ASSOCIATES IN FAMILY PSYCHOLOGY
Serving Individuals, Couples and Families

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PSYCHOLOGIST-CLIENT SERVICES AGREEMENT

INTRODUCTION

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.

Please read these documents carefully so that we can discuss any questions you have about our policies and procedures during your session. When you sign this document, it will represent an Agreement between us. You may revoke this Agreement in writing at any time. That revocation will be binding on me unless I have acted in reliance upon it; if there are obligations imposed on me by your health insurer in order to process or substantiate claims made under your policy; or if you have not satisfied any financial obligations you have incurred.

PSYCHOTHERAPY SERVICES

Psychotherapy is not easily described in general statements. It varies depending on the personalities of the psychologist and patient, as well as the particular problems you are experiencing. There are many different methods I may use to deal 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. Yet, there are no guarantees of what you will experience.

Our first few 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 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 should 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.

PROFESSIONAL FEES

My psychotherapy fees are **$185.00 (one hundred eighty-five dollars)** for the initial **45-50 minute** initial session and **$175.00 (one hundred seventy-five dollars)** per **45-50 minute** session thereafter. My office accepts cash, personal checks, debit, MasterCard, Visa, Amex and Discover, and most Health Savings Account debit cards. Be advised that there is a $**50.00 (fifty dollar)** charge on all returned fees. Payment in full is due at the time of service, unless I have a contract with your insurance to collect a copay or coinsurance amount.

SCHEDULING PSYCHOTHERAPY APPOINTMENTS

Attending sessions regularly is important to the success of your treatment. My office staff will assist you in scheduling your appointments. If you have limited availability, it is important to schedule your appointments in advance. We find that you will have the most appointment times available to you if schedule 6-8 appointments in advance and then make new appointments consistently. Please speak with me if you have any concerns with scheduling appointments.

PSYCHOTHERAPY SERVICES APPOINTMENT CANCELLATION POLICY

Since your appointment time is reserved for you and therefore not available to another client, your account will automatically be charged a $100.00 (one hundred dollar) cancellation fee for each 45 minute appointment time scheduled, unless you provide 24 hours advance notice of cancellation or we both agree that you were unable to attend due to circumstances beyond your control. The reason I ask for this courtesy is so that I may offer the appointment time to someone on my cancellation list.

Please speak directly with me if you have any questions.
My office staff is not authorized to negotiate or change any fees for you.

If you do not show for an appointment, my office staff will attempt to contact you to confirm your next appointment. If there has been no communication within 48 hours of a missed appointment, scheduled appointments may be cancelled and we will need to speak with you before scheduling future appointments. It is important to note that insurance companies do not provide reimbursement for missed or late cancelled sessions.

IMPORTANT:
It is your responsibility to keep track of your appointments via the Client Portal.
Appointment reminders are a courtesy and are not guaranteed.

EXTENDED SERVICES CANCELLATION POLICY

Appointments requiring more than typical 45 minute appointment times are referred to as "extended services" and require prepayment or deposits in order to schedule. A 50% deposit is required at the time of scheduling the appointment for a Gifted/IQ Testing and the other 50% is due upon arrival at the appointment. If you require a Saturday appointment, this service is payable in full at the time of scheduling. If you cancel within three business days of the appointment you may receive a full refund. If you cancel with less than three business days' notice, you may not receive a refund unless you and I both agree that you were unable to attend due to circumstances beyond your control. Please speak directly with me if you have any questions regarding this policy. My office staff is not authorized to negotiate or change any fees for you.

INTELLECTUAL (IQ)/GIFTED TESTING

My collogues and/or I, are happy to provide intellectual testing services for children, adolescents, and adults. This testing can be very helpful in understanding the nature and extent of academic, learning, emotional and/or psychological performance. Below you will find a description of how we structure psychological testing sessions. Typically, these services are not covered by insurance and I may require prepayment prior to scheduling the appointment. Gifted/Intelligence testing fees are **$475** (one 3 hour appointment = approximately 2-2.5 hours of testing and 1/2 to 1 hour for results and report writing). Saturday appointments when available are **$575**. Additionally, a written report with an interpretation of the results with any recommendations will follow about 5 business days later. Please note that software used in the testing process requires the doctor to record answers from the tester. These recordings are only saved until the scoring is complete and are then deleted.

