

Psychiatric & Psychological Associates of Durham, PLLC

Serving Our Community For Over 40 Years

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CONSENT AGREEMENT

This Consent Agreement contains information about the professional services and business policies of PPAD, PLLC. It also contains information about the Health Insurance Portability and Accountability Act (HIPAA), a federal law that went into effect April 14, 2003 and provides privacy protections and patient rights regarding use and disclosure of your Protected Health Information (PHI) for purposes of treatment, payment, and health care operations. Please read this Consent Agreement carefully. Your signature at the end signifies your consent to the Agreement. You may revoke your consent in writing at any time.

Treatment Treatment begins with an evaluation by your clinician, which usually lasts from 2 to 4 sessions. By the end of the evaluation, your clinician will offer you some first impressions of what your work will include and a treatment plan. Consider this information along with your own thoughts to decide whether to continue in treatment with this clinician. If you are not comfortable, your clinician will be happy to refer you to another clinician. Because treatment involves a commitment of time, energy, and money, select a clinician with care, and if you have questions about your treatment, discuss them with your clinician. If your doubts persist, your clinician will help you arrange a meeting with another mental health professional for a second opinion.

Most of the services that we offer involve psychotherapy, which calls for an active effort on the patient's part. To be successful, psychotherapy requires that you work on things during and outside of your sessions. Psychotherapy can have benefits and risks. Since it often involves discussing unpleasant aspects of your life, you may experience uncomfortable feelings like sadness, guilt, anger, frustration, loneliness, and helplessness. Benefits of psychotherapy over time include improved relationships, more productive problem solving, reduced distress, and increased sense of well-being. However, we cannot guarantee what feelings you will experience. As you continue in treatment, the following practices will apply:

- **Appointments** will usually be made with the clinician. Office staff is here between 8:30 am – 5:00 pm, Monday through Friday. Voice mail is available 24 hours a day, 7 days a week.
- **Cancellations** should be made **24 hours in advance** to avoid a **\$50 late cancellation fee**. The fee may be waived if there is a bona fide emergency. The missed appointment will be indicated on your billing statement, and insurance companies will not pay for it.
- **If you are late**, you will be seen for the remaining, not the entire, appointment time. If the clinician is **late for the appointment**, you will be seen for the full appointment time if both schedules permit, or your fee will be adjusted accordingly.
- **Behavior** must be appropriate on the premises. Threatening, assaultive, or violent behavior is not allowed. Guns and smoking are not allowed in the building. Children must be supervised.
- **Emergencies:** This is an outpatient facility, and we are set up to accommodate individuals who are reasonably safe and resourceful. For urgent problems, clinicians are available through the office staff during regular working hours. Outside of office hours, please leave a message on your clinician's confidential voice mail line

or follow other instructions provided (including using after hours contact information). If your clinician is out of town, coverage is provided by another clinician in the practice and the patient is instructed on how to reach that clinician. Generally, clinicians will return phone calls within 24-48 hours. If at any time this does not feel like sufficient support, please inform your clinician, and he or she can discuss additional resources. If you have a mental health emergency, we encourage you not to wait for a call back, but to do one or more of the following:

- Call Hope4NC Helpline at 1-855-587-3463 or text “hope” to 1-855-587-3463.
- Call National Suicide Prevention Lifeline at 1-800-273-8255.
- Go to your nearest emergency room and ask for the psychiatrist on call.
- Call 911 if you are experiencing a life-threatening emergency.

- **Privacy & Confidentiality:** We follow HIPAA and state regulations in assuring the privacy of your Protected Health Information (PHI), which are described in the included privacy notice. Your signature on this Consent Agreement indicates that you have read and understood the content of the Privacy Notice. Since confidentiality about your care is essential, your clinician and the staff will assume that the addresses and phone numbers you give us to reach you are secure for correspondence and messages to you. If this is not the case, please let your clinician know in writing. A clinician may use a cell phone for communicating with you. Please notify your clinician in writing if the use of a cell phone is not acceptable to you.
- **Children, Minors, or Adults Adjudicated Incompetent:** Only the custodial parent(s) or legal guardian may request or consent for treatment; request to review, inspect or amend the patient’s PHI; or consent to or authorize release of information from the patient’s PHI.
- **Termination:** Services will conclude as established in your treatment plan, unless other circumstances prompt the client or clinician to end the relationship earlier. If you become unable to keep your appointments or if attempts to contact you are unsuccessful, your clinician might decide to close your chart. Reopening your chart later and resuming treatment could be an option depending on your clinician’s availability.

