ANXIETY TREATMENT CENTER OF MARYLAND

Evidence-Based Treatment to Reduce Anxiety and Improve Quality of Life

Kelly Drake, PhD, LLC Courtney Keeton, PhD, LLC

Service Agreement and Informed Consent

Welcome to the Anxiety Treatment Center of Maryland! This document will provide you with information about our practice, office policies, and procedures. Signing this document represents an agreement between us. You may revoke this Agreement in writing at any time.

Credentials
All Center psychologists and psychiatrist hold doctoral/medical degrees and are licensed to practice in the state of Maryland.

Services
Psychotherapy refers to a set of intervention strategies that are designed to help individuals resolve emotional, behavioral, and interpersonal difficulties and improve their quality of life. Current research supports the use of cognitive-behavioral therapy (CBT) and its variants (e.g., exposure and response prevention, habit reversal training) for children, adolescents, and adults with anxiety-related disorders. CBT consists of a set of coping skills that are used to manage anxiety and, therefore, requires a very active effort on your part. In order to maximize the benefit of therapy, it is important that you practice these skills daily. Although we are primarily CBT-focused, we may use a variety of therapeutic approaches to individualize your treatment experience and maximize your benefits.

Psychotherapy can have both benefits and risks. Since psychotherapy often involves discussing things that are distressing, you (or your child) may experience transient uncomfortable feelings like sadness, guilt, anger, frustration, loneliness, and helplessness. On the other hand, psychotherapy has been shown to have many benefits. Therapy may lead to solutions to specific problems, better relationships, improved overall quality of life, and significant reductions in feelings of distress.

One aspect of CBT that is considered the key treatment ingredient is exposure to the feared objects or situations. Research has shown that this component is necessary for overcoming anxiety, phobias, and compulsions. During treatment, it may be recommended that you or your child practice "in-vivo" (live) exposures to feared object(s) or situation(s). We will work as a team and decide together what exposures are necessary and when to initiate them. There are significant benefits to exposure therapy and few risks. Exposures that are frequent and prolonged are the most effective. A possible risk of exposure, which occurs infrequently, is that a fear can sometimes be reinforced (strengthened) by exposure, but often this occurs when the exposure is brief and infrequent (or terminated at the peak level of anxiety, rather than after the level of anxiety has decreased). However, if you stick with it and repeat the exposures over and over, while using coping skills, the fear/anxiety will be reduced. Another risk is that patients may feel an initial wave of anxiety when exposed to an anxiety-provoking situation. The anxiety is often uncomfortable and unpleasant but generally decreases and subsides as the patient stays in the situation. This process is called *habituation*, which means that an individual will become used to a situation the longer they stay in it, and then the situation is no longer anxiety-provoking.

To reduce these risks, we strive to create a safe, warm, comfortable environment in which you (or your child) can speak openly and we can work toward solutions to specific problems and reduce feelings of distress. There are no guarantees of what you (or your child) will experience, and much of the progress depends on your active participation both in and out of the therapy sessions. If you have any questions, please feel free to ask. Once we complete the initial evaluation session, we will have a better idea of the therapeutic goals we will work toward.

Please be aware that we do not provide assessment services for custody evaluations, forensic issues, or other court proceedings. If you require such a service, please notify your provider and you will be provided with appropriate referrals.

Session Fees and Payment

Therapy sessions are $185 for 50-minute sessions (though the coding is for 45 minutes). The initial intake is longer (90 minutes) and the fee is $250. Sessions that are longer or shorter than the typical 50-minutes will be pro-rated based on a proportion of the regular session fee.

Payment is due at the time of service and can be made by cash, check, or credit card.

