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Services Agreement

Thank you for considering this practice. Following is information essential for you to know before we begin our work together. After you've read this overview, we can discuss any questions you may have before you sign at the end.

General Information

Consultation and treatment are in the context of a professional relationship; your confidence in my assistance and your comfort in my presence are integral to reaching your goals for health. Services will be uniquely tailored to your needs, and most generally will consist of 50-minute sessions delivered in a frequency suited to the problems that you are experiencing and the time you have to devote to the treatment.

My approach to your treatment will be based upon the problems you present, any symptoms you report, and the severity of your distress. You can visit my website (in the letterhead above) for more information about the various approaches in which I have been trained and practice.

Our first session will be an evaluation of your distress and your goals for treatment, and will likely last from 75-90 minutes. We will discuss these and other presenting factors and decide together what might be a reasonable first approach to your treatment plan. Our following sessions will usually last for 45-50 minutes. In the beginning, it is usually recommended that we meet weekly. As you begin to feel better, we can then change those frequencies to biweekly or monthly. As you have questions, we will address them, and if at any time you doubt my ability to be of help I can provide information about other area professionals you might consult for another opinion.

Psychotherapy is an active treatment and, as such, can have some unpleasant side effects. Although talking about painful topics is often necessary to either come to acceptance or to solve a problem, this can be a distressing process. Psychotherapeutic approaches and the strategies used can be life changing, and changes in your life will have impact upon your interpersonal relationships too. Others may notice and welcome these changes, or they may be uncomfortable when you do not respond or behave in familiar ways and patterns. It is important in our work to pay attention to these or any other "side effects" you notice.

Fee Policies

The cost for an initial evaluation is $250 (75-90 minutes), and the following 50-minute sessions are $165. Extended session times are available and the fee will vary according to the time you would like to allot for the session. I do not participate in any managed health care plans, but treatment may be covered in part by your insurance (I will be considered an out-of-network health care provider).

Payment can be made by cash, check, or credit card, and at the end of the month you will receive by email a statement providing the necessary documentation for filing your claim. Because an appointment secures my time for you alone, I do require a 24-hour notice for cancelling a session. Otherwise, no-shows or late cancellations will be billed as usual, and insurance providers do not reimburse these charges.

Unless you instruct me otherwise, your visit receipts and monthly statements will be emailed you through a HIPAA-compliant software system. In your first email, your password will be the initials of your first and last name and the telephone number (no dashes) all recorded on the page of this consent form. At this first log-in, you will then be prompted to choose a password of your own. If you have any difficulties, please do not hesitate to let me know and we will figure out the problem.

Emergency Contact

Please feel free to call me at any time, leaving me a voice mail or sending me a text if I am unavailable. I usually return calls within the day, although it may be early evening before I am able to call. If you believe that you are a danger to yourself or someone else, I ask that you either go directly to the nearest emergency room or call 911. If you are having thoughts of suicide, you can call the Suicide and Crisis Center of North Texas (214-828-1000) or the National Suicide Prevention Lifeline (1-800-273-8255). You can also look on the back of your insurance card and call the toll-free number for a referral to an in-network hospital. If for any reason I am going to be unavailable for an extended time, I will both give you ample notice and provide you with the name of a colleague who can help if need arises during my absence.

E-Mail/Text/Telephone/Skype Sessions

I realize that electronic devices are common and convenient. As long as you recognize that cellular towers and satellites sometimes fail, and that your privacy and confidentiality are not fully protected, you may use these forms of communication. My preferences are that you use email and text to send me short messages about appointment times, and that we use our sessions to discuss your personal matters.

Although I believe that treatment is most effective when conducted face-to-face, sometimes this isn't practical. As long as you understand that you are responsible for the confidentiality/privacy of the sessions, I am happy to work with you over the telephone or over the HIPAA-compliant platform that I use for such visits (the rates are the same as for in-person sessions). Not all insurance providers will reimburse for these sorts of visits, so if this is important to you please contact your provider for their policy.

Confidentiality and Privacy

Texas State law protects the communications in our sessions. I do not release information about your treatment to anyone else unless you provide me with a signed authorization form. There are a few exceptions to absolute confidentiality:

1. If you desire that I communicate with another health professional about your treatment, you can give me written authorization to do so for a specific period of time. This authorization can be withdrawn at any time.
2. If I am concerned that my treatment is not adequate, I may occasionally find it helpful to consult another health professional about the case. I make every effort to avoid revealing the

identity of any patient that I discuss for this purpose. The other professionals are also legally bound to protect this information.

