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THERAPIST – PATIENT AGREEMENT

Welcome to my practice! This document contains important information about my professional services and business policies. It also contains summary information about Health Insurance Portability and Accountability Act (HIPAA), a new federal law that provides privacy protections and new patient right with regard to the use and disclosure of your Protected Health Information (PHI) used for the purpose of treatment, payment and health care operations.

HIPAA requires that I provided you with a Notice of Privacy Practices (the Notice) for use and disclosure of PHI for treatment, payment and health care operations.

The Notice, which is attached to this Agreement, explains HIPAA and its application to your personal health information in greater detail. The law requires that I obtain your signature acknowledging that I have provided you with this information at the end of the session.

When you sign this document, it will also represent an agreement between us. You may revoke this Agreement in writing at any time. That revocation will be binding on me unless I have taken action in reliance on it; if there are obligations imposed on me by your health insurer in order to process or substantiate claims made under your policy; or if you have not satisfied any financial obligations you have incurred.

PSYCHOLOGICAL SERVICES

Most people who participate in psychotherapy find it helpful and will benefit from the experience. However, psychotherapy can have both benefits and risks. Since therapy often involves discussing unpleasant aspects of your life, you may experience uncomfortable feelings like sadness, guilt, anger, frustration, loneliness, and helplessness. On the other hand, therapy often leads to better relationships, solutions to specific problems and significant reduction is feelings of distress. It also may result in significant decisions or life chances that you do not expect at the beginning of treatment. We should discuss individual questions or concerns about the treatment process as they arise. If your concerns persist, I will be happy to help you set up another mental health professional for a second opinion.

MEETINGS

If psychotherapy is begun following your evaluation, I will usually schedule one 45 to 52-minute session (one appointment hour of 45 to 52-minutes duration) per week or two at a time we agree on although some sessions may be more or less frequent. Once an appointment is scheduled, you will be expected to pay the full session fee unless you provide 24 hour advance notice of cancellation (unless we both agree that you were unable to attend due to circumstances beyond your control). It is important to note that Insurance companies do not provide reimbursement for canceled sessions. (If it is possible, I will try to find another time to reschedule the appointment).

PROFESSIONAL FEES, BILLING, AND PAYMENTS AND INSURANCE REIMBURSEMENT

The hourly fee is generally $115.00 and up (the fee for the initial session is $135.00 and up). In addition to office appointments, I charge this amount for other professional services you may need, though I will break down the hourly cost if I work for periods of less than one hour. Other services may include report writing, telephone conversations, consulting with other professionals with your permission, preparation of records or treatment summaries, and the times spent performing may other service you may request of me.

If you become involved in legal proceedings that require my participation, you will be expected to pay for all of my professional time including preparation and transportation costs, even if I am called to testify by another party. (Because of the difficulty of legal involvement, I charge $175.00 per hour for preparation and attendance at any legal proceeding).

In order for us to set realistic treatment goals and priorities, it is important to evaluate what resources you have available to pay for your treatment. If you have a health insurance policy, it will usually provide some coverage for mental health treatment. I will fill out forms and provide you with whatever assistance I can in helping you receive the benefits to which you are entitled; however, you (not your insurance company) are responsible for full payment of my fees. It is very important that you find out exactly what mental health services your insurance policy covers.

You should be aware that your contract with your health insurance company requires that I provide it with information relevant to the services that I provide to you. I am required to provide a clinical diagnosis. Sometimes I am required to provide additional clinical information such as treatment plans or summaries, or copies of your entire clinical record. In such situations, I will make every effort to release only the minimum information about you that is necessary for the purpose requested. This information will become part of the insurance company files and will probably be stored in a computer. Though all insurance companies claim to keep such information confidential, I have no control over what they do with it once it is in their hands. In some cases, they may share the information with a national medical information data bank. By signing this Agreement, you agree that I can provide requested information to your carrier.

Once we have all of the information about your insurance coverage, we will discuss what we can expect to accomplish with the benefits that are available and what will happen if they run out before you feel ready to end your sessions. It is important to remember that you always have the right to pay for my services yourself to avoid the problems described above.

Your signature below indicates that you have read the information in this document and agree to abide by its terms during our professional relationship.

Full payment at the time of each session is expected, unless I am a provider for you insurance plan, then coinsurance or copays will be due at the time of service. If you do not have insurance coverage or have an insurance I am not a provider for, the office will be happy to provide you with a billing statement at the intervals you desire so that you may obtain reimbursement from your carrier. A finance charge of 1% per month (12% annual percentage rate) will be applied to all unpaid balances after 30 days. There will be a $20 service charge for returned checks.

