



# Psychotherapist and Patient Services Agreement

The SUMMIT Therapy Center  
4419 Cleveland Rd, Wooster, OH 44691  
Ph: (330)345-8450 Fax: (330)345-5899

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Welcome to The SUMMIT Therapy Center. This document (the Agreement) contains important information about our services and business policies. It also contains summary information about the **Health Insurance Portability and Accountability Act (HIPAA)**. HIPAA requires that we offer you a Notice of Privacy Practices (the Notice) for use and disclosure of personal health information for treatment, payment and health care operations. The Notice explains HIPAA and its application to your personal health information in greater detail. The law requires that we obtain your signature acknowledging that we have provided you with this information at the end of your first session. We can discuss any questions you may have about the information at that time. 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 unless we have taken action such as: if there are obligations imposed on us 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:

Psychotherapy varies depending on the personalities of the therapist and patient, and the particular problems you are experiencing. There are many different methods we may use to deal with the problems that you hope to address. Psychotherapy calls for an active effort on your part. In order for the therapy to be most successful, you may have to work on things we talk about both during your sessions and at home.

Since therapy often involves discussing unpleasant aspects of your life, you may experience uncomfortable feelings like sadness, guilt, anger, and helplessness. On the other hand, psychotherapy has many benefits. Therapy often leads to better relationships, solutions to specific problems, and significant reductions in feelings of distress. If you have any questions, please discuss them with your therapist as they arise.

## Meetings:

Your therapist typically conducts an evaluation that lasts 1 to 2 sessions. A one 50 minute session (one appointment hour of 50 minutes duration) per week is usually scheduled at an agreed upon time. Once an appointment hour is scheduled, you will be expected to pay for it unless you provide **12 hours 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 cancelled sessions. It is your responsibility to call and reschedule your missed appointment.

## Contacting Your Therapist:

Due to fluctuating work schedules, your therapist is open not immediately available by telephone. You do have the option of leaving a message for your therapist by voice mail, which is available 24 hours a day. The Office Manager is also available Monday thru Friday from 9 AM until 2 PM. Your therapist will make every effort to return your call on the same day you make it with the exception of weekends and holidays. The voice mail message provides a pager number for emergency use only. If you use the pager, the therapist who is on call will return your call. You may also contact your family physician, 911, the county crisis service (330)264-9029, or the nearest emergency room for immediate assistance.



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## **Limits On Confidentiality:**

The law protects file privacy of an communications between a patient and a psychotherapist. In most situations, we 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 you to provide written, advanced consent. Your signature on this Agreement provides consent for those activities, as follows:

- Your psychotherapist may occasionally find it helpful to consult other health and mental health professionals about a case. During a consultation, they will make every effort to avoid revealing the identity of the patient. The other professionals are also legally bound to keep the information confidential. Your therapist will note all consultations in your Clinical Record.
- The SUMMIT Therapy Center employs an Office Manager. In most cases, your therapist needs to share protected information with the Office Manager for administrative purposes, such as scheduling and billing.
- Information is shared with other SUMMIT Therapy Center psychotherapists as needed to provide “on-call” coverage when your therapist is away.

All mental health professionals are bound by the same rules of confidentiality. All of our staff members have received ethical training about protecting your privacy and have agreed not to release any information outside of The SUMMIT Therapy Center.

There are some situations where we are permitted or required to disclose information without either your consent or authorization:

- If a government agency is requesting the information for health oversight activities, your therapist may be required to provide it for them.
- If a patient files a complaint or lawsuit against a therapist, they may disclose relevant information regarding that patient in order to defend their self.
- The SUMMIT Therapy center therapists are mandated reporters. This means that the psychotherapist must report any abuse or neglect towards a child to Wayne County Children Services.
- Any threats of harm to others, or self-harm, must be reported to the appropriate service by your psychotherapist.

While this written summary of exceptions 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. In situations where specific advice is required, formal legal advice may be needed.



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## **Professional Records:**

Pursuant to HIPAA, your therapist will keep Protected Health Information about you in a professional record file that constitutes your Clinical Record. It includes information about your reasons for seeking therapy, a description of the ways in which your problem impacts your life, your diagnosis, use goals that we set for treatment, and your progress towards those goals. It also includes your medical and social history, your treatment history, past treatment history that we may receive from other providers, reports of any professional consultations, and any reports sent, including clinical reports to your insurance carrier.

Except in unusual circumstances that involve danger to yourself and others, you may examine and/or receive a copy of your Clinical Record if you request it in writing and the request is signed by you and dated not more than 60 days from the date it is submitted in writing. We recommend that you initially review your record in the presence of your therapist, or have them forward it to another mental health professional so you can discuss the contents with that professional. A copying fee of 50 cents per page will be assessed to you, plus postage if mailing is required.

## **Patient Rights:**

An Ohio Notice Form is posted in the lobby of SUMMIT Therapy Center for your review and a copy of the form can be made available to you upon request. Please refer to the Ohio Notice Form that describes policies and practices to protect the privacy of your health information.

## **Supervision:**

Supervision and consultations are provided by Leslie Feder, LISW-S and Douglas Princehorn, LISW-S. You may receive insurance statements with Leslie's or Doug's name on it. All information regarding your counseling services will be maintained within the strictest legal limits of confidentiality.

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

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Patient

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Date

\_\_\_\_\_

Therapist

\_\_\_\_\_

Date