Harbor Place
A Quiet Place to
Learn and Grow

Harbor Psychological Associates
and
Harbor Center for Sexual Health

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Stella Dial, Ed.D.
Licensed Psychologist

Margaret A. Lowe, Psy.D
Licensed Psychologist
Sex Therapist

Michelle A. Martin, MA
Licensed Marriage & Family Therapist
Limited Licensed Psychologist*
Certified Sex Therapist

Associates:

Jennifer Imbault, MA
Licensed Professional Counselor
Nationally Certified Counselor

June Martinez, Psy.D
Psychologist-
Doctoral Educational Limited*

Debra Tufts, MA
Limited Licensed Psychologist*
Education Specialist
Certified School Psychologist

Blake Martinez, Psy.D
Licensed Psychologist

Karli Baldus MA
Limited Licensed Psychologist*
Licensed Professional Counselor

Matthew Sharpe, MATS, MAC
Professional Counselor-
Educational Limited*

Joshua Martinez, MA
Temporary Limited Licensed Psychologist*
Limited Licensed Professional Counselor*

*Supervised by a Licensed Psychologist or
Licensed Professional Counselor

HARBOR PSYCHOLOGICAL ASSOCIATES
DISCLOSURE STATEMENT

Today's Date: _____

Printed name of client: _____

Printed name of legal guardian:_____

Welcome to Harbor Psychological Associates! We appreciate the opportunity to work with you. You, or a member of your family, are about to become involved in counseling or psychotherapy with a trained and license/certified therapist. We want to state some basic principles we believe essential in establishing a good counseling relationship between us. Please read through this information, asking questions as needed.

1. Initial Interview: Your first visit is considered a diagnostic or evaluation interview. At the time of this appointment, the following decisions will be made with you.
   a. Type of therapy needed (individual, group, couples, family, etc.)
   b. Frequency of therapy sessions (weekly, biweekly, etc.)
   c. Goals of therapy (what you hope to gain from this process.)

2. Appointments and Fees: Each appointment is approximately 45-60 minutes. Our charges are as follows:
   a. Initial Evaluation: $235.00
   b. Individual Sessions: $150.00 to $180.00
   c. Psychological Testing: $275.00 per unit

3. Cancellations: If you find that you need to cancel an appointment, please give as much notice as possible. You will be personally charged $75.00 for the session fee for appointments not canceled at least 24 hours in advance other than for emergency reasons. Insurance companies will not reimburse for appointments you schedule but do not attend.

4. Payments and Insurance: Some costs of therapy may be reimbursable by your insurance company. Our office will bill your insurance company for your sessions; however, you are responsible for verifying your coverage, deductibles, reimbursement rates, pre-authorization needs, co-payment and other aspects of your coverage (i.e., change of coverage, etc.)

   You are responsible for any charges not paid by your insurance company. Some charges that your insurance company will not pay are: missed appointments, those cancelled with less than 24 hours' notice, your part of the fee or co-pay, and any deductible amount. Deductibles and co-pays are due at the time of service. Late charges of 2% per month will be added to balances existing for more than 30 days.

   You also have the option of paying cash for services.

5. Other Rights and Considerations: you have a right to know your therapist's training and credentials. You have the right to stop treatment at any time and the right to request referral assistance from your therapist. If you are dissatisfied with any aspect of your therapist's work, please raise the concern immediately with your therapist. If you have an ethical concern about your treatment and cannot resolve this problem with your therapist, you can contact: Bureau of Health Professions, P. O. Box 30670, Lansing, MI 48909.

6. Confidentiality: What you share with us will be kept confidential unless you give written permission for its disclosure. However, there are some limits to confidentiality. If insurance is used to help pay for sessions, the insurance company may request information regarding diagnosis, symptoms, and counseling goals. If you indicate you pose a significant danger to yourself or others or that a child, elder, or disabled person is being abused, then we are required by law and ethical standards to notify an appropriate person. In some court situations, a judge may order to disclose confidential information. If your therapist holds a limited license in his/her discipline, supervision with a fully licensed therapist in the appropriate field is required by law. Also, if your experience a medical emergency in our presence, we are required to share enough information about you to insure you receive proper care.

7. Risks: Therapy does involve risks. Most people find that the benefits of counseling outweigh the risks.

8. Agreement:

If more than one adult patient, each person should check boxes and initial on the lines.

☐ Yes ☐ No _____ _____ I acknowledge that I have read and understand all of the foregoing statements and that my signature below indicates that I agree to abide by all of the above conditions.

☐ Yes ☐ No _____ _____ I have received a copy of the patient information form and Privacy Practices (HIPAA)

☐ Yes ☐ No _____ _____ I authorize the release of any medical information necessary to process my insurance claims.

☐ Yes ☐ No _____ _____ I authorize benefits to be paid directly to Harbor Psychological Associates.

☐ Yes ☐ No _____ _____ I consent to the exchange of treatment information between Harbor Psychological Associates and my primary care physician.

Patient(s): _____

Physician's Name, Office, and Phone Number: _____

_____

_____

Signature of Client or Legal Guardian: _____ Date: _____

For Minor Children:

I am legally authorized and consent to the treatment of my minor child.

Child's Name: _____

Parent/Legal Guardian Signature: _____