We are not members of any managed care plans and are therefore considered out-of-network providers for all insurance companies. We DO NOT participate in Medicare and cannot except any checks written directly from Medicare or any insurance company. If you want to seek reimbursement on your own, we will provide you with a detailed receipt when fees are paid in full. You may choose to submit this receipt to your insurance company, which may then reimburse you according to your plan. There is a great deal of variability in coverage and reimbursement policies for psychological services, and no amount of reimbursement can be guaranteed. You should be aware that your contract with your health insurance company requires that we provide it with information relevant to the services provided to you (e.g., diagnosis) if you submit claims. You are responsible for knowing and following the requirements of your insurance plan. We are available to assist you with this process if necessary. Please be aware that you are responsible for the full amount of our fees independent of any reimbursement from your insurance company.

Please be aware that returned checks will be subject to a $25 processing fee. If you have an outstanding balance that has not been paid in a timely manner and payment arrangements have not been agreed upon, your provider has the option to use legal means to secure the payment. This could involve hiring a collections agency or going through small claims court. Should such action become necessary, its costs will be included in the claim. In most collection situations, the only information released would be a patient's name, the nature of services provided, and the amount due.

Additional Fees

In addition to fees for weekly appointments, your provider may charge a pre-determined amount for other professional services you may need and/or request, though the cost will be pro-rated based on a proportion of the standard fee of $185 for a 45-50 minute session. Other services for which you may be billed include report writing, conversing with you by telephone if the conversation lasts longer than 5 minutes, consulting with other professionals with your permission, preparation of treatment summaries or similar records, and time spent performing other services you request. Please keep in mind that insurance does not reimburse for telephone calls or telephone sessions/consultations.

Since our focus is on providing therapy to you or your child, for separating or divorcing families, we believe that it is not in the child's best interest for us to be a part of any court hearings or testify in any way. However, if made to by the court (by subpoena) or should you become involved in litigation that may require your provider's participation, you will be expected to pay for any professional time that is required (e.g., calls, letters, any correspondence with attorneys), unless the other party has agreed or is compelled to pay. Your provider will charge a $1,500 retainer for preparation and testimony for court or a deposition, and all work on your provider's part that is related to the litigation will be billed at a rate of $300/hr, and billed in 15-minute increments. If you anticipate that you may be involved in litigation, please discuss this with your provider as soon as possible.

Cancellation Policies
Your appointment time is reserved specifically for you. In the event that you must cancel or reschedule an appointment for any reason, please give a *minimum* of 24 hours notice by calling or emailing your provider. If a minimum of 24 hours notice is not given, you will be charged the full session fee. Documented emergencies (e.g., going to the Emergency Room) or weather emergencies are the only exceptions to this policy. However, frequent or repeated cancellations for illness will be billed at your provider's discretion. Additionally, you will be charged the full session fee for any late arrivals. Please be aware that insurance companies do not reimburse for these charges. We understand that emergency situations do occasionally arise, in which case an exception to this policy may be made at the discretion of your provider.

Confidentiality
In general, the privacy of all communications between a psychologist and patient is protected by law, and your provider can only release information about your or your child with your written permission. However, there are a few exceptions to this rule. In the event that confidential information about your child is released, your provider will make all reasonable attempts to discuss this with you prior to disclosure. In the following situations, no authorization is required:

- You have signed an Authorization Form for Release of Clinical Record for specific individuals or agencies
- There is a court order for release of records
- Danger to self or others
- Suspected abuse or neglect of children or vulnerable adults
- You report that you were physically or sexually abused when you were under the age of 18
- You threaten your provider
- Parents may have the right to receive information about their child's treatment or evaluation if that child is under the age of 18
- If a patient files a complaint or lawsuit against a provider, state law permits the provider to disclose relevant information regarding that patient in order to defend her/himself

Minors
It is important for patients under the age of 18 who are not emancipated, and their parents, to be aware that the law may allow parents to examine their child's treatment records. However, because privacy in psychotherapy is very important, particularly with teenagers, we ask parents to agree that your provider may use her/his professional judgment to determine what is and what is not shared with parents of minor patients (with the exception of situations in which your provider is legally required to breach confidentiality). At the same time, because parental involvement in therapy is essential to successful treatment, your provider is always willing to share with parents general information about the progress of treatment.

