Kenneth F. Wise, Psy.D.
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Information on Office Services and Policies

Kenneth F. Wise, Psy.D. is committed to the goal of providing you with the best possible psychological care. The information contained herein is presented with the belief that your clear understanding of Dr. Wise's policies is an important part of maintaining a helpful and satisfying professional relationship.

Services include psychological evaluation, individual and conjoint therapy for adults and individual, play therapy, and parent consultation for children and adolescents. Office hours are by **appointment only**. Dr. Wise will discuss your diagnosis and treatment goals with you and create a customized treatment plan that fits your needs. Therapy is a joint effort between the therapist and client, the results of which cannot be guaranteed as progress depends on many factors including motivation, effort, and other life circumstances such as interactions with family, friends, and other associates. In undertaking therapy there are potential negative effects which include, but are not limited to, increased stress in relationships and temporarily increased emotional distress. Implications or potential negative effects of a particular therapeutic technique or approach may be discussed at any time with Dr. Wise.

Confidentiality: Information you share with Dr. Wise is confidential. All professional staff and office employees are bound by these rules of confidentiality. **However**, **by law, Dr. Wise is required to notify appropriate authorities if you are evaluated to be a danger to yourself or others, or if you are a minor, elderly, or disabled person and Dr. Wise believes you are or were a victim of abuse, or if you divulge information about such abuse**. **Additionally, Dr. Wise is obligated by law to report sexual abuse by another therapist or health care provider to appropriate authorities and licensing boards.** Confidential information may also be required to be made available by court order in disputed custody cases or other legal matters. In certain legal proceedings, such as child custody disputes, mental health malpractice suits, or other lawsuits concerning damages to mental health, the court may subpoena your records. If you choose to file insurance benefits, certain information is required to be furnished regarding your diagnosis, symptoms, treatment plan and supporting psychological data. Other then these exceptions information will not be released without written consent. We understand the importance of the privacy of information you may share here. Usually, Dr. Wise will not release information to others without your written consent. However, there are some exceptions to this general rule (**See Notice of Psychologist's Policies and Practices to Protect the Privacy of Your Health Information).**

Scheduling: If you decide to begin individual, family psychotherapy, or therapy for your child, scheduling a regular appointment time for sessions may be best. In contrast with other health care professionals who may intentionally "over book" treatment times, Dr. Wise reserves an hour exclusively for you or your child. Because he cannot schedule other work during this block of time, please let Dr. Wise know as far in advance as possible if you must reschedule a session, so the time may be released for use by others. A **cancellation fee of $75.00** will be added to your bill if you are unable to give at least **24 hours notice** that you will not be attending a scheduled session and the reason for canceling is not an emergency. **Insurance does not cover this fee.**

To reschedule a session, call Dr. Wise at (469) 252-1597 and leave a message. If you must reschedule a Monday session, please call or email over the weekend.

Service and Fees: Service charges for therapy and testing are based on a 50-minute session. The initial diagnostic session rate is **$200.00** (unless other arrangements are made with Dr. Wise prior to the first meeting). The rate for subsequent sessions is **$175.00** per session. Fees are subject to periodic adjustment. It is expected that you will pay for your first appointment at the time of that appointment, unless special circumstances (such as coverage by an insurance plan) require other arrangements. Follow up visits may be paid in full, or you may prefer to pay only your co-payment and allow Dr. Wise to file for insurance reimbursement directly to Kenneth F. Wise, Psy.D. To utilize your insurance coverage, benefits must be verified in advance. Please contact **CBM Medical Management** at **214-295-5890 (ext.4)** to verify coverage and with any questions about your insurance. Fees for professional services are customarily paid at the time services are provided. Make all checks payable to **Dr. Kenneth Wise**. Returned checks are subject to a **$25.00** service charge. Various bank cards may be accepted as a means of payment.

Website and Email: While Dr. Wise maintains a Website and has an email address, the email address is not to be used for emergencies as email messages may not be delivered or received in a timely manner. You should also understand that messages delivered by way of email are not confidential as you might expect the U.S. Mail to be. While unlikely, your email messages may be read by others while en route through the internet to your therapist.

Please understand you are ultimately responsible for payment of all professional fees, regardless of whether or not an insurance company reimburses Dr. Wise for his services.

Treatment: Dr. Wise will not accept you or your child into treatment unless there is some reasonable degree of assurance that it will be beneficial to the patient. However, as with all health care services, there are no absolute guarantees of results. Your active participation in treatment, often including a focus on treatment goals between sessions, will give you the best opportunity for success.

Ending Treatment: The decision to end treatment should be discussed openly when the problems or symptoms have been resolved. If indicated, Dr. Wise will discuss a plan for gradual tapering of services, and/or plans to continue self-help after discharge. If you fail to schedule an appointment at least once per month or miss more than two scheduled appointments, Dr. Wise will assume that you wish to end treatment. At that point your file will be closed and Dr. Wise will discharge you from his care.

Legal Testimony: As a matter of general policy Dr. Wise does not testify in custody or other legal matters. If you subpoena Dr. Wise to court to testify regarding you or your child's treatment, you are responsible for his fees including time out of the office, travel, and court proceedings. This also applies if Dr. Wise is required to provide testimony by deposition. Fees for time out of the office and travel are based on a forensic rate of $250.00 per hour with a minimum fee of $1,000.00. If Dr. Wise is required to be available for testimony for a full day, then a fee of $2,000.00 is charged. This fee must be paid on deposit at least one week prior to the scheduled testimony.

When spouses or other couples are seen conjointly for therapy or in family therapy, Dr. Wise will not testify at a future time on behalf of either spouse in the event of litigation between the spouses (e.g., civil litigation, including, but not limited to, divorce or disputed custody matters). An evaluation for purposes of disputed custody matters is distinct from therapy. **If an individual's purpose in seeking therapy or consultation involves issues related to child custody matters, this should be made known to Dr. Wise immediately**.

Emergencies: Discussions of problems in daily living are best reserved for regular therapy sessions. However, you may experience a crisis that leads you to believe that prompt action is necessary to prevent harmful or impulsive behavior. Example of this might include persistent thoughts of suicide, urges to harm others, or a sense that your thoughts or behaviors are out of control. If this happens, please **call 911** in such situations or visit the **emergency room** of a nearby hospital.

Questions: If you have any questions about the policies listed, please do not hesitate to ask for clarification. We look forward to being of help!

For Individuals Therapy, Evaluation, or Consultation

Your signature below indicates that you have read and agreed to comply with the office policies as described above. Additionally, your signature indicates that you are giving informed consent for evaluation and treatment.

_____ _____

Signature Date

Conjoint (Couples, Family, or Marital Therapy)

If two individuals are being seen for conjoint or marital therapy each should sign below confirming that they understand and agree to comply with office policies pertaining to therapy of couples and/or families as well as other office policies. Your signature below also indicates that you are giving consent for evaluation and treatment.

_____ _____

Signature Date

_____ _____

Signature Date

Therapy or Counseling for Minors

If a child is being seen for therapy each parent with legal rights and responsibilities pertaining to the child must sign below. Your signature represents your informed acknowledgement of Dr. Wise's Office Practices and Policies and informed consent for the provision of therapy and/or counseling services to your minor child.

_____ _____

Signature Date

_____ _____

Signature Date