3. If an individual threatens to harm himself/herself or someone else, I may be obligated to arrange for hospitalization, or to disclose this information to a medical professional or law enforcement personnel. Texas State law protects these types of disclosures.
4. If a government agency is requesting the information for health oversight activities, I may be required to provide the requested information (but only the specific information that they request).
5. If a patient files a complaint or lawsuit against me, I may disclose information necessary to defend myself.
6. When a worker's compensation claim or disability claim is made, I must upon request provide records relating to the treatment or hospitalization for which compensation is being sought.
7. If I have cause to believe that an elderly person or minor under the age of 18 has been or may be abused, neglected, or sexually assaulted, I am legally mandated to make a report within 24 hours to the appropriate governmental agency (usually the Department of Protective and Regulatory Services). I may also have to provide follow-up information.
8. If I learn of previous sexual exploitation by a mental health provider I am required to report it to the licensing board of the provider and the appropriate legal authorities in the county where the misconduct took place. In this case, the patient/client can remain anonymous if so chosen.
9. At times third-party payers (insurance companies) may request additional documentation before they determine whether or not they will reimburse for services for which you file claims. Although the notes from our sessions are not word-for-word narratives, I must document how much time we spend in each session, your diagnosis, your report of symptoms, my assessment of your current psychological state and progress, a brief summary of the session, and my plan for your treatment. This information becomes part of the payers' files.

If any of these situations arise, I will make a strong effort to discuss the impending action with you before proceeding, and I will limit any disclosures to what is absolutely essential.

Record Keeping

Texas State law, the Texas State Board of Examiners of Psychologists, and the Health Insurance Portability and Accountability Act (HIPAA) require both documentation and protection of your personal and health information. Your clinical record includes your physical health information and any medications you are using, your personal and social history, your reasons for seeking treatment, a description of the problems that you are having and how they affect your functioning, your diagnosis, the goals that we set for your treatment and your progress in reaching the goals, any past treatment records that I receive from others, any reports, your billing records, and any correspondence that you have authorized. Unless there is a specific reason that doing so would cause harm, you are entitled to review your records by request (I am required to retain records for ten years after the date of your last service). Additional rights provided by HIPAA are your ability to request that your record be amended, to request an accounting of most disclosures of health information, determining the location to which information disclosures are sent, having any complaints you lodge about my policies and procedures recorded in your record, and your right to a paper copy of this agreement. As a patient/client, you also have the right to review your records or request a summary of your records, and Texas law requires that this request be made in writing. If you request a copy of your records, I will provide them to you within two weeks of receiving your request. The fee for this service is $25, due at the time of your request.

NOTICE OF PRIVACY PRACTICES

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

Your health record contains personal information about you and your health. This information, which may identify you and relates to your past, present or future physical or mental health or condition and related health care services, is referred to as Protected Health Information ("PHI"). This Notice of Privacy Practices describes how we may use and disclose your PHI in accordance with applicable law. It also describes your rights regarding how you may gain access to and control your PHI.

We are required by law to maintain the privacy of PHI and to provide you with notice of our legal duties and privacy practices with respect to PHI. We are required to abide by the terms of this Notice of Privacy Practices. We reserve the right to change the terms of our Notice of Privacy Practices at any time. Any new Notice of Privacy Practices will be effective for all PHI that we maintain at that time. We will provide you with a copy of the revised Notice of Privacy Practices by posting a copy on our website, sending a copy to you in the mail upon request, or providing one to you at your next appointment.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU:

For Treatment. Your PHI may be used and disclosed by those who are involved in your care for the purpose of providing, coordinating, or managing your health care treatment and related services. This includes consultation with clinical supervisors or other treatment team members. We may disclose PHI to any other consultant only with your authorization.

For Payment. We may use or disclose PHI so that we can receive payment for the treatment services provided to you. This will only be done with your authorization. Examples of payment-related activities are: making a determination of eligibility or coverage for insurance benefits, processing claims with your insurance company, reviewing services provided to you to determine medical necessity, or undertaking utilization review activities. If it becomes necessary to use collection processes due to lack of payment for services, we will only disclose the minimum amount of PHI necessary for purposes of collection.

For Health Care Operations. ***We may use or disclose, as needed, your PHI in order to support our business activities including, but not limited to, quality assessment activities, employee review activities, reminding you of appointments, to provide information about treatment alternatives or other health related benefits and services, licensing, and conducting or arranging for other business activities. For example, we may share your PHI with third parties that perform various business activities (e.g., billing or typing services) provided we have a written contract with the business that requires it to safeguard the privacy of your PHI. For training or teaching purposes PHI will be disclosed only with your authorization.***

Required by Law. Under the law, we must make disclosures of your PHI to you upon your request. In addition, we must make disclosures to the Secretary of the Department of Health and Human Services for the purpose of investigating or determining our compliance with the requirements of the Privacy Rule.