Important: If your child may have been previously screened or tested for IQ, certain restrictions apply to retesting within a 6-month period. Please speak with your child's school guidance counselor.

FORENSIC EVALUATIONS/TESTIMONY/CUSTODY EVALUATIONS

Forensic evaluations, testimony or custody evaluations are **not** services I provide. If I am subpoenaed or ordered by the Court, you will be expected to pay for all of my professional time, including preparation and transportation time, even if I am called by another party. My fee is **$275.00 (two hundred seventy-five dollars)** per hour for preparation, communication, travel and attendance at any legal proceeding.

PSYCHOLOGICAL & PSYCHOEDUCATIONAL EVALUATIONS (ADULTS & CHILDREN)

Psychological Testing is sometimes necessary and can be extremely helpful in understanding the nature and extent of academic, learning, emotional and/or psychological difficulties. While each evaluation varies depending on the problem, comprehensive evaluations can be quite involved and usually require 6 to 8 hours, broken up into several sessions. Testing sessions typically involve an intake session, where the clinical interview is conducted to gather information about your concerns, followed by three to four (90-100 minute) testing sessions. Following the evaluation, the results will be discussed in detail with you during a feedback session. Please note that for every hour of direct testing, another hour is required for scoring, analyzing and interpreting the results. In addition to the verbal feedback session, a written report can be prepared at your request. The overall cost of an evaluation depends on the type of evaluation and **may range from $900-$2800**. Please note that software used in the testing process requires the doctor to record answers from the tester. These recordings are only saved until the scoring is complete and are then deleted.

RATES FOR PSYCHOEDUCATIONAL EVALUATIONS

My rates are **$185 per 45-50 minute consultation** and **$175 per 45-50 minutes** of testing, scoring, analyzing, and reporting thereafter. A 15% discount ($2,380) is offered for payment in full at time of scheduling. However, in light of the significant investment of time and finances, if you cannot make payment in full at the time of scheduling, the full estimated fee ($2,800) can be split into two equal payments. The first payment is due at the consultation and the second payment is due at the results/feedback appointment. All services must be paid in full prior to receipt of the final report.

BILLING AND PAYMENTS

To increase efficiency, my practice is automated and we require you to keep a valid credit card on file. When your service is invoiced, your card will be charged, whether for payment in full, or a coinsurance, no-show or late-cancellation fee. Payment is due at time of service. If you have any questions or concerns, please discuss this with me.

I have the option of using legal means to secure the payment for accounts 60 days past due. This may involve charging the credit card on file, hiring a collection agency or small claims court. This will require me to disclose otherwise confidential information. In most collection situations, the only information I release regarding a client's treatment is his/her name, the nature of services provided, and the amount due. If such legal action or use of a collection agency is necessary, the cost of legal action or collection fees will be included in the claim.

If someone else is responsible for your insurance coverage and/or payments on the account, my staff may need to contact them in the case of any balances owed or other means of managing your account. A release of information is required for communication regarding appointments and billing purposes.

WHY SELF-PAY?

Self-paying for your treatment offers the greatest level of privacy. Insurance companies require a DSM-5 psychiatric diagnosis and other information, which becomes part of your medical records with your insurance carrier. Some insurance carriers share this information with large medical data banks so that future insurers, or others, can search your records to look at your mental health history. Sometimes, this can be used as a basis for increasing your insurance premiums as a result of a pre-existing condition. Additionally, all carriers place some sort of limit on services, deciding what type of evaluations or amount of treatment they consider necessary.

IN-NETWORK INSURANCE REIMBURSEMENT

If you have a mental health insurance policy, it may provide some coverage for your treatment. For clients with in-network insurance benefits (excluding EAP) insurance companies with whom I am contracted), I will comply with claim filing requirements. I will assist you in receiving the benefits to which you are entitled; however, you (not your insurance company) are responsible for full payment of my fees. **If your insurance company deems your treatment as not medically necessary or denies any services, you are ultimately responsible for payment of these services**. This Agreement supersedes any insurance company or plan administrator of your policy.

Please read your policy's mental health benefits. If you have questions about the coverage, call your plan administrator. My office staff or I will assist you where possible; however, your insurance plan administrator will have the most accurate benefits information.

Your contract with your health insurance company requires that I provide information relevant to your treatment, **including a clinical diagnosis**. I may be required to provide a treatment plan, treatment summary, or copies of your entire Clinical Record. I will make every effort to release only what is necessary for the purpose requested. This information will become part of the insurance company files and may be stored in a National Database (EMR).

