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PSYCHOTHERAPIST-PATIENT SERVICES AGREEMENT

Welcome to my practice. This document contains important information about my professional services and business policies. It also contains summary information about the Health Insurance Portability and Accountability Act (HIPAA). HIPAA requires that I provide you with a Notice of Privacy Practices (the Notice) for use and disclosure of Protected Health Information (PHI) for treatment, payment and health care operations.

PSYCHOLOGICAL SERVICES

Psychotherapy involves the evaluation and treatment of people with emotional, behavioral, and mental problems. My approach is aimed at clarifying your concerns, establishing a collaborative relationship, and developing a plan to reach the therapeutic goals that we formulate together. In order for therapy to be successful, you will have to work on things that we talk about both during our sessions and at home.

Psychotherapy can have both benefits and risks. Risks might include experiencing uncomfortable feelings and recalling unpleasant memories. Benefits might consist of decreased depression and/or anxiety or increased self-esteem and improved relationships. While I cannot guarantee any specific results regarding your therapy goals, we will work together to achieve the best possible outcomes for you.

MEETINGS

I will usually schedule one 45-minute session per week.

PROFESSIONAL FEES

My 45-minute session fee is $228.

APPOINTMENTS AND CANCELLATIONS

I schedule my own appointments. If you need to cancel an appointment, please do so at least 24 hours before your scheduled appointment.

CONTACTING ME

I cannot always be reached by phone immediately. You may leave routine messages (i.e., to cancel or reschedule appointments at the University Medical Center at 269-473-2222.

EMERGENCIES

In emergencies, you may either attempt to call me on my cell phone (269-757-2154) or call the University Medical Center (269-473-2222) to have them contact me. If you are unable to reach me and feel that you can't wait for me to return your call you should call 911 or go to the nearest emergency room and ask for the mental health clinician on call.

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.

I may use or disclose PHI without your consent or authorization in the following circumstances:

1. *Child Abuse* – If I have reasonable cause to suspect child abuse or neglect, I must report this suspicion to the appropriate authorities as required by law.

2. *Adult or Domestic Abuse* – If I have reasonable cause to suspect that you have been criminally abused, I must report this suspicion to the appropriate authorities as required by law.

3. *Health Oversight Activities* - If I receive a subpoena or other lawful request from the Department of Health or the Michigan Board of Psychology, I must disclose the relevant PHI.

4. *Judicial or Administrative Proceedings* – If you are involved in a court proceeding and a request is made for information about your diagnosis and treatment or the records thereof, such information is privileged under state law, and I will not release information without authorization or a court order.

5. *Serious Threat to Health or Safety* – If you communicate to me a threat of physical violence against a reasonably identifiable third person and you have the intent and ability to carry out the threat in the foreseeable future, I may disclose relevant PHI and take the reasonable steps permitted by law to prevent the threatened harm from occurring. This may involve notifying the potential victim and contacting the police and/or seeking hospitalization for

you. If I believe that there is imminent risk that you will inflict serious physical harm on yourself (i.e., commit suicide), I may disclose information in order to protect you. This may involve seeking hospitalization for you or contacting family members or others who can help provide protection.

6. *Worker's Compensation* – I may disclose PHI regarding you to comply with laws relating to worker's compensation or other similar programs that provide benefits for work-related injuries or illness.

In addition, if you were to file a complaint or lawsuit against me, I may disclose relevant information regarding you and your treatment in order to defend myself.

PROFESSIONAL RECORDS

You should be aware that I keep Protected Health Information about you in your Clinical Record. Your Clinical Record includes information about your reasons for seeking therapy, a description of the ways in which your problem impacts your life, your diagnosis, the goals that we set for treatment, your progress toward those goals, your medical and social history, your treatment history, any past treatment records that I receive from other providers, reports of any professional consultations, your billing records, and any reports that have been sent to anyone, including reports to your insurance carrier.

You may examine and/or receive a copy of your Clinical Record if you request it in writing. 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.

PATIENT RIGHTS

HIPAA provides you with a number of safeguards with regard to your Clinical Records and protected health information. These rights are outlined in detail in the **HIPAA NOTICE FORM**. In general, the **HIPAA NOTICE FORM** specifies how PHI can be used and when it can be disclosed and under what conditions. In addition, it specifies patient's rights and psychologist's duties. I am happy to discuss your rights with you.

MINORS & PARENTS

Patients under 18 years of age and their parents should be aware that the law may allow parents to examine their child's treatment records. They should also be aware that patients over 14 can consent to (and control access to information about) their own treatment, although that treatment cannot extend beyond 12 sessions or 4 months.

It is usually my policy to request an agreement from any patient between 14 and 18 and his or her parents that I be permitted to share general information with parents

about the progress of treatment and the child's attendance at scheduled sessions. Any other communication will require the child's authorization unless the child is in danger or is a danger to someone else.

BILLING AND PAYMENTS

You will be expected to pay for each session at the time that it is held, unless we agree otherwise or unless you have insurance coverage that requires another arrangement.

INSURANCE REIMBURSEMENT

If you have a health insurance policy, it will usually provide some coverage for mental health treatment. I will provide whatever assistance that 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 your fees.

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.

"Managed Health Care" plans such as HMOs and PPOs often require authorization before they provide reimbursement for mental health services. These plans are often limited to short-term treatment approaches and it may be necessary to seek approval for more therapy after a certain number of sessions. (Some managed-care plans will not allow me to provide services after insurance benefits end. If this is the case, I will do my best to find another provider who will help you continue your psychotherapy.)

You should be aware that your contract with your health insurance company requires that I provide it with a clinical diagnosis. In addition, sometimes I am required to provide additional clinical information such as treatment plans or summaries, or copies of your entire Clinical Record. By signing this **AGREEMENT**, you agree that I can provide requested information to your carrier.

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.

Name of Client (Please Print): ____

Signature of Client: ____

Signature of Parent/Guardian: ____
(If Client is a Minor)

Date: ____

Witnessed: ____

Social Security Number: ____

Date of Birth: ____

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