Following is a list of the categories of uses and disclosures permitted by HIPAA without an authorization.

Abuse and Neglect	**Judicial and Administrative Proceedings**
Emergencies	**Law Enforcement**
National Security	**Public Safety (Duty to Warn)**

Without Authorization. ***Applicable law and ethical standards permit us to disclose information about you without your authorization only in a limited number of other situations. The types of uses and disclosures that may be made without your authorization are those that are:***

- ***Required by law, such as the mandatory reporting of child abuse or neglect or mandatory government agency audits or investigations (such as the social work licensing board or health department)***
- ***Required by Court Order***

- ***Necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. If information is disclosed to prevent or lessen a serious threat, it will be disclosed to a person or persons reasonably able to prevent or lessen the threat, including the target of the threat.***

Verbal Permission. ***We may use or disclose your information to family members that are directly involved in your treatment with your verbal permission.***

With Authorization. ***Uses and disclosures not specifically permitted by applicable law will be made only with your written authorization, which may be revoked.***

YOUR RIGHTS REGARDING YOUR PHI

You have the following rights regarding your personal PHI maintained by our office. To exercise any of these rights, please submit your request in writing directly to Dr. Anna R. Brandon.

- **Right of Access to Inspect and Copy.** You have the right, which may be restricted only in exceptional circumstances, to inspect and copy PHI that may be used to make decisions about your care. Your right to inspect and copy PHI will be restricted only in those situations where there is compelling evidence that access would cause serious harm to you. We may charge a reasonable, cost-based fee for copies.
- **Right to Amend.** If you feel that the PHI we have about you is incorrect or incomplete, you may ask us to amend the information, although we are not required to agree to the amendment.
- **Right to an Accounting of Disclosures.** You have the right to request an accounting of certain of the disclosures that we make of your PHI. We may charge you a reasonable fee if you request more than one accounting in any 12-month period.
- **Right to Request Restrictions.** You have the right to request a restriction or limitation on the use or disclosure of your PHI for treatment, payment, or health care operations. We are not required to agree to your request unless the request is to restrict disclosure of PHI to a health plan for purposes of carrying out payment or health care operations, and the PHI pertains to a health care item or service that you paid for out of pocket. In that case, we are required to honor your request for a restriction.
- **Right to Request Confidential Communication.** You have the right to request that we communicate with you about medical matters in a certain way or at a certain location.
- **Breach Notification.** If there is a breach of unsecured protected health information concerning you, we may be required to notify you of this breach, including what happened and what you can do to protect yourself
- **Right to a Copy of this Notice.** You have the right to a copy of this notice.

COMPLAINTS

If you believe we have violated your privacy rights, you have the right to file a complaint in writing with Dr. Brandon, with the Texas State Board of Examiners of Psychologists (800-821-3205), and/or with the Secretary of Health and Human Services at 200 Independence Avenue, S.W., Washington, D.C. 20201, or by calling (202) 619-0257. **We will not retaliate against you for filing a complaint.**

The effective date of this Notice is January 1, 2014.

There are times when it might be helpful for me to communicate with one of your other health care providers (*e.g.* previous psychotherapist, psychiatrist, obstetrician). If you want me to do so, please provide the necessary name and contact information below:

I give Anna R. Brandon, PhD, ABPP permission to release clinical information/receive clinical information from:

Provider Name Credentials (MD, DO, PhD, etc)

Practice Address City State Zip

From Date To Date

Patient Signature Date

Informed Consent

I have read and understood the preceding statements, have had the opportunity to any questions, and understand that I can withdraw my care from this provider at any time.

_____

Printed Name

_____

Signature Date

Patient Contact and Billing Information:

_____

Street Address

_____

City, State, Zip Code

Preferred Telephone Number: _____ OK to leave a message? Yes No

Email Address: _____

Circle your preference communications regarding appointment cancellations or rescheduling:

Voice Mail Text Email

Credit Card Number: _____

Name on Credit Card: _____

Expiration Date: _____ Billing Zip Code: _____ Security Code: _____

Notice of Privacy Practices (HIPAA)

Receipt and Acknowledgment of Notice

Patient Name: _____

Date of Birth: _____

I hereby acknowledge that I have received and have been given an opportunity to read a copy of Dr. Anna R. Brandon's Privacy Practices. I understand that if I have any questions or needs regarding the Notice or my privacy rights, I can contact Dr. Brandon directly.

_____

Signature of Patient/Client

_____

Signature or Parent, Guardian or
Personal Representative*

_____

Date

_____

* If you are signing as a personal representative of an individual, please describe your legal authority to act for this individual (power of attorney, healthcare surrogate, etc.).