your nearest emergency room or hospital for immediate evaluation.

Confidentiality

Following the New Jersey state law and the American Psychological Association (APA) code of ethics, the therapist-patient relationship is privileged and confidential. In most cases, I can only release information regarding our work together with your permission. However, there are several limitations to confidentiality depending on your particular circumstances. If your health insurance carrier falls under the federal ERISA act, this carrier is entitled to and may request information about your treatment. In most legal proceedings, you have the right to prevent me from sharing information regarding your treatment. However, in some cases, a judge may order my testimony if he or she finds this action to be necessary. If I believe that a child is being abused or neglected, I must report this suspected abuse to the appropriate state agency. If I believe that you are an imminent danger to yourself or others, I am required to take protective actions (e.g., call the police, warn a potential victim, or seek emergency psychiatric care for you). These situations do not occur frequently and I will make every effort to discuss these issues with you before taking action.

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Therapy Contract

By signing below, I verify that I have read and understand the therapeutic contract and give my consent for treatment:

Signature: _____ Date:_____

Notice of Privacy Practices

By signing below, I verify that I have received and reviewed the Notice of Privacy Practices. I understand that Dr. Feldman is committed to protecting my privacy and confidentiality as described in the Notice of Privacy Practices.

Signature: _____Printed Name: _____

Signature: _____Printed Name: _____
Parent (for Minor)