CLIENT INFORMATION

FULL NAME: _____ DATE: _____

COMPLETE ADDRESS_____

_____ZIP CODE_____

TELEPHONE: (Home)_____(Work)_____

DATE OF BIRTH: _____ AGE: _____ SEX: _____

MARITAL STATUS: _____ OCCUPATION: _____

SOCIAL SECURITY NUMBER: _____

REFERRED BY: _____

EMPLOYER AND ADDRESS: _____

_____

INSURANCE CO: _____POLICY#: _____GROUP#: _____

PERSON RESPONSIBLE FOR BILL: _____

ADDRESS OF ABOVE: _____

CONTACT IN CASE OF EMERGENCY: _____

Office policy is full payment at the time services are rendered. The office will provide clients with a complete itemized statement that contains all necessary information needed by the insurance company to process a claim. Failure to pay your fee or conform to the terms of your fee payment plan will result in a hiatus from services and may result in collection proceedings. If you have further questions concerning my practice, please do ask me. Your signature below constitutes an understanding of and agreement to the terms and conditions above.

I understand that I will be responsible for charges and will pay for services as rendered regardless of amounts, if any reimbursed to me by my insurance company and/or settled in a pending legal case. My signature below acknowledges that I understand the terms of this agreement and that each Associate operates as the sole proprietor of his or her practice.

Signature of responsible party: _____Date: _____

Copy received: _____

PSYCHOTHERAPIST-PATIENT SERVICES AGREEMENT

I want you to get all you can from your psychotherapy services here. I also want you to be an informed recipient of services as well. 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 new 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 this 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. You may revoke this Agreement in writing at any time. That revocation will be binding on me unless I have taken action in reliance on 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.

ASSESSMENT/EVALUATION is intended to enhance my understanding of you (and frequently your understanding of yourself.) Signing this form means that you understand that assessment interviews and devices have limited predictive validity. You are entitled to disagree with my opinion. You always have the option of seeking an opinion from another mental health practitioner and to discontinue seeing me at any time. If I do not believe I am the appropriate practitioner for you, I shall discontinue seeing you.

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.

If psychotherapy is begun, I will usually schedule one 50-minute session (one appointment hour of 50 minutes duration) per week at a time we agree on, although some sessions may be longer or at an interval that is more or less frequent. **Once an appointment hour is scheduled, you will be expected to pay for it unless you provide 24 hours advance notice of cancellation or unless we both agree that you were unable to attend due to circumstances beyond your control. It is important to note that insurance companies do not provide reimbursement for cancelled sessions.** If it is possible, I shall try to find another time to reschedule the appointment.

PSYCHOTHERAPY is meant to promote beneficial change and understanding. Although every effort will be made to make this a fulfilling experience to you, no outcome is guaranteed and this process can be emotionally painful at times. Change during therapy may affect areas of you life not originally identified as treatment goals – for better or worse. Although it is impossible for either you or me to predict the effects of personal change on others, you can work with me to minimize the risk of negative change in these other important areas of you life.

You are an active participant in your treatment planning and its implementation. Please do ask questions, make modifications, or refuse any treatment intervention you do not believe to be helpful to you. You have a right to know the purpose and nature of any therapeutic intervention as well as the potential risks and benefits as they can be known. You have the right to know the estimated length of treatment as well as alternative treatment procedures or techniques that can be used.

Most psychotherapies involve some kind of reappraisal of you experience and some experimentation with new behavior either on your own or with others who are important to you in you life. I hope that you will be able to use your therapy to reach goals that are agreeable to you!

CONFIDENTIALITY of client information is taken very seriously by me. Communication between a psychologist and client is strictly confidential and protected by the ethics of my profession unless you give your written authorization to the contrary. Legal and ethical exceptions exist.

Your insurance company or third party payer may require your diagnosis, number of sessions, summary of problems and treatment rationale, and possibly other information as part of the conditions of payment. If you are unclear or if this is of concern to you, please do not hesitate to ask me (or your insurance agent as appropriate) for clarification. The client record, including all notes, remains the property of me.

