Treatment Polices & Limits of Confidentiality

I have chosen to receive medication management and/or counseling services through the office of Dr. James B. Pinkston, Pinkston Psychology, Shreveport, Louisiana. My participation is voluntary. I may discontinue receiving these services at any time.

Topics discussed in the course of my treatment may make me uncomfortable. I understand this may be necessary. I understand that outcomes of mediation and therapy cannot be guaranteed. I understand that taking and discontinuing medications can cause side-effects. I will follow the prescribed dosage and frequency of any medication I receive from Dr. Pinkston and contact his office should I experience medication side-effects. I understand that if I am receiving medication management services Dr. Pinkston's office will be in communication with my identified PCP. I understand this is necessary and authorize this communication. I understand that this is an outpatient clinic and does not offer emergency psychiatric services. I realize that I should go to an emergency room in the case of an emergency.

The content of my psychotherapy sessions, treatment, and related files, are held in strict confidence and will not be disclosed to others without my written permission. Exceptions to this policy, as required by law, include any time I am judged to be a danger to myself or another person; any time I report knowledge of actual or suspected physical or mental abuse or neglect of a child, elderly individual, or vulnerable person; or as directed by court order. If I am involved in legal action and claim mental health issues related to that legal action, my mental health records may be required to be released. Communications I have with Dr. Pinkston will otherwise be kept confidential. I may request that Dr. Pinkston communicate with another person or agency at any time in the future by completing a release of information form.

I understand that Dr. Pinkston & Pinkston Psychology will not bill my insurance, and that I am responsible for the full cost of service. I understand that services will be billed as follows:

Medication Management / Counseling	
Intake Interview	$200.00
90 – 120 minutes	$140.00
31 – 60 minutes	$90.00
20 – 30 minutes	$60.00
Phone consult	$30.00
Letter preparation	$30.00
Prescription w/o visit	$30.00

I understand that I will be charged $50.00 for any appointments missed without 24-hours' notice, and that payment for missed appointments will be due at the beginning of my next appointment. I understand that if I miss three consecutive appointments without sufficient notice I will be discharged from care under the assumption that services are no longer needed or desired. Services rendered after hours, on weekends or holidays, or on an emergency basis may incur additional charges.

Having read and understood the above, I agree to these policies and limits of confidentiality.

_____
Name

_____ _____
Signature Date Witness Date

12.21.17

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