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AGREEMENT FOR MENTAL HEALTH SERVICES

This document (the Agreement) contains important information about our professional services and business policies. It also contains summary information about the Health Insurance Portability and Accountability Act (HIPAA), a federal law that stipulates privacy and patient rights with regard to the use and disclosure of your Protected Health Information (PHI) used for the purpose of treatment, payment, and health care operations. HIPAA requires that we provide you with a Notice of Privacy Practices (the Notice) for use and disclosure of PHI for treatment, payment and health care operations. The Notice, which is available at our office and which we give to each patient, explains HIPAA and its application to your personal health information in greater detail. The law requires that we obtain your signature acknowledging that we have provided you with this information by the end of this session. Although these documents are long and sometimes complex, it is very important that you read them carefully. We can discuss any questions you have about the procedures. When you sign this document, it will also represent an agreement between us. You may revoke this Agreement in writing at any time. That revocation will be binding on us unless we have taken action in reliance on it; if there are obligations imposed on us by your health insurer in order to process or substantiate claims made under your policy; or if you have not satisfied any financial obligations you have incurred. [You should be aware that we are not obligated to continue providing mental health services to you if you revoke this agreement.]

PSYCHOTHERAPEUTIC SERVICES

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.

Typically, our first few sessions will involve an evaluation of your needs. By the end of the evaluation, I will be able to offer you some first impressions of what our work will include and a treatment plan to follow, if you decide to continue with therapy. You should evaluate this information along with your own opinions of whether you feel comfortable working with me. Therapy involves a large commitment of time, money, and energy, so you should be very careful about the therapist you select. If you have questions about my procedures, we should discuss them whenever they arise. If your doubts persist, I will be happy to help you set up a meeting with another mental health professional for a second opinion or referral.

How long you remain in therapy is a matter best discussed and decided upon by you and your therapist, relative to the accomplishment of your goals. While it is your right to end therapy when you decide that termination is in your best interest, ending therapy is an important part of the treatment process and is most productive when discussed in the context of your therapy. I will remain willing to discuss this with you during any session.

MEETINGS

The frequency of our sessions will be discussed and determined by mutual agreement. Your sessions will usually last for ___ minutes. **Once an appointment hour is scheduled, you will be expected to pay for it unless you provide ___ hours advance notice of cancellation. It is important to note that insurance companies do not provide reimbursement for sessions that you did not attend.**

PROFESSIONAL FEES

Your initial fee has been set at \$ _____ per _____. I reserve the right to make periodic adjustments in your fee schedule. I will give you at least ___ days' notice of any change to your fee. In addition to weekly appointments, I charge this amount for other professional services you may need, though I will break down the hourly cost if I work for periods of less than one hour. Other professional services, including report writing, extended telephone conversations, consulting with other professionals with your permission, preparation of records or treatment summaries, and the time spent performing any other service you may request of me may incur additional charges. In the unusual situation when a session extends significantly beyond the usual time frame, your charge may be adjusted on a *pro rata* basis for that session. 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.

Charges for psychological assessment are always discussed in advance of testing, and include a copy of any assessment report that has been requested at the time testing was arranged.

CONTACTING ME

I am often not immediately available by telephone. Messages may be left for me at the above telephone number or at any other number that I have provided you. I routinely check my voice mailbox for messages during regular business hours and at least once on each weekend day and holiday (unless I have given you another contact number). If you are difficult to reach, please inform me of some times when you will be available. If I will be unavailable for an extended time, I will leave on my voicemail message the name of a colleague to contact, if necessary. **If you experience a life-threatening emergency, go to the nearest hospital emergency room and request to be seen by the mental health professional.**

LIMITS ON CONFIDENTIALITY

The ethics codes of the American Psychological Association and the Clinical Social Worker Federation, District of Columbia law, and the federal HIPAA all protect the privacy of all communications between a patient and a mental health professional. In most situations, I can only release information about your treatment to others if you sign a written authorization. This Authorization will remain in effect for a length of time you determine. In most cases, it cannot exceed 60 days. You may revoke the authorization at any time, unless I have taken action in reliance on it. However, there are some disclosures that *do not* require your Authorization, as follows:

- 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 therapist-patient privilege law. I cannot provide any information without your (or your legal representative's) 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.
- If a patient files a complaint or lawsuit against me, I may disclose relevant information regarding that patient in order to defend myself.
- If a patient files a worker's compensation claim, I must, upon appropriate request, provide a copy of the patient's record to the D.C. Office of Hearings and Adjudications, the patient's employer or insurer.
- Disclosures required by health insurers or to collect overdue fees are discussed elsewhere in this Agreement.