Use of Reported Information
Some of your reported information may be used for administrative or research purposes or both; any use of such information will be in aggregate (group) form, and you will not be personally identifiable either directly or indirectly. Your provider will be happy to answer any questions that you might have regarding these issues.

Regulatory Agency
The Maryland Board of Examiners of Psychologists is the regulatory agency that licenses individuals for the practice of psychology in Maryland. The Board also investigates and acts upon complaints against licensed psychologists. Any questions, concerns, or complaints regarding your provider's services may be directed to:

Maryland State Board of Examiners of Psychologists
4201 Patterson Avenue
Baltimore, MD 21215

Contacting us: Phone and Email
Telephone and email are the best way to contact us, but please be aware that we do not respond to calls or emails while we are in session. We will monitor our voicemail and email frequently and will make every effort to return your call/email within 24 hours with the exception of weekends and holidays.

If you are unable to reach us and feel that you cannot wait for us to return your call, you are advised to contact your family physician or the nearest emergency room and ask for the psychologist or psychiatrist on call. You will be notified if your provider is unavailable for an extended time.

We can use email to communicate with patients on a limited basis; however, your decision to use email indicates that you understand that it is not considered a secure form of communication. Please note that email should *not* be used to discuss clinical information, but can be used for scheduling appointments.

Emergencies
In case of an emergency, do not wait to take action until you hear back from your provider. We recommend using one of the following options:

- For life-threatening situations, dial 911 or go to the nearest emergency room
- If you are suicidal and in need of immediate help, dial 911 or 1-800-SUICIDE (1-800-784-2433)
- Domestic Violence Center: 410-997-2272
- Family Tree 24-hour Stressline: 1-800-243-7337
- Maryland Youth Crisis Hotline: 1-800-422-0009
- National Toll Free Hotline: 1-800-273-8255
- Howard County Mobile Crisis Team: 410-531–6677
- Baltimore County Crisis Team: 24/7 Hotline: 410-931-2214
- Baltimore Crisis Response (Baltimore City): 410-433-5255

Professional Records
The laws and standards of our profession require that your provider keep Protected Health Information (PHI) about you in your clinical record. You may examine or receive a copy of your clinical record if you request it in writing. In unusual circumstances in which disclosure is reasonably likely to endanger the life or physical safety of you or another person, your provider may refuse your request. In those situations, you have a right to a summary and to have your record sent to another mental health provider. Because these are professional records, they can be misinterpreted and/or upsetting to untrained readers. For this reason, we recommend you initially review them in the presence of your provider, or have them forwarded to another mental health professional so you can discuss the contents.

Patient Rights
HIPAA provides you with several new or expanded rights with regard to your clinical record and disclosures of PHI. These rights include: requesting that your provider amend your record; requesting restrictions on what information from your clinical record is disclosed to others; requesting an accounting of most disclosures of PHI that you have neither consented to nor authorized; determining the location to which PHI disclosures are sent; having any complaints you make about our policies and procedures recorded in your records; and the right to a paper copy of this agreement, the notice form, and our privacy policies and procedures. Your provider will be happy to discuss these rights with you.

Consent
I have read the terms and conditions outlined in this document. I understand them, and agree to be bound by them. Sign the "acknowledgement and agreement" page.

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MARYLAND NOTICE FORM

NOTICE OF PSYCHOLOGIST'S POLICIES & PRACTICES TO PROTECT THE PRIVACY OF YOUR HEALTH INFORMATION

THIS NOTICE DESCRIBES HOW PSYCHOLOGICAL AND MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Please note that in this Notice, "you" refers to the individual who is the subject of the health information. For minors, the child's personal representative has the right to exercise the rights explained here. The minor's personal representative is someone who is authorized to act on behalf of that child, such as a parent or guardian.

