# Meredith Hickory, Psy.D., PLLC

## PSYCHOLOGIST-CLIENT SERVICES AGREEMENT

Welcome, this document (the Agreement) contains important information about my professional services and business policies. It also contains summary information about the Health Insurance Portability and Accountability Act (HIPAA), a new federal law that provides new privacy protections and new patient rights 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 provide 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 accompanies 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 your initial intake session (or first session subsequent to the implementation date of April 14, 2003). Although these documents are long and sometimes complex, it is very important that you read them carefully before our next session. We can discuss any questions you have about them 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 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

Evaluations are a dynamic and collaborative process through which parents & clients may come to understand their child's strengths and areas of weakness. It is most successful when clients are able to develop an open, trusting relationship with the therapist, attend sessions regularly, and apply what they learn between sessions. If you have questions or concerns about your treatment, please discuss them with me as soon as they arise. If we are unable to resolve them to your satisfaction, I will be happy to assist you in getting a second opinion and/or transferring your care to another psychologist.

### APPOINTMENTS

You are strongly encouraged to keep appointments unless it is absolutely necessary to cancel or reschedule. In order to avoid being charged for the session, you should notify me at least 24 hours in advance that you will not be keeping the appointment. Fees are assessed for late cancellations (less than 24 hours advance notice) and no-shows (failing to notify me in advance that you will not be keeping the appointment.)

### FEE SCHEDULE

The following fee schedule outlines the services available and the current fees associated with those services. Please note that these fees are reviewed periodically and subject to revision.

| Service | Fee |
|---|---|
| Intake Interview (60-75Minutes) | $295.00 |
| *Individual / Family Psychotherapy Sessions* | |
| 30 Minutes | $140.00 |
| 50 Minutes | $280.00 |

| | |
|---|---|
| Extended Session | Prorated |
| *Neuro/Psychological Evaluations / Testing* | |
| Testing (Per hour) | $275.00 |
| Scoring / Interpretation / Report Preparation (Per hour) | $275.00 |
| Interpretive Session (45 minutes to 1 hour) | $275.00 |
| *Off-Site Consultations (Per hour including travel time)* | |
| IEP meetings | $200/hour |
| Court Appearances | $500.00/hour |
| Late Cancellation (Less than 24 hour) | $ 150.00 |
| No Show | Full Fee |

*Other professional time conducted from my office (e.g., telephone consultations, lengthy emails) are prorated and based on an hourly rate of $275.*

## CONTACTING ME

While I am usually in my office, I will not answer the telephone when I am with a patient. When I am unavailable, my telephone is answered by voice mail that I monitor frequently. I will make every effort to return your call on the same day you make it, with the exception of weekends and holidays. Additionally, you may contact me via email at drmeredithhickory@gmail.com. In case of an emergency, you may try to reach me at (919) 971-1495. If you fail to reach me you should exercise one of the following options: contact your psychiatrist or primary care physician, go to the nearest hospital emergency room and ask to speak with the psychiatrist on call, or call the Holly Hill Respond Unit at (919) 250-7000.

## LIMITS ON CONFIDENTIALITY

The law protects the privacy of all communications between a patient and a 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 case. 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 don't 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 PHI file.
- Disclosures required by health insurers or to collect overdue fees are discussed elsewhere in this Agreement.
- If I believe that a patient presents an imminent danger to his/her health or safety or to others, 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, the psychologist-client privilege law protects such information. I cannot provide any information without your written authorization, or a court order. If you are involved in or contemplating litigation, you should consult with your attorney to determine whether a court would be likely to order me to disclose information.
- If a government agency is requesting the information for health oversight activities, I may be required to provide it for them.
- If a client files a complaint or lawsuit against me, I may disclose relevant information regarding that patient in order to defend myself.
- If a client files a worker's compensation claim, and my services are being compensated through workers compensation benefits, I must, upon appropriate request, provide a copy of the client's record to the client's employer or the North Carolina Industrial Commission.

There are some situations in which I am legally obligated to take actions that I believe are necessary to attempt to protect others from harm and in so doing it may be necessary to reveal some information about a client's treatment. Such situations include:

- If I have cause to suspect that a child under 18 is abused or neglected, or if I have reasonable cause to believe that a disabled adult is in need of protective services, the law requires that I file a report with the County Director of Social Services. Once such a report is filed, I may be required to provide additional information.
- If I believe that a patient presents an imminent danger to the health and safety of another person, I may be required to disclose information in order to take protective actions, including initiating hospitalization, warning the potential victim, if identifiable, and/or calling the police.

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 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, 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 records. Except in unusual circumstances that involve danger to yourself and/or others or the records makes reference to another person (unless such other person is a health care provider) and I believe that access is reasonably likely to cause substantial harm to such other person, you may examine and/or receive a copy of your PHI record, if you request it in writing. Because these are professional records, they can be misinterpreted and/or upsetting to untrained readers. For this reason, I recommend that you initially review them in my presence, or have them forwarded to another mental health professional so you can discuss the contents. In most circumstances, you will be charged 25 cents per page for copying and at the standard hourly rate for my reviewing your records with you. If I refuse your request for access to your records, you have a right of review, which I will discuss with you upon request.

