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PSYCHOTHERAPIST-PATIENT SERVICES AGREEMENT

Welcome to my practice. 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 federal law that provides privacy protections and 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 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 our first session. 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 the procedures at that time. When you sign this document, it will also represent an agreement between us.

I. PSYCHOLOGICAL SERVICES AND INITIAL SESSIONS

Psychotherapy is not easily described in general statements. It varies depending on the personalities of the psychologist and patient, and the particular problems you are experiencing. There are many different methods I may use to assist with the problems that you hope to address. Psychotherapy is not like a medical doctor visit. Instead, it calls for a very active effort on your part. In order for the therapy to be most successful, you will have to work on things we talk about both during our sessions and at home.

Psychotherapy can have 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, psychotherapy has also been shown to have many benefits. Therapy often leads to

better relationships, solutions to specific problems, and significant reductions in feelings of distress. But there are no guarantees of what you will experience.

Our first few sessions (2 -4) will involve an evaluation of your needs. By the end of the evaluation, I will be able to offer you some first impressions of what our work will include and a treatment plan to follow, if you decide to continue with therapy. You should evaluate this information along with your own opinions of whether you feel comfortable working with me. Therapy involves a large commitment of time, money, and energy, so you should be very careful about the therapist you select. If you have questions about my procedures, we can discuss them whenever they arise. If your doubts persist, I will be happy to help you set up a meeting with another mental health professional for a second opinion.

II. APPOINTMENTS, FEES, PAYMENTS, AND CANCELATIONS:

Usually, for ease of scheduling and therapeutic consistency, we agree on a standing weekly appointment day and time. Other arrangements, however, can be considered.

The initial evaluation appointment is typically scheduled for 90 minutes and billed at $320.00. Subsequent individual or couple sessions are 45 minutes and billed at $160.00 per session. Fees are collected at then time of service and may be made via check, cash, or charge. Please note that you will be responsible for the fees incurred for a check returned due to insufficient funds. Extended telephone contacts or preparation of written reports will be billed on a prorated basis. A statement of all services billed, which can be submitted to your insurance company for possible **"out-of-network"** reimbursement will be provided on a weekly or monthly basis, depending on your preference.

Balances over 90 days may be sent to a third party for collection, 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.

Appointments canceled with less than 2 business day notice will be charged the full session fee of $160.00. NOTE: Insurance companies will not reimburse for late cancelation fees.

III. 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. 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.

I do not bill insurance companies directly or accept payment from insurance companies. I am considered an **"out-of-network"** provider. If you are expecting to file a claim for services with your insurance company, I recommend that you contact your insurance company so that you are aware of the deductibles (if any), co-payments/co-insurance, and limits to your coverage. Limits to coverage may include, but are not limited to: the number of sessions that are covered per calendar year, the need for pre-authorization of services, **exclusion of reimbursement for out-of-network providers**, and exclusions of coverage based on pre-existing conditions.

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. Of course, I will provide you with whatever information I can based on my experience and will be happy to help you in understanding the information you receive from your insurance company.

You should also 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. This information is limited to the dates of treatment and a brief description of the services provided, including the type of therapy provided. 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.

IV. CONTACTING ME

I am in the office Monday through Friday. Voicemail messages and emails are returned within one business day. If I am out of the office for an extended period of time, instructions in both my voice mail greeting and automatic email response will be provided. Please note that the confidentiality of email cannot be guaranteed. Please inform me if you do not wish to correspond via email, to include appointment calendar invites.

EMERGENCIES — IF A SITUATION REQUIRES IMMEDIATE ATTENTION, CALL 911 OR GO DIRECTLY TO YOUR NEAREST EMERGENCY ROOM. Please notify me of the emergency as soon as possible so that I may assist you with follow-up.

V. 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:

- 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.
- Disclosures required by health insurers or to collect overdue fees are discussed elsewhere in this Agreement.

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 your diagnosis and treatment, such information is protected by the psychologist-patient privilege law. I cannot provide any information without your (or your legal representative's) written authorization, or court order, or if a subpoena is served on me with appropriate notices, I may have to release

information in a sealed envelope to the clerk of the court issuing the subpoena. 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 patient files a complaint or lawsuit against me, I may disclose relevant information regarding that patient in order to defend myself.
- If a patient files a worker's compensation claim, I must, upon appropriate request, provide a copy of any mental health report.

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 have reason to suspect that a child is abused or neglected, the law requires that I file a report with the appropriate governmental agency, usually the Department of Social Services. Once such a report is filed, I may be required to provide additional information.
- If I have reason to suspect that an adult is abused, neglected or exploited, the law requires that I report to the Department of Welfare or Social Services. Once such a report is filed, I may be required to provide additional information.
- If a patient communicates a specific threat of immediate serious physical harm to an identifiable victim, and I believe he/she has the intent and ability to carry out the threat, I am required to take protective actions. These actions may include notifying the potential victim or his/her guardian, 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 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.

VI. PROFESSIONAL RECORDS

The laws and standards of my profession require that I keep Protected Health Information about you in your Clinical Record. Except in unusual circumstances that involve danger to yourself, you may examine and/or receive a copy of your Clinical 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. If I refuse your request for access to your records, you have a right of review, which I will discuss with you upon your request.

VII. TERMINATION

You may terminate treatment at any time. If you cancel or miss scheduled appointments and do not contact me for more than **30 days**, it is understood that you have terminated treatment. Once treatment is terminated, the therapist has no further clinical obligation to the patient.

VIII. PATIENT RIGHTS

HIPAA provides you with several rights with regard to your Clinical Record and disclosures of protected health information. These rights include requesting that I amend your record; requesting restrictions on what information from your Clinical Record 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 attached Notice form, and my privacy policies and procedures. I am happy to discuss any of these rights with you.

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.

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Signature Date

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Print Date