Therapy Expert
Therapy Contract
Dr Julie Scheiner, Chartered Psychologist
drjuliescheiner@protonmail.com
Tel:07958 283811

Terms and Conditions

1. **Clinic hours:** Sessions are typically offered at my home where my therapy room is based.
2. **Emergencies:** I do not provide any out of hour's service or emergency cover. If you feel you cannot keep yourself or young person safe you should contact:

- Your GP surgery
- Go to your local hospital A&E department
- Call the police and/or ambulance on 999

3. **Fees:** Initial consultation is £ per 50 minute session. Therapy appointments are £ per 50 minute session and payable in cash before the appointment or via BACS. Phone and/or email contact will be charged at the hourly rate, except that brief contacts for administrative purposes will not be charged. Neurodevelopmental assessments cost …….. (please note a deposit is payable).
4. **Payment Details:** Payment must be paid before or no longer than 72 hours post appointment. The initial consultation is payable before the session taking place.
5. **Non-payments:** In the event of non-payments Therapy Expert reserves the right to pass on your contact details to third parties that enable Therapy Expert to collect the due payments. This might include debt collection companies and solicitors.
6. **Health Insurance:** If you have been accepted for therapy through your insurance company and you have excess on your policy you are responsible for paying the appropriate excess directly to Therapy Expert. It is your responsibility to ensure that the costs of therapy are covered by your insurance policy. Please make sure that you have authorisation code. *DNAs and late (less than 72 hours) cancellations are typically not covered by health insurance policy and these are payable directly to Therapy Expert*
7. **Cancellations:** Appointments cancelled more than 72 hours before the appointment will not be charged. Appointments cancelled less than 72 hours before the appointment will be charged in full. Appointments may be cancelled by phone or email.
8. **Confidentiality and Disclosure:** In line with professional guidelines for clinical psychologists, your personal information will be treated strictly confidentially. Your file will be kept in a locked filing cabinet. Your emails and administrative information / reports will be stored on a password protected computer. Emails that contain therapeutic content will be printed and put in your file. All other emails will be

deleted at the end of therapy. I will keep your file for seven years after our last appointment, after which all contents will be destroyed.

9. It is recommended that you allow me to contact other professionals involved in the care of the individual referred to me, **especially your GP**.
10. I receive regular clinical supervision in which your case may be discussed for the purpose of ensuring the highest standards of treatment. This is subject to the same high standards of confidentiality. **Confidentiality will be breached only in very exceptional circumstances when there is a risk to a young person or others or if criminal activity has been disclosed. This means I will contact the relevant service that can best support you (e.g. your GP, Psychiatrist, Social Services, Police).**

Please tick if you agree to the following:

- ☐ Information being shared with your GP
- ☐ Information being shared with named health professional (s):
  …….
  ……..…
- ☐ You would like copies of reports
- ☐ Communication by email for the purposes of administration or therapy
- ☐ A voice mail message being left on your mobile
- ☐ A voice mail message being left on your landline
- ☐ A text message being sent to you on your mobile

Therapy Contract	
Client's name	
Date of Birth	
Address	
Postcode	
Telephone Number	
Email	
Health Insurance provider	
Health Insurance Number	
Health Insurance Authorisation Code	
Only complete this session if the client is under 18 year old	
Parent's/Carer's name and address	
Telephone number(s)	
Email	
Emergency/Next of Kin contact details	
Name	
Relationship	
Address and Telephone Number	
GP Name and Address	
GP Phone Number	

Name and contact of the person(s) I may speak to regarding appointments	

Could you please sign the document to indicate that:

1) you are aware of the fees, payment and cancellation policy and are willing to comply with these
2) you have read the information on confidentiality and disclosure and are satisfied with this
3) you have read the terms and conditions document, which outlines your rights and responsibilities in purchasing/utilising a private clinical psychology service provided by Dr Julie Scheiner and that you accept these terms.

Print Name	
Signature	
Date	
Signature (Dr Julie Scheiner)