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## PSYCHOTHERAPIST-PATIENT SERVICES AGREEMENT

Welcome to my practice. This Agreement contains important information about my professional services and business policies. When you sign this document, it will also represent an agreement between us. You may revoke this Agreement in writing at any time. In addition, The Health Insurance Portability and Accountability Act, a new federal law, requires that I provide you with a Notice of Privacy Practices and that I obtain your signature acknowledging that I have provided you with this information. Those Privacy Practices appear at the end of this document and constitute a part of this agreement and you will receive a copy at the end of our first session.

### Psychological Services

Psychotherapy is not easily described in general statements. It varies depending on the personalities of the psychotherapist and patient and 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. But there are no guarantees of what you will experience.

If you have questions about my procedures, we can discuss them whenever they arise.

### Sessions

Each individual session lasts 60 minutes; couples sessions are 90 minutes. If you are late for a session, that time is lost from your session. If I am late for a session, we will extend the session if you are willing to do so or we will make other arrangements by mutual consent. **Please note that both members of the couple are needed for a couples' session to take place so if your partner can't come, this will be treated like any other cancellation.**

### Professional Fees

Current fees are as follows:

$ 250 for 60 minute sessions for individuals
$ 300 for 60-minute sessions for couples
$ 350 for 75 minute sessions
$ 400 for 90 minute sessions – required for initial couples session

You are responsible for payment for each therapy session at the time of the session by cash, check or credit card. I do not participate in health insurance programs however I will provide you with an invoice with all the information needed should you wish to file a claim directly with the insurance company. It is <u>your</u> responsibility to contact your insurance company to determine if authorization for treatment is required and to communicate that requirement to me in writing.

**I am not a Medicare provider and therefore my services are not covered by Medicare.** Should you want services from me and you are a Medicare recipient, this will serve as a separate private contract so that you may pay me out of pocket. Under this circumstance, you understand that you (or your beneficiaries or legal representatives) are waiving the right to submit claims or be reimbursed by Medicare for any services I provide that would otherwise be covered by Medicare if there was no private contract and a proper claim was submitted. You have every right to obtain similar services from a provider who has not opted out of Medicare. You understand that Medigap does not pay for services not covered by Medicare. The period of this agreement will be 2 years from the time of signature. This language is legalese required of me by Medicare guidelines!

A fee of $60 per quarter hour is also billed for services such as telephone calls not related to scheduling, special reports, and collateral consultation. You are responsible for payments whether they are requested by you or necessitated by some other process.

During the course of treatment, it may become necessary to increase fees. Fees are reviewed in January and June of each year.

It is my policy not to become involved in legal proceedings and will not testify for clients involved in divorce proceedings. 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 $900 per hour for preparation and attendance at any legal proceeding.]

## Missed Appointments

Since a time slot is reserved for you that cannot be offered to anyone else, **you will be charged for all missed appointments not cancelled 48 hours in advance.** I ask that you keep a credit card on file even if you intend to pay by check. Fees for any appointments, including missed ones that have not been paid for by the end of the calendar month in which it occurred will be charged to that credit card.

Please note my **snow policy:** On days when Montgomery County Schools are late or closed, **I will be in the office unless I call you.** If you cannot make it to the appointment for weather reasons, please call or email me by 8:00 a.m. (301-943-3074 or joanne@the-chrysalis-group) and I will waive the 48 hour cancellation fee.

## Contacting Me

Due to my work schedule, I am often not immediately available by telephone. While I am usually in my office between 9 AM and 5 PM, I will not answer the phone when I am with a patient. When I am unavailable, my telephone is answered by voice mail that I monitor frequently. 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 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 and ask for the psychologist or psychiatrist on call. If I will be unavailable for an extended time, I will provide you with the name of a colleague to contact, if necessary.
It is very important to be aware that computers and email and cell phone communication can be relatively easily accessed by unauthorized people and hence can compromise the privacy and confidentiality of

such communication. I will assume that you have made an informed decision, will view it as your agreement to take the risk that such communication may be intercepted, and s/he will honor your desire to communicate on such matters via email and texts. Please do not use email or text for emergencies. Due to computer or network problems, emails and texts may not be deliverable, and I may not check my emails or texts frequently.

## Confidentiality & 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 is reasonably likely to endanger the life or physical safety of you or another person, you may examine and/or receive a copy of your Clinical Record, if you request it in writing. In those situations, you have a right to a summary and to have your record sent to another mental health provider. 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. Please refer to the Notice of Privacy Practices for further details.

There are some circumstances for which disclosure is required by the law. These include: when there is a reasonable suspicion of child, dependent or elder abuse or neglect; when a client presents a danger to self, to others, to property, or is gravely disabled or when client's family member/s communicate to the therapist that the client presents a danger to others.

For the purposes of emergencies only, should I be unable to perform my professional duties, my business partner Jude Marston, LCSW will contact you to make any arrangements necessary.

## Minors & Parents

Patients under 16 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. While privacy in psychotherapy is very important, particularly with teenagers, parental involvement is also essential to successful treatment. At times I may request an agreement from a patient between 16 and 18 and his/her parents allowing me to share general information about the progress of treatment and their child's attendance at scheduled sessions. 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 & Payments

You will be expected to pay for each session at the time it is held. 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 charging a late payment fee of 10% of the unpaid balance monthly and may use 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.]