There are some situations in which I am legally obligated to take actions in order to attempt to protect certain individuals from harm, and I may have to reveal some information about a patient's treatment.

- If I know or have reason to suspect that a child has been or is in immediate danger of being a mentally or physically abused or neglected child, the law requires that I file a report with the appropriate governmental agency, usually the Child Protective Services Division of the Department of Human Services. Once such a report is filed, I may be required to provide additional information.
- If I have substantial cause to believe that an adult is in need of protective services because of abuse, neglect or exploitation by someone other than my patient, the law requires that I file a report with the appropriate governmental agency, usually the Department of Human Services. Once such a report is filed, I may be required to provide additional information.
- In an emergency, if I believe that a patient presents a substantial risk of imminent and serious injury to him/herself, I may be required to take protective actions, including notifying individuals who can protect the patient or initiating emergency hospitalization.
- If I believe that a patient presents a substantial risk of imminent and serious injury to another individual, I may be required to take protective actions. These actions may include notifying the potential victim, contacting the police, or seeking hospitalization for the patient.

If such a situation arises, 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.

In all other situations, I will ask you for an advance authorization before disclosing any information about you. 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

You should be aware that, pursuant to HIPAA, I keep Protected Health Information about you in two sets of professional records. One set constitutes your Clinical Record. It includes information about your reasons for seeking therapy, a description of the ways in which your problem impacts on your life, your diagnosis, the goals that we set for treatment, your progress towards those goals, your medical and social history, your treatment history, any past treatment records that I receive from other providers, reports of any professional

consultations, your billing records, and any reports that have been sent to anyone, including reports to your insurance carrier. Except in unusual circumstances that involve a substantial risk of imminent psychological impairment or imminent serious physical danger to yourself and others, 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 by 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 situations, I am allowed to charge a copying fee of \$.50 per page (and for certain other expenses). The exceptions to this policy are contained in the attached Notice Form. If I refuse your request for access to your records, you have a right of review, which I will discuss with you upon request.

In addition, I may also keep a set of Psychotherapy Notes. These Notes are for my own use and are designed to assist me in providing you with the best treatment. While the contents of Psychotherapy Notes vary from client to client, they can include the contents of our conversations, my analysis of those conversations, and how they impact on your therapy. They also contain particularly sensitive information that you may reveal to me that is not required to be included in your Clinical Record, and they also include information from others provided to me confidentially. These Psychotherapy Notes are kept separate from your Clinical Record. Your Psychotherapy Notes cannot be sent to anyone else, including insurance companies without your written, signed Authorization. Insurance companies cannot require your authorization as a condition of coverage nor penalize you in any way for your refusal to provide it. As with your Clinical Record, you may examine these notes. A written request to review them will be handled as described above for your Clinical Record.

PATIENT RIGHTS

You have certain rights with regard to your Clinical Record and disclosures of protected health information. These rights include requesting that I amend your record; requesting restrictions on what information from your Clinical Record 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 willing to discuss any of these rights with you.

MINORS & PARENTS

Psychologists can provide psychological services to minors without parental consent if the psychologist determines that the minor is knowingly and voluntarily seeking the services and provision of the services is clinically indicated for the minor's well being. These services can only be provided for 90 days, but can be continued if the psychologist redetermines that the services are still clinically indicated. Parents do not have access to records of this treatment. Patients under 18 years of age but who are over 14 and who are not emancipated and whose parents have consented to treatment should be aware that parents can only review the child's records with the written authorization of the child. Children under 14, whose parents have consented to the treatment, should be aware that their parents can examine their child's treatment records unless I decide that such access is likely to injure the child, or we all agree otherwise. Because privacy in psychotherapy is often crucial to successful progress, particularly with teenagers, and because it is important for parents to have some information about their child's treatment, it is usually my policy to request an agreement of both the parents and child about what information parents will receive about their child's treatment. If the patient agrees, during treatment, I will provide parents only with general information about the progress of the child's treatment, and his/her attendance at scheduled sessions. I will also provide parents with a summary of their child's treatment when it is complete. 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

