Ruchi Bhargava, Ph.D.
Licensed Psychologist

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Policies and Practice Information

Welcome to my practice! This document contains important information that I am required to share about my professional services and business policies. Please read it carefully and make note of any questions you might have so that we can discuss them when we meet. When you sign this document, it will represent an agreement between us.

Psychological Services

You have chosen to receive psychotherapy and/or evaluation services for the purpose of improving your and/or your family's life. I provide psychotherapy to elementary school-age children, teens, and adults. The services I offer include individual therapy, couples therapy, family therapy, and group therapy. Psychotherapy has both benefits and risks. There is no guarantee in therapy. You may experience more emotional pain while working on deep issues. The therapy work is intended to increase insight and improve quality of life. All issues will be addressed with utmost care, respect and honesty.

The treatment process will begin with 1-3 sessions devoted to an initial intake. We will discuss questions you may have about my practice, and I will gather background information about you and/or your family. During the intake, we will also discuss ways to treat the primary issue(s) that prompted you to seek out therapy. Together we will formulate a treatment plan. You have the right and the obligation to participate in treatment decisions and in the development and periodic review and revision of your treatment plan. You also have the right to refuse any recommended treatment or to withdraw consent for treatment and to be advised of the potential consequences of such refusal or withdrawal. I will also consider whether I believe I am the right therapist for you; if not, I will give you referrals to others who may be better suited to help you.

Termination

I will attempt to contact you after your first missed appointment to reschedule. If you do not attend our sessions for two weeks in a row with no communication about the absences within the two weeks, I will remove you from the schedule. I will close your treatment file if you haven't communicated with me in 90 days. You are welcome to resume regular therapy sessions later. Should you decide to terminate therapy, I request that we have a final termination session to review your progress and to complete the treatment process.

Professional Fees (in-person and virtual – same fee)

- The fee for individual session (50 minutes) is $150
- The fee for couples therapy (60 minutes) is $170
- The fee for family therapy (60 minutes) is $170
- Extended couples/family therapy (75 minutes) is $190
- Extended couples/family therapy (90 minutes) is $210
- Additional professional services will be billed on a prorated basis of my session fee. These services may include report writing, phone calls longer than 15 minutes, completion of forms for treatment purposes. I will let you know if I will need to charge for the time involved at a rate of $80/hr (prorated). In addition, I am happy to attend school or other meetings pertaining to your child; my involvement in such meetings is billed at the rate of $170/hr (prorated, including travel time).

Payments

Payment is due at the time of service and may be paid using a major credit card, HSA credit card, cash or check (made payable to DARA Psychological Services, LLC).

You must cancel appointments at least 24 hours in advance to avoid being charged in full for the session. The late cancellation charge may be waived if we are able to reschedule your missed session for another time within the same week, but I cannot guarantee my availability. You will not be charged for late cancellations related to personal emergencies or unexpected illness. In the event of inclement weather, I am available to provide telehealth services using a secure HIPPA-compliant platform.

If a check of yours is returned by the bank for insufficient funds, you will be responsible for reimbursing any bank fees charged to my account for your returned check. 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 hiring a collection agency or an attorney to secure the payment. If such legal action should become necessary, its costs would be included in the claim. In addition, this process would require me to disclose otherwise confidential information. In most collection situations, the only information I release is the client's name, the nature of services provided, and the amount due.

Insurance

I am credentialed with Carefirst BCBS and will seek reimbursement accordingly.

For all other insurance companies, I am considered an out-of-network provider for insurance purposes. I can provide a superbill for you to file with your insurance company for reimbursement for out-of-network services. Not all insurance companies reimburse for out-of-

network providers; I encourage you to check with your insurance company to find out your benefits and responsibilities. You are responsible for the payment of services and submitting the bill for reimbursement. A superbill is not a guarantee of reimbursement. By signing this agreement, you are indicating that (1) you agree to pay for all services at the time they are rendered, (2) you understand that you may or may not be eligible to receive insurance reimbursement, and (3) I have no knowledge regarding your reimbursement eligibility.

Please be aware that if you choose to provide the superbill receipt for services to your insurance company, it must include a psychiatric diagnosis. In that event, I will inform you about the diagnosis that I plan to render before it is given. Any diagnosis made will become part of your permanent insurance records. In addition, you should also be aware that your contract with your health insurance company requires that I provide them with information relevant to the services that I provide to you if you submit claims. The state of Maryland permits me to send some information without your consent in order to file appropriate claims. I will inform you of any information that I need to send to your insurance company for treatment purposes. By signing this Agreement, you agree that I can provide requested information to your insurance carrier.

HIPAA

The Health Insurance Portability and Accountability Act (HIPAA) is a federal law that mandates privacy requirements and client rights pertaining to the use and disclosure of Protected Health Information in connection with treatment, payment, and health care operations. While I am not a covered entity, I take HIPAA guidelines into consideration when determining appropriate privacy practices and the protection of your personal health information.

Client Rights Including Confidentiality

At any time you may ask questions about the process and the course of therapy and/or refuse therapeutic or diagnostic procedures or methods. I expect that questions about the methods, effectiveness, and duration of therapy will be raised by both of us at regular intervals during the course of treatment in order to evaluate progress, make adjustments, and decide when to end your therapy. You are encouraged to discuss these topics and are reminded that you may end treatment at any time. You may also seek a second opinion if you wish to do so.

I treat the information you share with me with the greatest respect. The confidentiality of our conversations and my records are protected by standards for professional practice established in the Ethical Principles of Psychologists of the American Psychological Association and by specific Maryland state law governing privilege and confidentiality.