I. Uses and Disclosures for Treatment, Payment, & Health Care Operations

I may *use* or *disclose* your *protected health information (PHI*), for *treatment, payment*, and *health care operations* purposes with your consent. Here are definitions of these terms:

- **PHI -** refers to information in your health record that could identify you. It includes information about your symptoms, test results, diagnosis, treatment, and related medical information.
- **Treatment, Payment, and Health Care Operations –**
  - *Treatment* is when I provide, coordinate or manage your health care and other services related to your care. An example would be when I consult with another health care provider, such as your family physician or another psychologist.
  - *Payment* is when I obtain reimbursement for your healthcare. Examples of payment are when I disclose your PHI to your health insurer to obtain reimbursement for my services to you or to determine eligibility or coverage.
  - *Health Care Operations* are activities that relate to the performance and operation of my practice. Examples of health care operations are quality assessment and improvement activities, business-related matters (such as audits and administrative services), case management, and care coordination.
- **Use -** applies only to activities within my practice, such as sharing, applying, utilizing, examining, and analyzing information that identifies you.
- **Disclosure -** applies to activities outside of my practice, such as releasing, transferring, or providing access to information about you to other parties.

II. Uses and Disclosures Requiring Authorization

I may use or disclose PHI for purposes outside of treatment, payment, and health care operations when your appropriate authorization is obtained. An "authorization" is written permission, above and beyond the general consent that permits only specified disclosures. In these instances when I am asked for information for purposes outside of treatment, payment and health care operations, I will obtain a written authorization from you before releasing this information. I will also need to obtain an authorization before releasing psychotherapy notes. "Psychotherapy notes" are notes I have made about our conversation during an individual, group, joint, or family counseling session, which have been kept separate from the rest of your record. These notes are given more protection than PHI.

You may revoke all such authorizations (for PHI or psychotherapy notes) at any time, provided each revocation is in writing. You may not revoke an authorization to the extent that (1) I have relied on that authorization or (2) if the authorization was obtained as a condition of obtaining insurance coverage, and the law provides the insurer the right to contest the claim under the policy.

III. Uses and Disclosures with Neither Consent nor Authorization

I may use or disclose PHI without your consent or authorization in the following circumstances:

- **Child Abuse –** If I have reasonable cause to believe that a child has been subjected to abuse, I must report this immediately to the appropriate authorities.
- **Adult and Domestic Abuse –** If I reasonably believe that a vulnerable adult is the subject of abuse, neglect, or exploitation, I may report the information to the appropriate authority.
- **Health Oversight Activities-** If I receive a subpoena from the Maryland Board of Examiners of Psychologists because they are investigating my practice, I must disclose any PHI requested by the Board.
- **Judicial or Administrative Proceeding –** If you are involved in a court proceeding and a request is made for information about your evaluation, diagnosis, and treatment and the records thereof, such information is privileged under state law, and I must not release this information without written authorization from you or your persona or legally-appointed representative, or a court order. The privilege does not apply when you are being evaluated for a third party or where the evaluation is court ordered. You would be informed in advance if this were the case.
- **Serious Threat to Health or Safety –** If you communicate to me a threat of imminent serious harm against a readily identifiable victim or if I believe that there is clear, imminent risk of physical or mental injury being inflicted against another individual, I must make disclosures that I believe are necessary to protect that individual from harm. If I believe that you present an imminent, serious risk of physical or mental injury or death to yourself, I may also make disclosures that I believe are necessary to protect you from harm.

There may be additional disclosures of PHI that I am required or permitted by law to make without your consent or authorization; however, the disclosures listed above are the most common.

IV. Patient Rights and Psychologist's Duties

Patient's Rights -

- **Right to Request Restrictions –** You have the right to request restrictions on certain uses and disclosures of protected health information. I am not required to agree to a restriction at your request but will make the effort to accommodate reasonable requests.
- **Right to Receive Confidential Communications by Alternative Means and at Alternative Locations –** You have the right to request and receive confidential communication of PHI by alternative means and at alternative locations. For example, you may not want a family member to know that you are seeing me. Upon your request, I will send your documents to another address.

