Lisa Y. Livshin, Ed.D.
Licensed Psychologist
772-263-7100
lisa.livshin@icloud.com

PRIVATE PRACTICE INFORMATION AND FINANCIAL AGREEMENT

Welcome! When an appointment is made, I have set aside time in my schedule for you. No overlapping appointments are made, and unless an emergency arises, every effort will be made to begin and end each session on time.

The goal of therapy is to produce change. Changing feelings, thoughts, and behaviors are difficult tasks and may require exploring past experiences, setting goals, and planning for the future. Psychotherapy calls for a very active effort on your part. In order for the therapy to be most successful, you will have to work on things we talk about both during our sessions and at home.

As your therapist, I have made a commitment to your treatment. For progress to occur in therapy, it is necessary that you share this commitment and attend all appointments in a timely manner. Make your therapy sessions a priority in your schedule. Each session begins at the time agreed upon. If you arrive late for an appointment, the session will end as scheduled.

CANCELLATION POLICY

If an emergency arises which requires that you cancel an appointment, it is your responsibility to call my office or email me at least 24 hours in advance of the session to notify me. When a patient forgets an appointment or cancels without adequate notice, I am not able to fill the appointment time. Please note that insurance companies will not reimburse for cancelled or broken appointments.

EMAIL

When trying to schedule an appointment via email, I may offer you one or more potential session times. Please try to respond to me as soon as possible, as I am unable to hold on to times for very long, and may have to offer the time to someone else if I do not hear back from you in a timely manner. I try to check email regularly, but only use it for patient scheduling, not for lengthly communications between sessions.

CONFIDENTIALITY

Communications between a licensed Psychologist and his or her patient are confidential. This means that I will not release records or respond to questions about your therapy without your prior written consent. Your record will be securely stored.

There are however, legal exceptions to this confidentiality rule. The laws of the Commonwealth of Massachusetts require that a Psychologist break confidentiality and notify appropriate authorities if the patient presents a clear and present danger to himself/herself or others and refuses explicitly by his or her behavior to voluntarily accept further appropriate treatment. Such reporting may occur without consultation. This duty to warn and protect includes but is not limited to child/elderly abuse or neglect. Finally, in some legal proceedings a psychologist may be compelled by the Court to provide confidential information when the laws of the Commonwealth of Massachusetts require disclosure to protect the rights and safety of others. These situations have rarely occurred in my practice. If a similar situation occurs, I will make every effort to fully discuss it with you before taking any action.

FEES

Fees available upon request

BILLING AND PAYMENTS

Payment is due in full at the time of the appointment. I am a contracted provider with Blue Cross Blue Shield, Medicare, and Tufts Health Plan. I bill these policies directly. You are responsible for the co-payment or deductible at the time of service.

If I do not accept your insurance, and you have out of network benefits, I will ask you to make payment at the time of your visit. I will provide you with a receipt with the necessary information for you to obtain reimbursement.

Checks, credit cards and HSA cards are accepted.

Payments not received within 90 days are subject to collection in small claims court action, and you may be held responsible for any associated fees.

EMERGENCY CALLS AND COVERAGE

If you believe you may be a danger to yourself or to others, call me immediately. If I am not available, you should go to or call your nearest hospital emergency room. If I know I am going to be unavailable for an extended time, I will give you the name and number of a colleague to contact, if necessary.

Your signature below indicates that you have read this agreement and agree to its terms during our professional relationship.

Patient Signature	Date