

## **Ana V. Cofresi, Ph.D., HSPP**

### **Introduction to Psychological Services**

Welcome to my practice. I look forward to working with you, and hope this handout will provide useful information. Please feel free to ask questions any time.

**PROFESSIONAL BACKGROUND:** I was awarded a Bachelor of Science degree in Psychology from the University of Texas at El Paso in 1983 and an M.A. and Ph.D. in Clinical Psychology from Arizona State University. I completed my pre-doctoral clinical internship in Clinical Child and Pediatric Psychiatry at the Children's Memorial Hospital in Chicago. I have been working in Indianapolis since 1992.

**APPOINTMENTS:** Individual psychotherapy sessions are scheduled for a 45-minute clinical hour. Because the appointment time is reserved for you, it is necessary to charge for appointments which are not cancelled at least 24 hours in advance, unless we agree that an emergency has occurred.

**CLIENT'S RIGHTS:** You may at any time question and/or refuse therapies or diagnostic procedures, or obtain any information you want about the process and course of psychotherapy, and you can of course seek a second opinion from another clinician. You are assured confidentiality, which is protected by professional and ethical standards by Indiana State law. There are, however, several legally mandated exceptions to confidentiality. I am required to report to relevant others if, (1) I believe that you intend to seriously harm yourself or others, (2) I suspect child abuse, neglect or molestation, (3) I suspect abuse of the elderly, or (4) my records have been subpoenaed by a court order. In addition, your insurance company may require clinical information from me.

**TELEPHONE & EMAIL COMMUNICATION:** If you choose to communicate via email, please note that this is not protected information and I cannot guarantee your confidentiality. As such, I request that any email correspondence be limited to setting up appointments, transmittal of statement receipts and only very brief and general feedback. I also do not communicate via text, other than to communicate information regarding appointments.

**TERMINATION:** Termination of psychotherapy may occur at any time and may be initiated by either the client or the therapist. If a referral is indicated, it can be made at any time.

**FEES:** The fees for my services are based on the usual and customary fees for this area. My charges are \$180.00 per 45-minute clinical hour, which includes record keeping, session preparation, and routine telephone calls for the purpose of scheduling or clarifying billing

information. Payment is expected at the time of service, and I request that your check be made out in advance so that our entire time can be spent attending to your concerns. I am able to accept cash or checks for payments and certain credit cards, as well as Zelle and Venmo. Please note that, if you choose to use a credit card, you will be charged the additional credit card fees (.0375%). You will also need to provide all of the relevant card information to keep (confidentially) on file. Any balance not paid will be reported to a collection agency and could result in collection agency fees being added to your account balance.

Please note that telephone consultation over 10 minutes will be billed accordingly. If you have numerous issues/concerns to discuss, it is best for you to set up an office appointment with me.

Also, any written reports, summaries or letters and consultations with other professionals will be billed at \$210.00/hour).

**INSURANCE:** I am presently not contracted with any insurance providers. However, if you have health insurance, your insurance company may reimburse part of the cost of your visit. I am able to provide you with the needed, relevant information for you to file your own claim. You are responsible for knowing the terms of your policy and for keeping track of the extent of your coverage. Often insurance companies require diagnostic and treatment information before reimbursing you. I will release that information if requested. I will be happy to discuss the “diagnosis” I give your insurance company. While this information is sensitive and is usually treated as such by insurance carriers, I cannot guarantee how any particular insurance carrier will protect this information. If you prefer that I not release this information to your insurance carrier for reimbursement purposes, you will be responsible for the fees.

**FEE SCHEDULE**  
**(Effective 05/15/21)**

<b>Initial Consultation (up to 75 minutes, including Initial forms)</b>	<b>\$220.00</b>
<b>Individual Psychotherapy (45-minute clinical hr.) (if needed, 60-min sessions can be arranged for \$195.00)</b>	<b>\$180.00</b>
<b>Family/parent therapy or parent feedback (with or without child/children) Any amount of time, above 5 min. to up to 60 min.)</b>	<b>\$195.00</b>

Written reports, letters, email with notable clinical information/recommendations, and outside consultations (with lawyers, Parenting Coordinators, Guardian Ad Litem, educators, physicians, therapists, etc.) **\$210.00/hour**

Please note that if subpoenaed for Court appearance/testimony this will require a \$1500.00 retainer to be paid 3 days prior to Court date. Additional charges for extra hours/services will be billed at \$250.00/hour.

I have read the information presented in this introduction/disclosure statement. My signature indicates that I understand the above and agree with the conditions of therapy stated or implied here.

I understand that this agreement does not guarantee that we will achieve my goals; however, I agree that I will pay for all services provided based on the services and fees noted above for access to Dr. Cofresi's resources as a psychologist and her willingness to apply those psychological resources in good faith.

I further stipulate that this agreement will become part of my psychological/clinical record, which is accessible to Dr. Cofresi and her administrative staff (if applicable), but to no other person without my written consent.

Again, I welcome our work together.

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Name Printed	Name Signed	Date

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Name Printed	Name Signed	Date