It is your responsibility to obtain information from your insurance carrier regarding deductible amount, percentage of fees covered by your plan, dollar limits and visit limits, and prior authorizations. You may review this information with Lisa, my billing manager.

CONTACTING ME

Due to my work schedule, I am often not immediately available by telephone. While I am usually in my office between 8AM and 5PM, I do not answer the phone when I am with a patient. When I am unavailable, my telephone is answered by my secretary, or answering service. I will make every effort to return your call on the same day you make it, with the exception of weekends and holidays. If you are difficult to reach, please inform me of some times when you will be available. After hours requested for an immediate call back should be reserved for emergencies only.

If you are unable to reach me and feel that you can't wait for me to return your all, contact your family physician or the nearest emergency room and ask for the psychologist or psychiatrist on call. If I will be unavailable for an extended time, I will provide you with the name of a colleague to contact, if necessary.

LIMITS ON CONFIDENTIALITY

The law protects the privacy of all communications between a patient and psychologist. In most situations, I can only release information about your treatment to others if you sign a written authorization form that meets certain legal requirements imposed by HIPAA. There are other situations that require only that you provide written, advance consent. Your signature on this Agreement provides consent for those activities, as follows:

- I may occasionally find it helpful to consult other health and mental health professionals about a patient. During a consultation, I make every effort to avoid revealing the identity of my patient. The other professionals are also legally bound to keep the information confidential. If you do not object, I will not tell you about these consultations unless I feel that it is important to our work together. I will note all consultations in your Clinical Record (which is called "PHI" in my Notice of Psychologist's Policy and Practices to Protect the Privacy of Your Health Information).
- You should be aware that I practice with other mental health professionals and that I employ administrative staff. In most cases, I need to share protected information with these individuals for both clinical and administrative purposes, such as scheduling, billing and quality assurance. All of the mental health professionals are bound by the same rules of confidentiality. All staff members have been given training about protecting your privacy and have agreed not to release any information outside of the practice without the permission of a professional staff member.
- Disclosures required by health insurers or to collect overdue fees are discussed elsewhere in this Agreement.
- If a patient threatens to harm himself/herself, I may be obligated to seek hospitalization for him/her, or to contact family members or others who can help provide protection.

- There are some situations where I am permitted or required to disclose information without either your consent or Authorization:
    - If you are involved in a court proceeding and a request is made for information concerning the professional services that I provided you, such information is protected by the therapist-patient privilege law. I cannot provide any information without your written authorization, or a court order. If you are involved or contemplating litigation, you should consult with your attorney to determine whether a ocurt would be likely to order me to disclose information.
    - If I am providing treatment for conditions directly related to a worker's compensation claim, I may have to submit such records, upon request, to the Chairman of Worker's Compensation Board on such forms and at such times as the Chairman may require. There are some situations in which I am legally obligated to take actions which I believe are necessary to attempt to protect others from harm and I may have to reveal some information about a patient's treatment. These situations are unusual in my practice.
    - If I receive information in my professional capacity from a child or the parents or guardian or other custodian of a child that gives me reasonable cause to suspect that a child is an abused or neglected child, the law requires that I report to the appropriate governmental agency, usually the statewide central register of child abuse and maltreatment, or the local child protective services office. Once such a report is filled, I may be required to provide additional information.
    - If a patient communicates an immediate threat of serious physical harm to an identifiable victim, I may be required to take protective actions. These actions may include notifying the potential victim, contacting the police, or seeking hospitalization for the patient. If such a situation arises, I will make every effort to fully discuss it with you before taking any action and I will limit my disclosure to what is necessary.

While this written summary of expectations to confidentiality should prove helpful in informing you about potential problems, it is important that we discuss any questions or concerns that you may have now or in the future. The laws governing confidentiality can be quite complex, and I am not an attorney. In situations where specific advice is required, formal legal advice may be needed.

PROFESSIONAL RECORDS
The laws and standards of my profession require that I keep Protected Health Information about you in your Clinical Record.

YOUR SIGNATURE BELOW INDICATES THAT YOU HAVE READ THIS AGREEMENT AND AGREE TO ITS TERMS AND ALSO SERVES AS AN ACKNOWLEDGEMENT THAT YOU HAVE RECEIVED THE HIPAA NOTICE FORM DESCRIBED ABOVE.

_____

Patient name (Please print)

_____

Patient signature (parent or guardian signature if patient is a minor) **Date**

_____

Witness signature **Date**