ASSIGNMENT OF BENEFITS AND RELEASE OF INFORMATION

By signing this Agreement, you agree that I can provide requested information to your insurance company and that you are assigning benefits to be paid directly to your provider.

MEDICARE NOTICE

I am not a Medicare provider. This means any government programs such as Medicaid, Staywell, Tricare, etc. are not eligible for reimbursement for services provided here. If you are eligible or become eligible for Medicare or any government program, you will be considered to be under Private Contract for self pay services only. You are required to notify me or my office staff immediately. If you do not notify me or my office staff 24 hours PRIOR to any appointment you have scheduled, the full fee for services are payable as of the date of eligibility. Please read Medicare's official guidelines for a Medicare Private Agreement available on our website (www.FamPsych.com) under the Forms link.

OUT OF NETWORK INSURANCE

All clients using out-of-network (insurance companies with whom I am not contracted) benefits will be asked to pay the full fee at time of service. An office staff member will provide you documentation of services for each session, which you may use to submit to your insurance company, should you choose to do so.

SECONDARY INSURANCE

I do not offer billing services for secondary or supplemental coverage you may have. If I am contracted with your primary insurance company, I will send claims to that insurer for your services and any deductibles, co-insurance or co-pays due will be collected at the time of service. Your primary insurance company will provide you with an explanation of benefits and you may use that to bill your secondary insurer for any benefits you are entitled to with your policy. If we are contracted with your secondary insurer, we will provide you documentation of your services for reimbursement.

CONTACTING ME

Due to my work schedule, I am often not immediately available by telephone. When I am unavailable, my telephone is answered by office staff or our voice mail system. I will make every effort to return your call on the same day you make it, with the exception of weekends and holidays. If you are difficult to reach, please inform me of times when you will be available. Also, I do not provide emergency services. In an emergency, please go to the nearest emergency room or dial 911.

PHONE SESSIONS

In rare circumstances, the need for a phone session may arise. Phone sessions are not covered by health insurance and must be paid before the phone session begins. Phone sessions are scheduled in full 45-50 minute sessions at my usual rate of $175.

ELECTRONIC COMMUNICATION AND SOCIAL MEDIA

I use email communication only with your permission and only for administrative purposes. That means that email exchanges with my office should be limited to things like setting and changing appointments, sending and receiving forms, billing matters and other related issues. Please do not email me about clinical matters because **email is not a secure way to contact me**. Telephone or face to face contacts are the most secure form of communication. I do not communicate with, or contact, any of my clients through social media platforms like Twitter and Facebook. Although we have a Facebook page, in order to protect your privacy, we do not communicate directly with clients or "friend" clients.

PROFESSIONAL COMMUNICATION ON YOUR BEHALF

Comprehensive and ethical treatment may involve coordinating care with other professionals. Please be aware that such communication is not covered by your insurance company. With your permission, I may communicate briefly with your referring provider. Any additional communication will be billed according to our 45-minute session rate, with a 15-minute minimum charge ($52.50). Additionally, the time it takes to review any information you provide us or send through email is a billable service which is not covered by health insurance. This service will be billed as described above.

SUPPLEMENTAL ASSESSMENTS

There may be times in your treatment when additional assessment may be needed to clarify symptoms or aid in treatment planning. If I feel there is a need to use one of these assessments as a part of your treatment or evaluation, we can discuss the process and any fees.

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 if you sign a written authorization form that meets Health Insurance Portability and Accountability Act (HIPAA) requirements. There are other situations that require only that you provide written, advance consent. 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.

Your signature on this Agreement provides consent for those 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 conceal the identity of my client. Other professionals are also legally bound to keep the information confidential.
- I practice with other mental health professionals and that I employ administrative staff. I may need to share protected information with these individuals for both clinical and administrative purposes, such as scheduling,

billing and quality assurance. All mental health professionals are bound by the same rules of confidentiality. All staff members have been given training about protecting your privacy and have agreed not to release any information without consent.

