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## **PSYCHOTHERAPIST-PATIENT 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 federal law that provides privacy protections and patient rights with regard to the use and disclosure of your Protected Health Information (PHI). PHI is used for the purpose of treatment, payment, and health care operations. HIPAA requires that I provide you with a Notice of Privacy Practices (Notice) for use and disclosure of PHI for treatment, payment and health care operations. The Notice, which is separate from this Agreement, explains HIPAA and its application to your PHI in greater detail. The law requires that I obtain your signature acknowledging that I have provided you with this Notice. Although this document and the Notice are long, it is very important that you read them carefully. We can discuss any questions you have. When you sign this document it will represent an agreement between us.

### **PSYCHOLOGICAL SERVICES**

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, or helplessness. On the other hand, psychotherapy has also been shown to have many benefits. Therapy often leads to solutions to specific problems, better relationships, and reduction in feelings of distress. However, there are no guarantees of what you will experience in terms of outcome.

Our first 1-3 sessions 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 opinion of whether you think I am the best person to provide the services you need in order to meet your treatment goals.

Therapy involves a commitment of time, money, and energy so you should be careful about the therapist you select. If you have questions about my procedures, we should discuss them whenever they arise. If your doubts persist, I will be happy to help you set up a meeting with another behavioral healthcare professional for a consultation should you so desire.

### **MEETINGS**

If psychotherapy is begun after the initial evaluation sessions, appointments are scheduled on the basis of a 50-minute hour (one appointment hour of 50 minutes duration) per week or biweekly at a time we agree on. **Once an appointment hour is scheduled, you will be responsible to pay for it unless you provide 24 hours advance notice of cancellation. It is important to note that insurance companies do not provide reimbursement for cancelled sessions.** [I will reschedule the appointment without a cancellation charge if another appointment is available within 48 hours.]

### **PROFESSIONAL FEES**

My hourly fee is \$175 for the initial consultation and for subsequent psychotherapy sessions. This amount is charged for other professional services you may need, though charges will be prorated for periods of time of less than one hour. Other services include things such as report writing, telephone conversations lasting longer than 10 minutes, review of email or other electronic communication, consulting with other professionals with your permission, and preparation of records or treatment summaries.

If you become involved in legal proceedings that require my participation you will be expected to pay for all of my professional time including preparation and transportation time. [Because of the difficulty of legal involvement, I charge \$250 per hour for preparation and attendance at any legal proceeding.]

### **CONTACTING ME**

Due to my work schedule I am often not immediately available by telephone. When I am unavailable my telephone is answered by a voice mail [that I monitor frequently], or by my secretary who knows where to reach me. I will make every effort to return your call within 24 hours with the exception of weekends and holidays. If you are difficult to reach, please inform me of some times when you will be available. [In emergencies call 316.631.1222 and select extension number 2 to leave a message.] If you are unable to reach me and you are experiencing an emergency, contact your family physician or go to the nearest medical emergency room. If I will be unavailable for an extended time, I will provide you with the name of a colleague to contact in an emergency.

I only use email communication with your permission and only for administrative purposes unless we have made another agreement. This means that email exchanges with my office should be limited to administrative matters. This includes things like setting and changing appointments, billing matters, and other related issues. You should be aware that I cannot guarantee the confidentiality of any information communicated by email. Therefore, I will not discuss any clinical information by email and prefer that you do not either. Also, I do not regularly check my email, nor do I respond immediately, so this method **should not** be used if there is an emergency. I prefer that you use the telephone voicemail system at 316-631-1222.

### **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 defined by HIPAA. There are other situations that require you to provide written, advance consent. Your signature on this Agreement provides consent for the 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 a patient. The other professionals are also legally bound to keep the information confidential. If you do not 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 Clinical Record (PHI).
- You should be aware that I employ administrative staff. In most cases I need to share protected information with these individuals for administrative purposes such as scheduling, billing, and quality assurance. All staff members have been given training about protecting your privacy and have agreed not to release any information outside of the practice without the permission of a professional staff member.
- I also have a business contract with a separate organization who assists with billing. As required by HIPAA, I have a formal business associate contract with this business in which they promise to maintain the confidentiality of data except as specifically allowed in the contract or otherwise required by law. If you wish I can provide you with the names of these organizations and/or a blank copy of this contract.
- Disclosures required by health insurers, or to collect overdue fees, are discussed elsewhere in this Agreement.

