THE CHRYSALIS GROUP INC.

Judy Wendkos Liss, LCSW-C

4405 East West Highway • Suite 301 • Bethesda, Maryland 20814 • 301·652·1582 • Fax 301·718·8338

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 (HIPAA), 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. You will receive a copy to keep 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 either **45 or 60** minutes and family sessions are **60-80** 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.

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 24 hours in advance.

Please note my snow policy: I do not follow Montgomery County's snow policy. Unless you hear from me in the morning, I will assume that we will be meeting. If you cannot make it to the appointment for weather reasons, please call or email me by 8:00 a.m. (301-652-1582 or judy@the-chrysalis-group.com) and I will waive the 24-hour cancellation fee.

If you do not reschedule an appointment within one month of our last session, I will assume that you have decided to discontinue treatment with me. Please be assured that you are always welcome to return regardless of how much time has lapsed since our last session.

PROFESSIONAL FEES

Please confirm current fees with therapist:

_____for 45-minute sessions

_____for 60-minute sessions

_____ for 75-minute sessions

Additional time is billed at $50 per quarter hour. These fees are also billed for services such as telephone calls not related to scheduling, special reports, and collateral consultation. 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 your responsibility to contact your insurance company to determine if an authorization for treatment is required and to communicate that requirement to me.**

Please note, 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!

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

If you become involved in legal proceedings that require my participation, you will be expected to pay for all of my professional time and expenses, including preparation costs, transportation costs, and attorney's fees, even if I am called to testify by another party. My professional time related to these activities is $350 per hour.

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 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. If you communicate confidential or private information via email or text, 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 will honor your desire to communicate on such matters via email

or text. 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 faxes frequently.

CONFIDENTIALITY AND PROFESSIONAL RECORDS

There are some circumstances in which disclosure is required by law. These include: when there is a reasonable suspicion of child, dependent or elder abuse or neglect; where 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.

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 and conditions of confidentiality. For purposes of emergencies only, should I be unable to perform my professional duties, my colleagues Dr. Joanne Irving or Jude Marston, LCSW-C, will contact you to make any arrangements necessary.

MINORS & PARENTS

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. In cases where a child whose parents are currently separated or divorced and the parents have joint custody, both parents are required to consent for the child's treatment.

BILLING AND PAYMENTS

You will be expected to pay for each session at the time it is held, unless we agree otherwise. 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, the costs for taking such action will be included in the collection claim.]

THE CHRYSALIS GROUP INC.

4405 East West Highway • Suite 301 • Bethesda, Maryland 20814 • 301·652·1582 • Fax 301·718·8338

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 September 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.

THE CHRYSALIS GROUP INC.

Judy Wendkos Liss, LCSW-C

4405 East West Highway • Suite 301 • Bethesda, Maryland 20814 • 301· 652·1582

Signature Page

Your signature below indicates that you have received a copy of the Psychotherapist-Patient Services Agreement and the Notice of Privacy Practices Forms and agree to abide by the terms during our professional relationship.

_____ _____

Client or Responsible Party Signature Date

_____

Printed Name of Signature

_____

Printed Name of Client, if a minor

_____

_____

Address for Billing, Office Correspondence

(This authorizes me to send identifying information to this address).

_____

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).

Please be advised that **NO** e-mail correspondence is considered confidential and may be recovered by other parties at any time. **You may lose your right to confidentiality by corresponding with me by e-mail and by receiving correspondence from me by e-mail.**

_____

Signature regarding approval of receiving e-mail from me knowing limits of confidentiality.

Office Use Only
Diagnosis: _____

Updated 11/2/2017

THE CHRYSALIS GROUP INC.

Judy Wendkos Liss, LCSW-C

4405 East West Highway • Suite 301 • Bethesda, Maryland 20814 • 301· 652·1582

PAYMENT AGREEMENT AND CREDIT CARD AUTHORIZATION

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

- $_____ per 45-minute session*
- $ _____ per 60-minute session*
- $ _____ per 75-minute session*
- $_____ per 90-minute session*

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 Inc**. You may choose any payment option at any appointment. Please note that a $35 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. This will be stored securely and not retained on this form.

Client Name: _____

Email Address: _____

My signature below indicates that I have read and understand the **Psychotherapist-Patient Services Agreement** and the **Notice of Privacy Practices** regarding practices to protect the privacy of my PHI, and that I agree to abide by its terms during our professional relationship. I authorize The Chrysalis Group to charge this credit card in payment for therapy sessions. I understand The Chrysalis Group will charge this credit card automatically, unless I specify that I prefer to pay via cash or check.

_____ _____

Signature of Cardholder Date

For office use only:

Dx Code: _____

Credit Card Authorization: Credit card payments 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 ☐ Amex

Credit card number: _____

Expiration date:_____/ _____

***As per the contract, clients are charged the full fee for appointments not cancelled at least 24 hours in advance.**

Updated Updated 11/2/2017