### PATIENT RIGHTS

HIPAA provides you with several new or expanded rights with regard to your PHI records and disclosures of protected health information. These rights include requesting that I amend your records; requesting restrictions on what information from your records is disclosed to others; requesting an accounting of most disclosures of protected health information that you have neither consented to nor authorized; determining the location to which protected information disclosures are sent; having any complaints you make about my policies and procedures recorded in your records; and the right to a paper copy of this Agreement, the Notice form, and my Privacy Policies and Procedures. I am happy to discuss any of these rights with you.

### MINORS & PARENTS

In the state of North Carolina, children and adolescents less than 18 years of age cannot independently consent to or receive mental health treatment without parental consent. While privacy in psychotherapy is very important, particularly with adolescents, parental involvement is also essential to successful treatment and this may require that some private information be shared with parents. It is my policy not to provide treatment to a child under 18 unless he/she agrees that I can share general information about the progress of the child's treatment and his/her attendance at scheduled sessions. Before giving parents any information, I will discuss the matter with the child, if possible, and do my best to handle any objections he/she may have, unless I feel that the child is in danger or is a danger to someone else, in which case, I will notify the parents (or other authorities) of my concern immediately and regardless of any objections the child may have to me doing so.

### BILLING AND PAYMENTS

You will be expected to pay for services at the time they are rendered, unless we agree otherwise. If your account has not been paid for more than 45 days and arrangements for payment have not been agreed upon, I have the option of using legal means to secure the payment. This may involve hiring a collection agency or going through small claims court which will require me to disclose otherwise confidential information. In most collection situations, the only information I release regarding a patient's treatment is his/her name, the nature of services provided, and the amount due. If such legal action is necessary, those costs will be included in the claim.

### INSURANCE REIMBURSEMENT

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 and/or testing. While I will provide you with whatever assistance I can in helping you receive the benefits to which you are entitled, you (not your insurance company) are responsible for full payment of my fees. It is therefore very important that you find out the extent to which my services are reimbursable through your insurance company.

You should carefully read the section in your insurance coverage booklet that describes mental health services. If you have questions about the coverage, call your plan administrator or human resources consultant.

You should also be aware that your contract with your health insurance company may require that I provide them with information relevant to the services that I provide to you in order for you to obtain reimbursement. Your account statement provides the information most commonly requested (e.g., clinical diagnoses, CPT codes, date of service, etc.) Your health insurance company may request additional clinical information such as treatment plans or summaries, or even copies of your entire record (although this is not common.) In such situations, I will make every effort to release only the minimum information about you that is necessary for the purpose requested and only upon your request. 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 databank. I will provide you with a copy of any report I submit, if you request it. By signing this Agreement, you agree that I can provide requested information to your insurance company.

It is important to remember that you always have the right to pay for my services yourself to avoid the problems described above (unless expressly prohibited by your insurance policy.) Paying for my services yourself provides maximal privacy protection and control over the services you receive.

### Legal Policy

If you are separated or divorced from the child's other parent, please be aware that it is my policy to notify the other parent that I am meeting with your child. I believe it is important that all parents have the right to know, unless there are truly exceptional circumstances, that their child is receiving mental health evaluation or treatment.

Although my responsibility to your child may require my involvement in conflicts between the two of you, I need your agreement that my involvement will be strictly limited to that which will benefit your child. This means, among other things, that you will treat anything that is said in session with me as confidential. Neither of you will attempt to gain advantage in any legal proceeding between the two of you from my involvement with your children. In particular, I need your agreement that in any such proceedings, neither of you will ask me to testify in court, whether in person, or by affidavit. You also agree to instruct your attorneys not to subpoena me or to refer in any court filing to anything I have said or done. My professional time responding to a subpoena or legal proceeding requested by anyone will require payment by you at the rate of $500 an hour.

> Note that such agreement may not prevent a judge from requiring my testimony, even though I will work to prevent such an event. If I am required to testify, I am ethically bound not to give my opinion about either parent's custody or visitation suitability. If the court appoints a

custody evaluator, guardian ad litem, or parenting coordinator, I will provide information as needed (if appropriate releases are signed or a court order is provided), but I will not make any recommendation about the final decision. Furthermore, if I am required to appear as a witness, the party responsible for my participation agrees to reimburse me at the rate of $500 per hour for time spent traveling, preparing reports, testifying, being in attendance, and any other case-related costs. I request payment at time of service. By signing this agreement you agreed to the statements above.

Your signature below indicates that you have read the information in this document (patient agreement) and agree to abide by its terms.

________________________________________

Patient Name (Print)

________________________________________

Your Name (Print if authorizing treatment for minor)

________________________________________

Relation to Patient

________________________________________

Signature

________________________________________

Date

Psychologist-Client Services Agreement, 2022