- 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.

There are some situations where I am permitted or required to disclose information without either your consent or Authorization:

- If the release of your record is ordered by a court.
- 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 you file a worker's compensation claim, and I have examined or treated you in regard to such claim, I must, upon appropriate request, provide a report to the patient's employer or the employer's insurance company.

There are some situations in which I am legally obligated to take action, which I believe is necessary to attempt to protect others from harm, and I may have to reveal information about a patient's treatment in the process. These situations are unusual in my practice:

- If I have reason to suspect that a child under 18 has been injured as a result of physical, mental, or emotional abuse; neglect or sexual abuse; or that an adult has been or is being abused, neglected, exploited, or is in need of protective services, the law requires that I file a report with the appropriate government agency. Once such a report is filed I may be required to provide additional information.
- If a patient communicates an imminent, specific threat of harm against a specific individual and I believe that there is a substantial risk that the patient will act on that threat in the foreseeable future, I may be required to take protective actions. These actions may include notifying the potential victim, contacting the police, or seeking hospitalization for the patient.

If such a situation arises 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 have now or in the future. The laws governing confidentiality can be complex. In situations where specific advice is required, formal legal consultation may be needed.

### **PROFESSIONAL RECORDS**

Except in unusual circumstances that involve danger to yourself and others or circumstances that make 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, or where information has been supplied to me by others confidentially, you may examine and/or receive a copy of your Clinical Record if you request it in writing. These are professional records that can be misinterpreted by 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 with them.

In most circumstances I am allowed to charge a copying fee of \$.25 per page and a fee for staff time in producing copies. The exceptions to this policy are contained in the attached Notice Form. If I refuse your

request for access to your Clinical Records, you have a right of review [except for information supplied to me confidentially by others], which I will discuss with you upon request.

### **PATIENT RIGHTS**

HIPAA provides you with several new or expanded rights with regard to your Clinical Records 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 believe 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 and the Notice Form of privacy policies and procedures. I am happy to discuss any of these rights with you.

### **MINORS & PARENTS**

Patients under 18 years of age who are not emancipated, and their parents, should be aware that the law may allow parents to examine their child's treatment records. Because privacy in psychotherapy is often crucial to successful progress, particularly with teenagers, it is my policy to request an agreement from parents that they consent to the confidentiality of session time alone with a child or adolescent. If parents agree to this confidentiality, I will provide general information about the progress of the child's treatment, and his/her attendance at scheduled sessions. If requested, I will also provide parents with a summary of their child's treatment when it is complete. Any other communication will require the child's Authorization, unless I feel that the child is in danger or is a danger to someone else. In this case, I will notify parents of my concern. 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.

### **BILLING AND PAYMENTS**

You will be expected to pay for each session at the time it is held. If you utilize health insurance to assist in paying for any session, you are responsible for any self-pay portion of costs at the time of the session. [In circumstances of unusual financial hardship, I may be willing to negotiate a fee adjustment or payment installment plan.]

If your account has not been paid for more than 60 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, contact information, the nature of services provided, and the amount due. [If such legal action is necessary, its 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. I will 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.

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. In addition, 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.

Due to the rising costs of health care, insurance benefits have increasingly become more complex. “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 designed to work out specific problems that interfere with a person’s usual level of functioning. While much can be accomplished in short-term therapy, some patients feel that they need more services after insurance benefits end. You may then choose to pay for services on your own. If paying for services on your own is not affordable, I will do my best to help you find a more affordable alternative for treatment services.

You should be aware that your contract with your health insurance company may require that I provide the company with information relevant to the services that I provide to you. I am required to provide a clinical diagnosis, type of service, and dates of service. Sometimes I am required to provide additional clinical information such as treatment plans or summaries. In such situations I will make every effort to release only the minimum information about you that is necessary for the purpose requested.

This information will become part of the insurance company files. 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 carrier.

Once we have information about your insurance coverage, we can discuss what you can expect to accomplish with the benefits that are available, and what will happen if they run out before you feel ready to end your sessions. It is important to remember that you always have the right to pay for services yourself to avoid the potential problems described above.

Your signature below indicates that you have read this agreement and consent to its terms.

\_\_\_\_\_  
Patient Name

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

or

\_\_\_\_\_  
Parent/Guardian Signature  
(if patient is a minor)

\_\_\_\_\_  
Date