Fishers Youth Counseling and Psychiatry
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PSYCHOLOGIST-PATIENT SERVICES AGREEMENT

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 new federal law that provides new privacy protections and new 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. 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.

PSYCHOLOGICAL SERVICES

Brief therapy involves goal directed, problem focused treatment. I may use a variety of techniques to address your concerns but, in general, I adhere to evidence based practices that include, but are not limited to cognitive behavioral therapy, brief solution oriented therapy and motivational interviewing techniques. You will also take an active role in setting and achieving your treatment goals. 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. If you ever have questions related to the nature of the treatment I am providing, please do not hesitate to ask.

Risks and Benefits. 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. But there are no guarantees of what you will experience.

Meetings. In general, our first meeting of approximately 60 minutes will consist of an initial assessment. By the end of the assessment, 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. Subsequent therapy sessions are scheduled for 30 to 60 minutes depending on the need to be determined by the psychologist. Therapy sessions will occur at a mutually agreed upon frequency. ***Initial here:*** _____

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 and/or Indiana law. However, in the following situations, no authorization is required:

- If I have reason to believe that a child is a victim of *child abuse or neglect*, the law requires that I file a report with the appropriate government agency, usually the local child protection service. Once such a report is filed, I may be required to provide additional information.

- If I have reason to believe that someone is an *endangered adult*, the law requires that I file a report with the appropriate government agency, usually the adult protective services unit. Once such a report is filed, I may be required to provide additional information.

- If a patient communicates an actual *threat of physical violence* against an identifiable victim, or evidences conduct or makes statements indicating imminent danger that the patient will use physical violence or other means to cause serious personal injury to others, I may be required to disclose information in order to take protective actions. These actions may include notifying the potential victim, contacting the police, or seeking hospitalization for the patient.

- If a patient communicates an *imminent threat of serious physical harm to him/herself*, I may be required to disclose information in order to take protective actions. These actions may include initiating hospitalization or contacting family members or others who can assist in providing protection.

- 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 feel 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).

- If you are involved in a *court proceeding* and a request is made for information concerning the professional services I provided to you, 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.

If such a situation arises, 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.

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. The laws governing confidentiality can be quite complex, and I am not an attorney. In situations where specific advice is required, formal legal advice may be needed. ***Initial here:*** _____

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 that disclosure would physically endanger you and/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 circumstances, I am allowed to charge a copying fee of $0.50 per page. If I refuse your request for access to your records, you have a right of review, which I will discuss with you upon request.

Initial here: _____

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. ***Initial here:*** _____

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 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. ***Initial here:*** _____

PROFESSIONAL FEES

The fee for initial assessments is $200. The fee for psychological testing is $200 per hour. Family therapy sessions are billed at $200 per session. My fee for individual therapy sessions varies by length of time. In addition to therapy appointments, I charge this amount for other professional services you may need, though I will break down the hourly cost if I work for periods of less than one hour. Other services include report writing, telephone conversations lasting longer than 5 minutes, consulting with other professionals with your permission, preparation of records or treatment summaries, and the time spent performing any other service you may request of me. *My scope of practice does not include forensic psychology and I do not solicit business of a legal nature*. 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 costs, even if I am called to testify by another party. Because of the difficulty of legal involvement, I charge $300 per hour for preparation and attendance at any legal proceeding. ***Initial here:*** _____

BILLING AND PAYMENTS

Should you be utilizing your health care benefits to pay for services, you are ultimately responsible for obtaining prior authorization from your insurance carrier though I will provide what assistance I reasonably can. As a courtesy, I will submit a bill to your insurance company on your behalf; however, you (not your insurance company) are responsible for full payment of my fees. You are responsible for co-payments / co-insurance amounts and deductibles as set forth by your benefit plan. You are also responsible for informing me if there is a change in status regarding your health care benefits.

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. Failure to do so may disrupt delivery of services. Payment schedules for other professional services will be agreed to when they are requested. In circumstances of unusual financial hardship, I may be willing to negotiate a fee adjustment or payment installment plan.
Initial here: _____

CANCELLATION / MISSED APPOINTMENT POLICY

Scheduled appointment times are reserved especially for you. If an appointment is missed or canceled with less than 24 hours notice, you will be billed $50 or at the discretion of the psychologist. Your insurance company cannot be billed for fees associated with missed or canceled appointments. If you are a private pay patient, your missed appointment fee is also $50. Repeated missed/canceled appointments may result in termination of services or referral to another practitioner. ***Initial here:*** _____

CONTACTING ME

Due to my work schedule, I am often not immediately available by telephone. When I am unavailable, my telephone is answered by voice mail that I monitor frequently. I will make every effort to return your call within 48 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. If you are unable to reach me and feel that you can't wait for me to return your call, contact your family physician or the nearest emergency room. In the event of a mental health emergency,

you may also contact Community Health Network's 24 hour crisis line at (317) 621-5700. If I will be unavailable for an extended time, I will provide you with the name of a colleague to contact, if necessary. ***Initial here:*** _____

RELEASE OF INFORMATION

I authorize release of information to my Primary Care Physician, other health care providers, institutions and referral sources for the purpose of diagnosis, treatment, consultation and professional communication. If I am an insured client, I further authorize the release of information for claims, certification, case management, quality improvement, benefit administration and other purposes related to my health plan. ***Initial here:*** _____

CONSENT FOR TREATMENT

I authorize and request my practitioner to carry out psychological and/or psychiatric exams, treatment and/or diagnostic procedures which are now, or during the course of treatment become, advisable. I understand the purpose of these procedures will be explained to me upon my request and that they are subject to my agreement. I also understand that while the course of treatment is designed to be helpful, my practitioner can make no guarantees about the outcome of my treatment. ***Initial here:*** _____

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.

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Patient Signature / Date Witness Signature / Date

GENERAL CONSENT FOR DEPENDENT TREATMENT

I am the legal guardian or legal representative of the patient and on the patient's behalf legally authorize the practitioner to deliver mental health services to the patient. I also understand that all policies described in this statement apply to the patient I represent.

_____ _____

Patient Name Patient Date of Birth

_____ _____

Signature of Legal Representative / Date Relationship to Patient