Payment

• Fees: Current fees for the most frequent charges are:	<u>M. D.</u>	<u>Ph.D./Psy.D./LCSW/</u>
<u>LPC</u>		
Initial diagnostic interview (External/internal referral)	\$265 / \$220	\$200
Individual psychotherapy, 60 minutes*	\$200	\$175
Individual psychotherapy, 45 minutes*	\$180	\$150
Individual psychotherapy, 30 minutes*	\$140	\$100
Outpatient pharmacological management	\$80	NA
Family psychotherapy, without patient	\$160	\$180
Family psychotherapy, with patient	\$180	\$200
Psychological testing (per hour)	NA	\$185
Psychological report writing (per hour)	\$185	\$185
Missed appointment without 24-hour notice	\$50	\$50

*With an MD or NP a psychotherapy session may include medication management.

Charges for procedures not listed will be discussed with you prior to providing the service. Fees are expected to be paid at the time of service in their entirety or as a co-pay if you have insurance. You will be notified by an office posting or by your clinician prior to a fee increase. There will be a \$25 charge for returned checks.

- **Insurance Reimbursement:** If we are providers with your insurance or managed care company, you must communicate your mental health benefit to us and make your co-pay at each visit and your deductible annually. Some companies require prior authorization to cover services, and it is your responsibility to determine whether this is the case. If we are not providers for your insurance company or you do not have mental health coverage, you will be responsible for the entire fee at the time of the appointment. It is your responsibility to alert us of any changes in your insurance plan. If we have made all efforts to comply with your mental health insurance carrier, but the company refuses payment, or you have exhausted the limits of your policy, you will be responsible for the entire bill.
- **Managed Care:** If your managed care plan requires utilization review to authorize continued reimbursement for services, you are consenting to PHI being reported to case managers in the form of written or verbal reports. Even if you and your clinician have complied with all of the utilization review requirements, there is no guarantee that your insurance company will authorize further treatment. In the case of a disagreement between your managed care plan and clinician's recommendation, your clinician will notify you about suggested next steps in your treatment process.
- **Unpaid Bills:** If you have neglected to pay at the time of service, and if you have a balance due, that balance will be considered in default after 90 days past due.

Health Care Operations

- **Billing:** You will receive a billing statement at the end each month with that month's payment activity and total balance. Your primary insurance will be filed monthly. Secondary insurance claims will not be filed. We will accept automatic crossover from Medicare. The Billing Manager is available to answer any questions and assist you in seeking payment on claims.
- **Credit Balances:** Any credit balance on your account will be used to offset charges for future services. If you are not in active treatment, any credit balance will be refunded to the appropriate party.
- **Default:** If your account is declared in default, the total outstanding balance will be declared immediately due, an annual 18% interest (1.5% per month) will be added to the outstanding balance, and an attorney or credit service will be employed to pursue payment. Only your demographic information and amount owed will be disclosed for collection purposes.
- **Electronic Communications:** In signing this document, you agree that for communication between sessions, your clinician may use email communication and text messaging for administrative purposes only. Administrative matters include setting up and changing appointments and billing. Because we cannot guarantee the confidentiality of any information communicated by email or text, our clinicians will not discuss clinical information by email or text and prefer that you do not either. They do not always frequently check their email or texts, so these methods should not be used to communicate an emergency.

Informed Consent

Your signature certifies that you: (1) understand, consent to, and agree to abide by the business and clinical procedures outlined in this Consent Agreement; (2) received a copy of this Consent Agreement; (3) received a copy of, read, and understand the Privacy Notice: Policies and Procedures to Protect the Privacy of Your Mental Health Information. The signature of the clinician below indicates that she or he has discussed this form with you and has answered any questions you have regarding this information.

Patient's Name (Please Print)

Date

Patient's Signature

If applicable:

Parent's or Legal Guardian's Name (Please Print)

Date

Parent's or Legal Guardian's Signature

Parent's or Legal Guardian's Name (Please Print)

Date

Parent's or Legal Guardian's Signature

Clinician's Signature

Date