- **Right to Inspect and Copy –** You have the right to inspect or obtain a copy (or both) of PHI in my mental health and billing records used to make decisions about you for as long as the PHI is maintained in the record. I may deny your access to PHI under certain circumstances, but in some cases, you may have this decision reviewed. On your request, I will discuss with you the details of the request and denial process for both PHI and Psychotherapy Notes.
- **Right to Amend –** You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. On your request I will discuss with you the details of the amendment process. I may accept or deny your request.
- **Right to an Accounting –** You generally have the right to receive an accounting of disclosures of PHI, including PHI for which you have not provided either consent or authorization (as described in Section III of this Notice). On your request, I will discuss with you the details of the accounting process.
- **Right to a Paper Copy –** You have the right to obtain a paper copy of the notice from me upon request, even if you have agreed to receive the notice electronically.

Psychologist's Duties -

- I am required by law to maintain the privacy of PHI and to provide you with a notice of my legal duties and privacy practices with respect to PHI.
- I reserve the right to change the privacy policies and practices described in this notice. Unless I notify you of such changes, however, I am required to abide by the terms currently in effect.
- If I revise my policies and procedures, I will provide you with a revised Notice by posting a copy in the waiting room, providing a copy during session, or mailing a copy to you.

V. Questions and Complaints

- If you have questions about this notice, disagree with a decision I make about access to your records, or have other concerns about your privacy rights, you may contact the Anxiety Treatment Center of Maryland, at 5022 Dorsey Hall Drive, Suite 201, Ellicott City MD 21042 or 410-800-7591. If you are concerned that your privacy rights have been violated, please contact me as soon as possible.
- You may also send a written complaint to the Maryland Board of Examiners of Psychologists and/or the Secretary of the U.S. Department of Health and Human Services. I can provide you with the appropriate addresses upon request.
- More information about filing a complaint is available at the website of the Office of Civil Rights, http://www.hhs.gov/ocr/privacy/hipaa/complaints/index.html.
- You have specific rights under the Privacy Rule. I will not retaliate against you for exercising your right to file a complaint.

VI. Effective Date, Restrictions, and Changes to Privacy Policy

- This notice went into effect on January 1, 2014.
- The Co-Directors (Drs. Keeton and Drake) reserve the right to change the terms of this notice and to make the new notice provisions effective for all PHI that we maintain. If this is the case, we will provide you with a revised notice by regular mail at your last known address we have noted in our files.

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ACKNOWLEDGEMENT & AGREEMENT:

Patient Services Agreement & Notice of Privacy Policies and Practices

Your signature below indicates that you have read the Patient Services Agreement notice (informed consent) and that you agree to its terms. Your signature below also serves as an acknowledgement that you have received the Maryland HIPAA notice (Notice of Privacy Policies and Practices).

_____ _____

Signature of Patient/Parent of Patient Date

_____ _____

Print Patient Name Patient's Date of Birth

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AUTHORIZATION FORM FOR RELEASE OF CLINICAL RECORD

This form when completed and signed, authorizes the release of protected information from your (or your child's) clinical record to the person or institution you designate.

Patient Name: _____ DOB: _____

Address:_____

Phone:_____

I, _____, authorize Drs. Kelly Drake, Courtney
(name of parent/patient)
Keeton, and/or Mark Riddle to:

☐ Release from my record ☐ Receive from my record

Description of disclosure: ___*information about previous psychological/psychiatric/psycho-educational evaluations and treatment history to facilitate ongoing treatment*_____

I understand that Drs. Drake/Keeton/Riddle cannot re-disclose information received from another health care provider if that health care provider requested that the information not be re-disclosed.

This information shall remain in effect for a period of one year from the date below or until_____.