Unless we agree otherwise or unless you have insurance coverage that requires another arrangement, you will be expected to pay for psychotherapy services _____.
For psychological assessment, 50% of the total is due on the date that testing is initiated, with the remainder due on the date the test results are presented to you. Payment for court appearances and other services that are related to legal proceedings is due in advance of those services. Payment schedules for other professional services will be agreed to when they are requested.

Any balance that is 30 days past due (i.e., 30 days past the statement date on which it appears) is subject to a ___% monthly interest charge. If your account has not been paid for more than 60 days past the statement date and arrangements for payment have not been agreed upon, I reserve 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. You will be responsible for all court, attorney, and other fees incurred in attempts to collect outstanding balances over 60 days past due. If you pay by check and that check is not honored by your bank, our bank will charge us a fee. That charge will be passed on to you and you will be responsible for its payment.

INSURANCE REIMBURSEMENT

You (not your insurance company) are responsible for full payment of my fees. It is very important that you find out exactly what mental health services your insurance policy covers. If you wish to use your health insurance to seek payment for treatment, I will ask you to fill out an authorization so that I can provide information to your insurance company that will allow me to provide the information necessary to secure payment for the services I provide for you. This Authorization will be in effect for one year, but can be revoked at any time. However, if revoked, I will continue to have the right to forward information necessary to process claims for services already provided.

You should carefully read the section in your insurance coverage booklet that describes mental health services. If you have questions about the coverage, call your plan administrator. Of course, I will provide you with whatever information I can based on my experience and would be willing to assist you in understanding the information you receive from your insurance company.

Due to the rising costs of health care, insurance benefits have increasingly become more complex. It is sometimes difficult to determine exactly how much mental health coverage is available. "Managed Health Care" plans such as PPOs often require authorization before they provide reimbursement for mental health services. These plans are often limited to short-term treatment approaches designed to work out specific problems that interfere with a person's usual level of functioning. It may be necessary to seek approval for more therapy after a certain number of sessions. While much can be accomplished in short-term therapy, some patients feel that they need more services after insurance benefits end.

You should also be aware that your contract with your health insurance company may require that I provide it with information relevant to the services that I provide to you, for which you seek coverage. Under the laws of the District of Columbia, the information that I can provide is limited to diagnostic information, including a treatment plan, the reasons for continuing treatment and the prognosis of how long the treatment will need to continue. If the Insurance Company determines that more information is necessary, the

insurance company must appoint an independent reviewer and the additional information can only be disclosed to the reviewer. You should also be aware that some self insured employee benefit plans are not subject to this law. In such situations, I will make every effort to release only the minimum information about you that is necessary for the purpose requested. This information will become part of the insurance company files and will probably be stored in a computer. Though all insurance companies claim to keep such information confidential, I have no control over what they do with it once it is in their hands. In some cases, they may share the information with a national medical information databank. I will provide you with a copy of any report I submit, if you request it.

Once we have all of the information about your insurance coverage, we will discuss what we can expect to accomplish with the benefits that are available and what will happen if they run out before you feel ready to end your sessions. It is important to remember that you always have the right to pay for my services yourself to avoid the problems described above.

I, _____, have read, understand, and accept the policies described in this agreement. The fee for which I agree to assume responsibility is:

\$ _____ per psychotherapy session, or
\$ _____ for psychological assessment, or
\$ _____ for other services: _____

YOUR SIGNATURE BELOW INDICATES THAT YOU HAVE READ THIS AGREEMENT AND AGREE TO ITS TERMS AND ALSO SERVES AS AN ACKNOWLEDGEMENT THAT YOU HAVE RECEIVED THE HIPAA NOTICE FORM DESCRIBED ABOVE.

signature of patient or authorized representative

date signed

signature of patient or authorized representative

date signed

signature of parent of a minor child

date signed

signature of therapist

date signed