# NOTICE OF PRIVACY PRACTICES

*This notice describes how psychological and medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.*

**Uses and Disclosures for Treatment, Payment, and Health Care Operations**

I may use or disclose your protected health information (PHI), for treatment, payment, and health care operations purposes with your written authorization. To help clarify these terms, here are some definitions:

- **PHI** refers to information in your health record that could identify you.
- "**Treatment, Payment, and Health Care Operations"**
- **Treatment** is when I provide, coordinate, or manage your health care and other services related to your health care. An example of treatment would be when I consult with another health care provider, such as your family physician or another psychologist.
- **Payment** is when I obtain reimbursement for your healthcare. Examples of payment are when I disclose your PHI to your health insurer to obtain reimbursement for your health care or to determine eligibility or coverage.
- **Health Care Operations** are activities that relate to the performance and operation of my practice. Examples of health care operations are quality assessment and improvement activities, business-related matters such as audits and administrative services, and case management and care coordination.
- **Use** applies only to activities within my office, such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.
- **Disclosure** applies to activities outside of my office, such as releasing, transferring, or providing access to information about you to other parties.
- **Authorization** is your written permission to disclose confidential mental health information. All authorizations to disclose must be on a specific legally required form.

**Other Uses and Disclosures Requiring Authorization**

I may use or disclose PHI for purposes outside of treatment, payment, or health care operations when your appropriate authorization is obtained. In those instances when I am asked for information for purposes outside of treatment, payment, or health care operations, I will obtain an authorization from you before releasing this information. You may revoke all such authorizations at any time, provided each revocation is in writing. You may not revoke an authorization to the extent that I have relied on that authorization or, if the authorization was obtained as a condition of obtaining insurance coverage, law provides the insurer the right to contest the claim under the policy.

I will also obtain an authorization from you before using or disclosing:

- PHI in a way that is not described in this Notice.
- Psychotherapy notes

**Uses and Disclosures Without Authorization**

I may use or disclose PHI without your consent or authorization in the following circumstances:

- *Child Abuse* – If I have reason to believe that a child has been subjected to abuse or neglect, I must report this belief to the appropriate authorities.

- *Adult and Domestic Abuse* – I may disclose protected health information regarding you if I reasonably believe that you are a victim of abuse, neglect, self-neglector exploitation.
- *Health Oversight Activities* – If I receive a subpoena from the Maryland Board of Examiners of Psychologists because they are investigating my practice, I must disclose any PHI requested by the Board.
- *Judicial and Administrative Proceedings* – If you are involved in a court proceeding and a request is made for information about your diagnosis and treatment or the records thereof, such information is privileged under state law, and I will not release information without your written authorization or a court order. The privilege does not apply when you are being evaluated or a third party or where the evaluation is court ordered. You will be informed in advance if this is the case.
- *Serious Threat to Health or Safety* – If you communicate to me a specific threat of imminent harm against another individual or if I believe that there is clear, imminent risk of physical or mental injury being inflicted against another individual, I may make disclosures that I believe are necessary to protect that individual from harm. If I believe that you present an imminent, serious risk of physical or mental injury or death to yourself, I may make disclosures I consider necessary to protect you from harm.
- When the use and disclosure without your consent or authorization is allowed under other sections of Section 164.512 of the Privacy Rule and the state's confidentiality law. This includes certain narrowly-defined disclosures to law enforcement agencies, to a health oversight agency (such as HHS or a state department of health), to a coroner or medical examiner, for public health purposes relating to disease or FDA-regulated products, or for specialized government functions such as fitness for military duties, eligibility for VA benefits, and national security and intelligence.

**Your Health Information Rights**

- **Right to Request Restrictions** – You have the right to request restrictions on certain uses and disclosures of protected health information. However, I am not required to agree to a restriction you request.
- **Right to Receive Confidential Communications by Alternative Means and at Alternative Locations** – You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations. (For example, you may not want a family member to know that you are seeing me. On your request, I will send your bills to another address.)
- **Right to Inspect and Copy** – You have the right to inspect or obtain a copy (or both) of PHI in my mental health and billing records used to make decisions about you for as long as the PHI is maintained in the record. I may deny your access to PHI under certain circumstances, but in some cases you may have this decision reviewed. At your request, I will discuss with you the details of the request and denial process.
- **Right to Amend** – You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. I may deny your request. At your request, I will discuss with you the details of the amendment process.
- **Right to an Accounting** – You generally have the right to receive an accounting of disclosures of PHI. At your request, I will discuss with you the details of the accounting process.
- **Right to a Paper Copy** – You have the right to obtain a paper copy of the notice from me upon request, even if you have agreed to receive the notice electronically.

- **Right to Restrict Disclosures When You Have Paid for Your Care Out-of-Pocket.** You have the right to restrict certain disclosures of PHI to a health plan when you pay out-of-pocket in full for my services.
- **Right to Be Notified if There is a Breach of Your Unsecured PHI.** You have a right to be notified if: (a) there is a breach (a use or disclosure of your PHI in violation of the HIPAA Privacy Rule) involving your PHI; (b) that PHI has not been encrypted to government standards; and (c) my risk assessment fails to determine that there is a low probability that your PHI has been compromised.

