

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

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 (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 **45-60** minutes; couples and family sessions are **60** 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.

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: On days when Montgomery County

Schools are closed or are closing early, the office will be closed unless I call you and we agree to an alternate arrangement.

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

Current fees are as follows: _____ for 45 to 50-minute sessions
_____ for 60-75 minute sessions
_____ for 90-minute sessions

Additional time is billed at _____ 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 payments whether they are requested by you or necessitated by some other process. **Please note that I am not a Medicare provider and do not accept payment for services from that program or any other HMO, managed care, or insurance companies. It is your responsibility to contact your insurance company to determine if a preauthorization for treatment is required and to communicate that requirement to me.**

During the course of treatment, it may become necessary to increase fees. Such increases will be limited to no more than 5% in any calendar year. 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, including preparation and transportation costs, even if I am called to testify by another party. [Because of the difficulty of legal involvement, I charge \$500 per hour for preparation and attendance at any legal proceeding.]

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.

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.

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.

BILLING AND PAYMENTS

You will be expected to pay for each session at the time it is held, unless we agree otherwise or you have insurance coverage that requires another arrangement. Payment schedules for other professional services will be agreed to 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.]

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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.

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.

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.

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.

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.

Effective Date, Restrictions, and Changes to Privacy Policy

This notice will go into effect on May 1, 2003.

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.

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Signature Page

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

Client or Responsible Party Signature

Date

Printed Name

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.



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OPTIONAL: CREDIT CARD AUTHORIZATION

By signing below, I authorize The Chrysalis Group to charge my credit card for any services not paid for at the time services were rendered, as follows:

- \$_____ per 45-50 minute session*
- \$_____ per 60-75 minute session*
- \$_____ per 90 minute session*
- \$_____ Copayment per session
- \$_____ Owed on account balance
- \$_____ Other agreed upon services such as extended phone calls, collateral consultation, etc.

_____ MC _____ VISA

Card # _____ Exp. date _____

Signature _____

Name (printed): _____

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