- I also have contracts with security, practice management software company, and building maintenance services. As required by HIPAA, I have a formal business associate contract with these businesses, in which they promise to maintain the confidentiality of this data except as specifically allowed in the contract or otherwise required by law.
- 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 a court order. If you are involved in or contemplating litigation, consult with an 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, within its appropriate legal authority, 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, and I am providing necessary treatment related to that claim, I must, upon appropriate request, submit treatment reports to the appropriate parties, including the patient's employer, the insurance carrier or an authorized qualified rehabilitation provider.

I am legally obligated to take actions I believe are necessary to attempt to protect others from harm. In these circumstances, I may have to reveal treatment information. These situations are unusual in my practice.

- If I know, or have reason to suspect, that a child under 18 is abused, abandoned, or neglected by a parent, legal custodian, caregiver, or any other person responsible for the child's welfare, the law requires that I file a report with the Department of Child and Family Services. Once such a report is filed, I may be required to provide additional information.
- If I know, or have reasonable cause to suspect, that a vulnerable adult has been or is being abused, neglected, or exploited, the law requires that I file a report with the central abuse hotline. Once such a report is filed, I may be required to provide additional information.
- If I believe that there is a clear and immediate probability of physical harm to the patient, to other individuals, or to society, I may be required to disclose information to take protective action, including communicating the information to the potential victim, and/or appropriate family member, and/or the police or seeking hospitalization of the patient.

If such a situation arises, if I am able, 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.

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 disclosure would physically endanger you and/or others or refers to another person (other than a health care provider) and I believe that access is reasonably likely to cause substantial harm to such other person, 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 request. There may be a fee for copies of records.

It is my general policy not to release information about sessions involving other parties without the consent of each individual involved. This would include family sessions, couples/marital sessions, or parent sessions.

The client record will be closed and treatment will be terminated after a period of six months with no scheduled appointments or contact by an existing client. Should the need arise, you may contact the office to schedule an appointment to reestablish treatment.

CLIENT/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 Records 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.

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. Children between 13 and 17 may independently consent to (and control access to the records of) diagnosis and treatment in a crisis situation. Because privacy in psychotherapy is often crucial to successful progress, particularly with teenagers, ***parental involvement is essential***, it is usually my policy to request an agreement with minors 13 and older and their parents about access to information. This agreement provides that during treatment, I will provide parents with only general information about the progress of the treatment, and the patient's attendance at scheduled sessions. 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 which case, I will notify the 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. By signing this Agreement, you consent to treatment of yourself and/or minor child.

UPDATES TO THIS AGREEMENT

From time to time, I may find it necessary to update or amend the terms of this Agreement and will clearly post the updates in the Client Portal and in my office. By continuing to use the services I provide you are in agreement with this policy.

SUMMARY

Thank you for taking the time to review this information. I know your time is valuable, and I appreciate your willingness to work with me to develop a clear and effective treatment relationship. My goal is to provide you with the highest quality psychological care and to work in cooperation with you to achieve your treatment goals. Please retain your copy of this packet for future reference, and feel free to discuss any questions during our appointment.

ASSOCIATES IN FAMILY PSYCHOLOGY
13430 Parker Commons Blvd. Suite 101 Fort Myers, Fl 33912 Phone: 239/561-9955 Fax: 239/561-9779
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I HAVE READ AND UNDERSTOOD THE ASSOCIATES IN FAMILY *PSYCHOLOGY PSYCHOLOGIST-CLIENT SERVICES AGREEMENT* AND THE *HIPAA NOTICE* AND AGREE TO THE TERMS.

I UNDERSTAND AND AGREE TO THE CANCELLATION POLICY AND WILL PROVIDE AT LEAST 24 HOURS-NOTICE FOR ANY CHANGES TO MY SCHEDULED APPOINTMENTS OR I MAY BE CHARGED THE FULL FEE FOR THE SERVICE SCHEDULED.

I FURTHER UNDERSTAND AND AGREE TO PAY FOR ALL SERVICES NOT REIMBURSED BY INSURANCE ACCORDING TO THE TERMS DISCUSSED IN THE ASSOCIATES IN FAMILY PSYCHOLOGY PSYCHOLOGIST-CLIENT SERVICES AGREEMENT.

_____ _____
Signature of Prospective Client Date

_____
Print Name

_____ _____
Signature of Prospective Client Date

_____
Print Name

If patient is a minor: Child's Name: _____

_____ _____
Signature of Parent/Legal Guardian Date

_____
Print Name

_____ _____
Signature of Parent/Legal Guardian Date

_____
Print Name