Julie Davis, PhD

Licensed Clinical Psychologist
(716) 939-1438

Welcome!

Welcome to my practice! I am excited to have the opportunity to work with you and/or your family, and I look forward to meeting with you soon. Based on the information you provide in this packet and that which you share with me during the first few sessions, I will offer you feedback about the type of therapy, frequency, and duration of treatment I recommend for you or your child. I will also let you know whether my areas of expertise are best suited to your family's needs. If so, and if you feel we are a good fit, we will move forward together to set achievable goals for you and/or your child.

The enclosed materials answer some of the most common questions about my practice, and it contains information about my professional services and business policies. Please read it over carefully before your first visit and initial by each section.

Please fill out the intake information form and bring it to your first session. If you have any questions or concerns about the information in this packet or about the information I am requesting from you, feel free to leave the section blank for now and we can discuss your questions or concerns at the beginning of your first session.

Sincerely,

Dr. Julie Davis, PhD
Licensed Clinical Psychologist

Julie Davis, PhD

Licensed Clinical Psychologist
(716) 939-1438

Policies and Procedures

Initial: **Cancellations:**

____

In order for therapy to be as effective as possible for you or your child, it will be important that you take responsibility for attending each of the scheduled sessions. If you need to cancel an appointment, I need at least 24 hours notice by calling 716-939-1438. **If you no-show for an appointment or give less than 24 hours notice, I reserve the right to charge you for the appointment.**

Each missed appointment will be charged at a rate of: $50

Initial**: Fees:**

_____

My fee for an initial 75 minute intake session is $175. All following sessions will be approximately 50-55 minutes and cost $150.

Initial **Payments:**

_____

Payment is due at the time of each visit. Your payment can be made using *cash, personal check or credit card*. If you do not bring your payment or co-payment to the session, there will be a $10 charge applied to your account each time this occurs. There is a $30.00 fee for each returned check to cover accounting and bank fees.

If payment is neglected, I reserve the right to discontinue treatment until the balance is met. In the unfortunate event that a collection agency is employed to collect an outstanding bill, you will be given notice before this action is taken and will be liable for the agency's fees beyond the original balance due.

Initial: **Emergencies**

____

***I do not offer emergency coverage*.** *If you or your child is regularly in need of emergency services, we will need to discuss transitioning care to another setting that offers a higher level of care than I can offer as an independent practitioner.*

If you feel that your own life or someone else's life is in danger you should **call 911 or go to the nearest emergency room**.

Erie County offers the following 24/7 crisis numbers:

Children under the age of 18: 716-882-4357 (Spectrum Cares)
Adults: 716-834-3131 (Crisis Services)

Julie Davis, PhD

Licensed Clinical Psychologist
(716) 939-1438

The following crisis resources are also publicly available:
Crisis text line: Text the word "Home" to the number 741-741
National Suicide Prevention Lifeline: 1-800-273-8255

The above services are not in any way affiliated with or condoned by my practice, rather they are public crisis services that I want you to be aware of should the need arise.

Initial: **Phone calls and practice coverage:**

____

If a non-emergency concern arises between sessions that you feel cannot wait until the next scheduled session, you are welcome to call and leave me a message at 716-939-1438. I will do my best to respond to your call in a timely manner, but it may take up to 48 hours for me to return your call depending on the day the call is left. Depending on the nature of the concern and whether it can be efficiently addressed by phone, I may indicate that we should schedule another session at an earlier date to discuss your concern.

A colleague will cover my practice when I am out of town and, unless I have had to leave town unexpectedly, I will do my best to let you know when this occurs. Your consent to treatment provides me permission to share necessary information about you with the person covering my practice.

Initial: **Divorce Proceedings:**

____

Parental divorce/separation can be a stressful time, especially for children. Therapy must be a safe and consistent space for children. To this end, confidentiality is critical; children need confidence that they can speak openly in therapy without consequences. In rare circumstances, a judge may require my testimony, despite my best effort. As your child's therapist, it is outside of my role to provide recommendations on custody decisions, visitation arrangements, etc. I will provide only the minimum amount of information necessary if I am ordered to appear in court. If I am required to attend court, my $150 hourly rate applies, as well as time for travel. This is to be paid in advance. **I do not, under any circumstances, provide custody evaluations.**

Initial: **Confidentiality and minors:**

____

For children age 12 and under, I typically request parent involvement during all or a portion of each session. This facilitates parents' ability to encourage skills outside of therapy and improves communication between parents and children, which is critically important for symptom reduction.

Julie Davis, PhD
Licensed Clinical Psychologist
(716) 939-1438

Parents or guardians of minors are entitled to information communicated by their child in therapy. However, as consistent with my profession's ethics and mental hygiene law, information will be communicated only in ways that will be helpful. For adolescents (age 13 and above), I request an agreement between myself, the adolescent, and their parent(s)/guardian(s), allowing me to share general information about the progress of treatment, targeted skills, and any serious safety concerns. Communication regarding other information the adolescent shares with me will require your adolescent's authorization. **This is important because violation of the trust in therapy can undermine your adolescent's progress and result in reluctance to share sensitive information.** I understand this takes much trust on your part. Please understand that if I feel your child/adolescent is in danger or is a danger to others, I will notify you of my concern. These limits to confidentiality will be explained to your child/adolescent in the first visit and reviewed during other instances if it is warranted.

Initial: **Privacy and emails:**

_____

As you or your child's psychologist, I am responsible for protected health information (PHI)- that is information in the health record that could identify you or your child. I abide by federal regulations (HIPAA) to best ensure you and/or your child's privacy. Therefore, I will primarily communicate with you face-to-face, via telephone, or via US mail. Email communication is reserved for scheduling only. **I ask that you do not email me regarding clinical questions about you or your child. If this occurs, I will encourage you to set up an appointment.**

Initial: **HIPAA**

_____

The Health Insurance Portability and Accountability Act (HIPAA), a federal law that provides extensive privacy protections and patient rights with regard to the use and disclosure of your Protected Health Information (PHI), requires that I provide you with a Notice of Privacy Practices (NPP) for my practice. A copy will be available for you prior to or at the time of your first appointment. It explains HIPAA and its application to your personal health information in greater detail. The law also requires that I obtain your signature acknowledging that you have received this information, which I will also do at or before the time of our first meeting. You will also be asked to sign Consent Forms at or before the time of our first meeting, enabling me to treat you if indicated and to use your PHI for "Treatment, Payment and Health Care Operations." These uses of information, which are spelled out in the NPP, include communicating with other physicians or providers involved in your mental health and/or related care and for billing purposes.