"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. It may be necessary to seek approval for more therapy after a certain number of sessions. Although much can be accomplished in short-term therapy, some patients believe they need more services after insurance benefits end. 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 such as treatment plans or summaries, or copies of your entire Clinical Record. This information will become part of the insurance company files and will probably be stored in a computer. 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 carrier. Signing this form authorizes me to release any and all information requested by your managed care company or insurance carrier for treatment planning, session authorization, and payment for services. I cannot prevent any other practitioner or insurance company from redisclosing information sent to them. Signing this form holds me harmless from their redisclosure.

OFFICE HOURS are kept by appointment. After hours contact may be occasionally necessary for emergency purposes, but calls longer that five (5) minutes are charged at quarter hour increments. Please call between sessions only as necessary and keep calls as brief as possible. My office number is 536-0019. After hours, an answering service will take my calls and contact me or another filling in for me. If you require emergency intervention at times when I am inaccessible, please do not hesitate to contact Helpline (539-1000 or 539-3424), the mental health center (533-1970), or one of the hospital emergency rooms for assistance as needed.

PROFESSIONAL RECORDS. The laws and standards of my profession require that I keep Protected Health Information (PHI) about you in your Clinical Record. Except in unusual circumstances that involve danger to yourself or others, 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. In most situations, I am allowed to charge a copying fee of $1.00 per page (and for certain other expenses). If I refuse your request for access to your records, you have a right of review, which I will discuss with you upon request.

PATIENT RIGHTS. HIPAA provides you with several new or expanded 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.

PATIENTS UNDER 14 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 unless I decide that such access is likely to injure the child, or we agree otherwise. Because privacy in psychotherapy is often crucial to successful progress, particularly with teenagers, it is sometimes my policy to request an agreement from parents that they consent to give up their access to their child's records. If they agree, during treatment, I will provide them only with general information about the progress of the child's treatment, and his/her 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.

BILLING AND PAYMENTS. You will be expected to pay for each session at the time it is held, unless we agree otherwise or unless you have insurance coverage that requires another arrangement. Payment schedules for other professional services will be offered when they are requested. 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, 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. A health insurance policy 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. 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. If it is necessary to clear confusion, I will be willing to call the company on your behalf. Once we have all of the information about your insurance coverage, we will discuss what we 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 my services yourself to avoid the problems described.

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.

_____ _____

(Client) (Date)

_____

(Witness)

STATEMENT OF UNDERSTANDING
CONFIDENTIALITY OF COMMUNICATIONS

The content of client communication will not be released without the expressed written authorization of the client. However, legal and ethical limits to the extent of confidentiality exist.

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 that you provide written advance consent. Your signature on this Agreement provides consent for those activities, as follows:

1. 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 my patient. The other professionals are also legally bound to keep the information confidential. If you don't object, I will not tell you about these consultations unless I believe that it is important to our work together. I will note all consultations in your Clinical Record (which is called "PHI" in my Notice of Psychologist's Policies and Practices to Protect the Privacy of Your Health Information).

2. You should be aware that I practice with other mental health professionals and that I employ administrative staff. In most cases, I need to share protected information with these individuals for both clinical and administrative purposes, such as scheduling, transcription, billing and quality assurance. All of the 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 outside of the practice without the permission of a professional staff member.

3. I also may have contracts with other businesses such as an accounting firm or attorney. 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. If you wish, I can provide you with the names of these organizations and/or a blank copy of this contract.

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

5. 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:

1. 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, you should consult with your attorney to determine whether a court would be likely to order me to disclose information.

2. If a government agency is requesting the information for health oversight activities, I am required to provide it for them.

3. If a patient files a complaint or lawsuit against me, I may disclose relevant information regarding that patient in order to defend myself.

4. If a patient files a worker's compensation claim, I may disclose information relevant to that claim to the patient's employer or the insurer.

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.

1. If I know or suspect that a child under the age of 18 has been abused or neglected, the law requires that I file a report with the appropriate governmental agency, usually the Alabama Department of Human Resources. Once such a report is filed, I may be required to provide additional information.

2. If I know that an elderly or disabled adult has been abused, neglected, exploited, sexually or emotionally abused, the law requires that I file a report with the appropriate governmental agency, usually the Alabama Department of Human Resources. Once such a report is filed, I may be required to provide additional information.

I hereby acknowledge that these limitations on confidentiality have been read by me and/or explained to me and I agree to abide by them.

_____ _____

(Client) (Date)

_____

(Witness)