

## Psychologist-Patient Services Agreement

Welcome to my practice. This document contains important information about my professional services and business policies. Please read it carefully and ask about any aspects that are not clear to you. Your signature attests that you understand your rights and responsibilities and agree to them. You may revoke this Agreement in writing at anytime, unless 1) I have already taken action in reliance on it, 2) your health insurance company imposes obligations on me in order to process or substantiate claims, 3) or if you have not satisfied any financial obligations you have incurred.

### **Risks and Benefits of Psychotherapy:**

Psychotherapy can have benefits and risks. Since therapy often involves discussing unpleasant aspects of your life, you may experience uncomfortable feelings like sadness, anxiety, guilt, anger, frustration. You may experience changes in your relationships

On the other hand, psychotherapy has been shown to have many benefits. Therapy often leads to better and more satisfying relationships, solutions to specific problem, and significant reductions in feelings of distress. But there are no guarantees of what you will experience or what specific results may occur. Nonetheless, you are strongly encouraged to discuss any concerns you have about your experience in therapy and effectiveness of the treatment plan.

### **Initial Evaluation and Sessions:**

I normally conduct an evaluation that will last from one to three sessions. During this time, we can both decide if I am the best person to provide the services you need in order to meet your treatment goals. Once we agree to work together, I will schedule sessions at a time and frequency we agree on.

### **Professional Fees and Payment:**

You are expected to pay for each session by *check or cash at the beginning of each session*, unless we agree otherwise. Receipts will be provided (if desired) at the end of each month. Please note that I charge \$35 for any check returned to me due to insufficient funds.

Payment schedules for other professional services will be discussed when they are requested. I do not charge for routine phone calls or routine paperwork required for insurance reimbursement and access of benefits. However, there may be additional fees for professional time requested of me above and beyond what is usually required. Such activities might include preparation of records or treatment summaries, more extensive consultation with other professionals or insurance companies, or frequent and/or more lengthy telephone calls.

**Cancellation Policy:**

Once an appointment is scheduled, please give a minimum of **24 hours advanced notice** if you need to cancel. Otherwise, you will be responsible for payment of the full fee (not just the co-payment) as insurances do not reimburse for cancelled sessions. Occasionally I am able to fill your time, or find another time you can come within the same week; in that event, you will not be charged.

**Health Insurance:**

If you use health insurance to help pay for your sessions, ***you are responsible for verifying and understanding the limits of your coverage, as well as any co-payments and deductibles.***

You should also be aware that most insurance companies require the release of clinical information, including, but not limited to, dates of service, diagnoses, treatment plans, and outcome. Signing this document gives me ***permission to release to your insurance company*** the information needed to obtain payment for my services.

Although I will fill out the necessary forms and provide the necessary information that will help you receive the benefits to which you are entitled, it is important to be aware that ***you (not your insurance company) are responsible for the full payment of my fees.*** If problems in reimbursement arise, it is your responsibility to call your carrier in order to address the problem. If during the course of treatment, your insurance ceases to cover your sessions, you have the option of continuing treatment with me on a self-pay basis.

In the extremely rare instance in which your account has not been paid for more than 90 days (most likely due to problems in insurance reimbursement), 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.

**Contacting Me:**

I am often not immediately available by telephone. When I am unavailable, my telephone is answered by voice mail that (only) I monitor frequently. I will make every effort to return your call within 24 hours, with the exception of weekends and holidays. It helps if you clearly state your telephone number (even if you think I have it) and when you can best be reached. ***If you feel in crisis and are either unable to reach me or feel that you can't wait for me to return your call, please contact your family physician or nearest emergency room and ask for the mental health crisis worker 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.

### **Limits On Confidentiality:**

The privacy of all communications between patient and psychologist is of primary importance in the psychotherapy process and is protected by law; ***I can only release information about our work to others with your written permission (an authorization form that meets certain legal requirements imposed by HIPAA and/or Illinois Law).***

There are some situations, unusual in my practice, in which I am legally obligated to take actions, which I believe are necessary to attempt to protect others from harm and I may have to reveal some information about a patient's treatment. If such a situation were to arise, 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.

- If I have reasonable cause to believe that a ***child under 18*** known to me in my professional capacity may be an ***abused child or a neglected child***, the law requires that I file a report with the local office of the Department of Children and Family Services, and possibly provide additional information.
- If I have reason to believe that an ***adult over the age of 60*** living in a domestic situation has been ***abused or neglected*** in the preceding 12 months, the law requires that I file a report with the agency designated to receive such reports by the Department of Aging. Once such a report is filed, I may be required to provide additional information.
- If you have made a ***specific threat of violence against another*** or if I believe that you present a clear, imminent risk of serious physical harm to another, 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 your hospitalization.
- If I believe that you present a ***clear, imminent risk of serious physical or mental injury or death to yourself***, I may be required to disclose information in order to take protective actions. These actions may include seeking your hospitalization or contacting family members or others who can assist in protecting you.

There are other situations that also do not require authorization:

- 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 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.)
- ***Disclosures required by health insurers*** or to collect overdue fees are discussed elsewhere in this Agreement.
- 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-patient privilege law. I cannot disclose any information without 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.
- If a patient files a complaint or lawsuit against me, I may disclose relevant information regarding that patient in order to defend myself.
- If you file a worker's compensation claim, and I render treatment or services in accordance with the provisions of Illinois Workers' Compensation law, I must, upon appropriate request, provide a copy of your record to your employer or his/her appropriate designee.

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.

**Professional Records:**

The laws and standards of my profession require that I keep Protected Health Information about you in your Clinical Record (PHI). 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 \$2.00 per page (and for certain other expenses).

**Patient Rights:**

HIPPA 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, If you have a complain about my privacy practices, you can send a written complaint to the Secretary of the Department of Health and Human Services (200 Independence Avenue S.W., Washington, D.C. 20201) and I agree to take no retaliatory action against you.

*Your signature below indicates that you have read the information in this document and agree to abide by its terms during our professional relationship. Please note that you may request a copy of this document from me or obtain it from my website.*

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date