In most situations, I can only release information about your treatment to others if you sign a written Authorization form. However, there are some circumstances in which no authorization is required. Federal Law (HIPAA) specifies these circumstances. As you will see below, the Federal requirements are aimed at protecting the rights of clients and psychologists, and in some cases, the community at large. Most of them reflect the legal and ethical responsibility of a

psychologist to take action to protect endangered individuals from harm when such a danger exists. Fortunately, such situations are rare. If a crisis of this sort should occur, it is my policy to discuss these matters fully with you before taking any action, unless in my professional judgement there are compelling reasons not to do so. Confidentiality will be respected in all cases, except as noted below:

- 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-client privilege law. I cannot provide any information without your 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 a government agency is requesting the information for health oversight activities, I may be required to provide it for them.
    - Being subject to a subpoena issued by a court for my records (a judge may order my testimony if he/she/they determined that the issues demand it, and I must comply with that court order).
- If a client files a complaint or lawsuit against me, I may disclose relevant information regarding that client in order to defend myself.
- If health insurers require disclosures or it is necessary to collect overdue fees, I may disclose relevant information as specified elsewhere in this agreement.

There are situations in which I am legally obligated to take action to protect others from harm. In certain situations, I am not legally able to maintain confidentiality. Situations where confidentiality will be limited or revoked include:

- If I have reason to believe that a child or vulnerable adult has been subjected to abuse or neglect – including my becoming aware of marks/bruises on a child's body inflicted by an adult – or that a vulnerable adult has been subjected to self-neglect, or exploitation, the law requires that I file a report with the appropriate government agency, usually the local office of the Department of Social Services. Once a report is filed, I may be required to provide additional information.

- If I know that a client has a propensity for violence and the client indicates the intention to inflict imminent physical injury upon a specified victim(s), I am required to take protective actions. These actions may include establishing and undertaking a treatment plan that is calculated to eliminate the possibility that the client will carry out the threat such as seeking hospitalization of the client and/or informing the potential victim or the police about the threat.

- If I believe that there is an imminent risk that a client will inflict serious physical self-harm or death, or that immediate disclosure is required to provide for the client's emergency health care needs, I am required to take appropriate protective actions, including initiating hospitalization and/or notifying family members or others who can protect the client.

If such a situation arises, I will make every effort to discuss it with you before taking any action and I will limit my disclosure to what is necessary.

With the exception of situations in which I am legally required to breach confidentiality, you agree that I may use my professional judgment to determine what is and what is not shared with parents of child/minor clients. This allows minors (particularly adolescents) to participate in therapy without feeling at risk of having their personal information shared with parents. This creates a private, therapeutic environment, and offers a respectful attitude toward my minor clients. I welcome any questions or concerns about this aspect of my practice.

In the event of my unplanned absence from practice, whether due to injury, illness, death, or any other reason, I maintain a detailed Professional Will with instructions for an Executor to inform you of my status and ensure your continued care in accordance with your needs. Please let me know if you would like the names of my Executor and Secondary Executor. You authorize the Executor and Secondary Executor to access your treatment and financial records only in accordance with the terms of my Professional Will, and only in the event that I experience an event that has caused or is likely to cause a significant unplanned absence from practice.

While this written summary of exceptions to confidentiality should help to inform 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; in situations where specific advice is required, formal legal advice may be needed.

Professional Records

I am required by State law and HIPAA regulations to maintain a record of your treatment for a certain period of time after treatment has ended. Please reach out with any questions you may have about this. To release a copy of the records, your written consent or the written consent of a legal guardian is required. Clients under 18 years of age who are not emancipated and their parents should be aware that the law allows parents to examine their child's treatment records. While privacy in psychotherapy is very important, particularly with teenagers, parental involvement is often essential to successful treatment. I will provide parents with a summary of their child's treatment if requested. If I feel that the child is in danger or is a danger to someone else, I will notify the parents of my concerns. Before giving parents any information, I will attempt to discuss the matter with the minor client, if possible, and do my best to handle any objections they may have.

Communication and Emergencies

I am often not immediately available by telephone. I return all calls within 24-48 hours. If you are unable to reach me and feel that you cannot wait for me to return your call and it is an emergency, go to the nearest emergency room or dial 911. I can be reached by phone at (301) 363-1288 or by e-mail at drbhargava6@gmail.com. The privacy of e-mails to this address cannot be guaranteed. I use email communication and text messaging only with your permission and only for administrative purposes. These forms of communication should be limited to setting and changing appointments, billing matters and other related issues.

Social Media

I do not communicate with, or contact, any of my clients through social media platforms like Twitter, Facebook, or Instagram. In addition, if I discover that I have accidently established an online relationship with you, I will cancel that relationship.

Consent To Treat

I, _____, consent to my/my child's participation in psychotherapy services with Ruchi Bhargava, Ph.D., and I agree to the policies of her practice as detailed in the above paragraphs. I understand that services will be rendered in a professional manner, consistent with accepted ethical standards. I am aware that if psychotherapy services are not rendered in a professional and ethical manner, I may file a complaint with the Maryland State Board of Examiners of Psychologists.

I have read this agreement and agree to its terms. The contents of this documents have been satisfactorily explained to me, and I have had the opportunity to ask questions and clarify my understanding of these policies. I have been provided a copy of this agreement.

Whenever possible, I prefer to have both parents' signatures in the case of minor clients. Both parents must sign their consent to treatment of a minor if parents are in the process of separating, or are separated/divorced and have joint legal custody.

_____ _____

Client or, in case of minor, Parent/Guardian *(print name)* Client or, in case of minor, Parent/Guardian *(print name)*

_____ _____

Client or, in case of minor, Parent/Guardian *(signature)* Client or, in case of minor, Parent/Guardian *(signature)*

_____ _____

Date Date

_____ _____

Ruchi Bhargava, Ph.D. Date