**Our responsibilities**

- I am required by law to maintain the privacy of PHI and to provide you with a notice of my legal duties and privacy practices with respect to PHI.
- I reserve the right to change the privacy policies and practices described in this notice. Unless I notify you of such changes, however, I am required to abide by the terms currently in effect.
- If I revise my policies and procedures, I will provide that to you by mail or in person.

**Breach Notification Addendum to Policies & Procedures**

- When the Practice becomes aware of or suspects a breach, as defined in Section 1 of the breach notification Overview, the Practice will conduct a Risk Assessment, as outlined in Section 2.A of the Overview. The Practice will keep a written record of that Risk Assessment.
- Unless the Practice determines that there is a low probability that PHI has been compromised, the Practice will give notice of the breach as described in Sections 2.B and 2.C of the breach notification Overview.
- The risk assessment can be done by a business associate if it was involved in the breach. While the business associate will conduct a risk assessment of a breach of PHI in its control, the Practice will provide any required notice to patients and HHS.
- After any breach, particularly one that requires notice, the Practice will re-assess its privacy and security practices to determine what changes should be made to prevent the re-occurrence of such breaches.

**To receive additional information or report a problem**

If you have questions about this notice, disagree with a decision I make about access to your records, or have other concerns about your privacy rights, you may contact Dr. Joanne Irving of the Chrysalis Group. If you believe that your privacy rights have been violated and wish to file a complaint with our office, you may send your written complaint care of Dr. Joanne Irving, including your preferred method of contact. You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services. The person listed above can provide you with the appropriate address upon request.
You have specific rights under the Privacy Rule. I will not retaliate against you for exercising your right to file a complaint.

This notice will go into effect on October 1, 2013.

I reserve the right to change the terms of this notice and to make the new notice provisions effective for all PHI that I maintain. Should this occur, a revised notice will be posted in my office and a copy will be available to you if you so request.

Your signature below indicates that you have received a copy of my **Psychologist - Patient Services Agreement** including the **Notice of Privacy Practices** regarding practices to protect the privacy of your PHI, and agree to abide by its terms during our professional relationship.

_____ _____

Client or Responsible Party Signature Date

_____

Printed Name

_____

Address for Billing, Office Correspondence Street
(This authorizes me, to send identifying information to this address).

_____

city, state, zip code

_____

Phone Number(s) for Office Contact
(This authorizes me to contact you at this number(s), and I will leave my first name and a number for return contacts from you. This includes leaving messages on answering machines or voice mail. Please **DO NOT** include numbers where you prefer not to be contacted or have messages left for you).

_____

E-Mail Address for Office Contact
(only by previous agreement with my clinician and be advised I do not check email regularly or use it as a primary source of contact).

## Patient Agreement and Credit Card Authorization

All session charges are based on the fee schedule and as specified in the Patient Agreement.

Payment in full is due at the end of each session. We accept payments via cash, check, or credit card. Clients who choose to pay by check should make checks payable to The Chrysalis Group. You may choose any payment option at any appointment. Please note that a $25 fee applies for all returned checks.

*Regardless of the chosen method of payment, we collect credit card information from all clients to have on file as a backup method of payment.*

**Credit Card Authorization:** Credit card payments are processed within three business days of the session and will appear on your credit card statement as The Chrysalis Group. This authorization will expire upon termination of therapy and when your account with Chrysalis is settled.

Cardholder's Name _____

Type of card: ☐ Visa ☐ MasterCard

Credit card number: _____

Expiration date: _____ / _____ DVV Number (3 digit code on back)_____

Cardholder's Billing Address _____

_____

My signature below indicates that I understand the above policies and authorize The Chrysalis Group to charge this credit card in payment for therapy sessions. I understand that this card will be charged automatically, unless I specify that I prefer to pay via cash or check.

_____

Signature of card holder Date

*As per the contract, clients are charged the full fee for appointments not cancelled 48 hours in advance. Fees are adjusted on a yearly basis in July and January.

## *Taping Consent Form
### Consultation – for Client and Therapist Benefit

Therapists regularly require consultation of their work for their own ongoing professional development and to enhance their work with their clients. It is very useful to use tapes for consultation with a qualified training professional. Tapes and discussions are treated with the utmost confidentiality and are never to be used for other purposes, such as presentations or publicity, without the express prior consent of the client(s). Consultation is sometimes held individually or in a consultation group.

We authorize Joanne B Irving, Ph.D.to [ ] video and/or [ ] audio tape our therapy sessions for the purpose of enhancing our work together sometimes by using the tape for consultation as stated above in the introduction. All tapes will be used only within the context of professional consultation and will never be used in a public setting.

Client signature _____

Client signature _____

Therapist signature _____

Date _____

*This is not a requirement for being in therapy with me, but it has the potential for greatly enhancing our work together. Most often I use the tapes to review certain portions of the session to see if I can improve my interventions and be more helpful to you.