The information is to be released to/released from:

Name: _____ Position:_____
Address: _____
Phone & Fax: _____

I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to Drs. Drake, Keeton, and/or Riddle. However, revocation cannot be retroactive, and the revocation will not be effective if this authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim. I understand that my provider generally may not condition psychological services upon the signing of an authorization unless the psychological services are provided to me for the purpose of creating health information for a third party. I understand that information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient of the information and no longer protected by the HIPPA Privacy Rule.

Patient or Legally Authorized Individual Signature: _____DATE:_____

Relationship to the patient if signed on behalf of the patient: _____

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Fee Agreement

Service:	CPT Code:	Fee:
Initial Evaluation (90-120 minutes)	90791	$250
Individual therapy*		
Standard session (45-50 minutes)	90834	$185
Brief session (20-30 minutes)	98032	$110
Extended session (60 minutes)	90837	$200
Extended session (90 minutes)	90837	$270
Prolonged session (120 minutes)	90837	$360
Family therapy without the patient (45-50 minutes)	90846	$185
Family therapy with the patient (45-50 minutes)	90847	$185
Child Anxiety Prevention (8 weekly sessions, 3 monthly booster sessions)		$1650
Clinical supervision		$185/hr
Training in CBT for Anxiety	Contact us for group and individual rates	

* includes sessions with the patient &/or family member

By signing this document, I agree to the terms above and will be responsible for full payment of the details described.

_____ _____

Signature of Patient/Parent of Patient Date

_____ _____

Print Patient Name Patient's Date of Birth

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Credit/Debit Card Authorization Form

In case there are times when patients may not pay at the time of services (e.g., forgotten checkbook, minors coming to session without parents, missed appointments, etc.), we ask that you provide a credit/debit card number to keep on file, to which any unpaid balance may be charged on a monthly basis. Credit/debit card transactions are processed through Wells Fargo bank which encrypts its data and complies with Payment Card Industry Data Security Standards. No information about the services provided, other than cost, is shared with the company.

I, _____, authorize my provider at the Anxiety Treatment Center of Maryland to keep my signature on file and to charge my credit/debit card as outlined above. I understand that this form is valid for one year unless I cancel the authorization through written notice to my provider.

By signing this document, I agree to the terms above and will be responsible for full payment of the details described.

_____ _____

Patient Name Today's Date

_____ _____

Cardholder Name Cardholder Signature

_____

Billing Address City State Zip

Circle Card Type: Mastercard Visa Discover American Express

_____ _____ _____

Card Number Expiration Date V-Code

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Handling of Confidential Information

Home Telephone: _____

May I call you at home?	☐ Yes	☐ No
May I leave messages for you at home?	☐ Yes	☐ No

Self/Parent1: _____

Cell Phone: _____

May I call you on your cell?	☐ Yes	☐ No
May I leave messages on your cell?	☐ Yes	☐ No

Work Phone: _____

May I call you at work?	☐ Yes	☐ No
May I leave messages for you at work?	☐ Yes	☐ No

Parent 2: _____

Cell Phone: _____

May I call you on your cell?	☐ Yes	☐ No
May I leave messages on your cell?	☐ Yes	☐ No

Work Phone: _____

May I call you at work?	☐ Yes	☐ No
May I leave messages for you at work?	☐ Yes	☐ No

Written Communication:

Home Address: _____

May I send mail to your home address?	☐ Yes	☐ No*

*If no, please provide the address you would like me to use for mail: _____

Electronic Communication:

I cannot guarantee confidentiality with electronic communication. It is important that you understand that the nature of the Internet is that any emails you send or receive may also be intercepted by other people.

May I communicate with you via email?	☐ Yes	☐ No

If yes, please provide an email address(es): _____

Are there any restrictions for email?	☐ Yes*	☐ No

*If yes, please describe: _____

Other Requests: _____

All reasonable requests to receive communication of your health information by alternative means will be granted. Please describe any additional means of communication by which you prefer to receive your health information.

_____ _____

Signature of Patient/Parent of Patient Date