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Keith T. Foster, Ph.D., PA

PATIENT CONSENT FORM

TREATMENT INFORMATION

Thank you for the opportunity to work together. I hope that you will find your work with me to be worthwhile. I'm giving you this information about my practice, as it will tell you how we will work together. Please read this information feel free to ask me any questions as they arise. There will be a place for both of our signatures to verify your understanding of this information. Psychotherapy is a life expanding undertaking and, like any change process, it is challenging, exciting and sometimes unsettling. Sometimes you might feel challenged to stay in therapy when progress doesn't go as fast as you might like it to, or when the material being worked on causes some discomfort. Learning to tolerate the inevitable anxiety that change brings is very much a part of the process. While therapy cannot eliminate life's problems, it does help you face them in a more productive way.

My approach to psychotherapy varies depending on what your needs are as well as the nature of the problems. Primarily, I utilize a psychodynamic approach to treatment, along with cognitive-behavioral interventions. My style is interactive, as I view the therapeutic relationship as a partnership between us.

INSURANCE AND PAYMENT

Your health insurance will pay for a portion of the fees for my services. The amount paid will vary with the particular plan you have and the limitations of its coverage, necessary deductibles or copays, and the type of therapy (individual, couples, group) that you participate in. I am a participating provider in only a few insurance plans, which may expand your available benefits. Many policies require pre-authorization for mental health services. I will make good effort to determine your coverage and meet any requirements for certifying your treatment with the insurance company, but

please understand that you are ultimately responsible for knowing the requirements of your insurance company and for the payment for my services (except where my contract with the insurance company limits your liability). I am happy to discuss billing and payment information with you and/or your representative at any time during our work together. Please feel free to ask questions about any billing issues that concern you.

My fees are $175 for the initial consultation (generally 50-60 minutes) and $150 for continuing therapy appointments (generally 45-50 minutes). Other fees for other services may apply and I will discuss these with you in advance. I reserve the right to change my fees at any time, but I will not change any fee without discussing it with you. My agreements with certain insurance companies, such as being a participating provider, may affect the actual fee you are responsible for. As an example, as a participating provider with Medicare, I am only allowed to charge the fee set by Medicare and your responsibility is only the difference between what Medicare pays and the total fee they allow.

CONFIDENTIALITY

My professional code of ethics and Federal Law requires me to keep everything we discuss in the strictest of confidence, meaning that I do not discuss anything you share with me outside of the office, except where provided for by law. I will maintain a medical file with notes I often take during the therapy session. The material in this file is confidential and will not be released to anyone without your written permission, except where provided for by law. When appropriate, and with your written permission, I will exchange information with physicians, hospitals or other professionals. If you use health insurance to pay for these services, please understand that you have given authorization in another document for me to send information about your treatment, including a diagnosis for which you are being treated, to that insurance company. If you request it I will provide you with a copy of any information, other than normal billing data where any clinical information is limited to a diagnosis, sent to your insurance company. There are certain exceptions to your right to confidentiality that are mandated by law. These exceptions include situations involving child or elder abuse, statements made by you that indicate you are a danger to yourself or others, legal situations where you may use your mental state as a defense, or threats made by you indicating an intention to harm another person. I will be happy to discuss issues of confidentiality and its limits at any time.

MY BACKGROUND

I have been in clinical practice since 1977. I received my Ph.D. in Clinical Psychology from Oklahoma State University in 1978 and interned at Springfield Hospital Center and the Sheppard-Pratt Hospital in Maryland. My graduate program and my internship were accredited by the American Psychological Association for training in Psychology. I served on the staff of the Springfield Hospital Center in Sykesville, MD and on the staff at the Brook Lane Psychiatric Center in Hagerstown, MD between 1977 and 1983. From 1981 to 2001, I was in private practice in Frederick, Maryland with Psychotherapy Services, LLC. In addition to my practice in Frederick, I served on the staff of the Johns Hopkins University Medical School's Department of Psychiatry for 5 years as a member of a research group examining possible genetic markers for serious psychiatric disorders. I relocated to Naples, Florida in June 2001 where I was in solo practice, Keith T Foster PhD PA. I am a Licensed Psychologist in Florida and Maryland. In Florida I have served as an adjunct faculty member at Florida Gulf Coast University and served on the staff of Naples Community Hospital. I have received extensive post-graduate training in individual, relationship and geriatric psychotherapy as well as in psychological testing. In late 2011 I began the process of transitioning from my practice in Florida to a practice in Maryland. As of June 1, 2012 I closed my Florida office and I am full time in Maryland.

Your signature below (1) attests to your having read and understood this form; (2) acknowledges your agreement to the terms and conditions established in this document for our work together; and (3) confirms your consent to be treated by me.

_____	_____
Signature of patient or representative	Keith T. Foster, Ph.D. Keith T. Foster, Ph.D,PA
_____	_____
Date	Date