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PSYCHOTHERAPIST-PATIENT SERVICES AGREEMENT

This document (the Agreement) contains important information about my professional services and business policies. It also contains summary information about the Health Insurance Portability and Accountability Act (HIPAA), a new federal law that provides new privacy protections and new 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 I 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 attached to this Agreement, explains HIPAA and its application to your personal health information in greater detail. The law requires that I obtain your signature acknowledging that I have provided you with this information at 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 me unless I have taken action in reliance on it; if there are obligations imposed on me 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.

PSYCHOLOGICAL SERVICES

Psychotherapy is not easily described in general statements. It varies depending on the personalities of the psychologist 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. There are no guarantees of what you will experience.

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.

MEETINGS

I normally conduct an evaluation that will last from 1 to 3 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. If psychotherapy is begun, I will usually schedule one 50-minute session (one appointment hour of 50 minutes duration) per week at a time we agree on, although some sessions may be longer or more frequent.

PROFESSIONAL FEES

My fees are as follows: Initial 90 minute visit is $250.00; Individual Therapy 50 minute therapeutic hour fee is $160.00; and, Family Therapy 50 minute session is $160.00. Other services include report writing, 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. 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. I charge $250.00 per hour for preparation and attendance at any legal proceeding. Please be advised there will be periodic increases. Should you have any questions regarding fee changes, please feel free to discuss them with me.

CANCELLATIONS

Your appointment time is reserved exclusively for you. Please help us serve you better by keeping scheduled appointments. Unless cancelled at least 24 hours in advance, you will be charged for the missed appointment/late cancellation at the rate of a normal office visit. It is important to note that insurance companies do not provide reimbursement for cancelled sessions. Please accept responsibility for keeping your appointments as **WE DO NOT CALL YOU OR MAIL YOU A REMINDER**.

CONTACTING ME / EMERGENCIES

While I am usually in my office Monday through Thursday, I do not answer the phone when I am with a patient. When I am unavailable, my telephone is answered by an auto-attendant voice mail that I monitor frequently. I will make every effort to return your call on the same day you make it. 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 provide you with the name of a colleague to contact, if necessary.]

For psychological emergencies after hours, call 911 or go to the nearest hospital.

LIMITS ON CONFIDENTIALITY

The law protects the privacy of all communications between a patient and a psychologist. In most situations, I can only release information about your treatment to others if you sign a written Authorization form that meets certain legal requirements imposed by HIPAA. There are other situations that require only that you provide written, advance consent. Your signature on this Agreement provides consent for those activities, as follows:

- 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 it is important to our work together.

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- You should be aware that I practice in a shared office space environment with other mental health professionals and that I contract with independent business associates to handle the paperwork of my daily business operations. In most cases, I need to share protected information with these individuals for both clinical and administrative purposes, such as scheduling, billing and quality assurance. All of these mental health professionals and business associates are bound by the same rules of confidentiality and have been given training about protecting your privacy and have agreed not to release any information outside of this practice without permission. As required by HIPAA, I have a formal business associate contract with these businesses, in which they promise to maintain the confidentiality of this data except as specifically allowed in the contract or otherwise required by law. If you wish, I can provide you with the names of these organizations and/or a blank copy of this contract.

- Disclosures required by health insurers or to collect overdue fees are discussed elsewhere in this Agreement.

- Licensed Psychological Associates are required by NC statute to receive supervision for providing psychological services. As a level III Psychological Associate, Dr. Steve Heymen will be discussing your PHI during supervision with Dr. Chuck Burnett, PhD on a once per month basis.

- If I believe that a patient presents an imminent danger to his/her health or safety, I may be obligated to seek hospitalization for him/her, or to contact family members or others who can help provide protection.

There are some situations where I am permitted or required to disclose information without either your consent or Authorization:

- If you are involved in a court proceeding and a request is made for information concerning the professional services that I provided you, such information is protected by the psychologist-patient privilege law. I cannot provide any information without your 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, and my services are being compensated through workers compensation benefits, I must, upon appropriate request, provide a copy of the patient's record to the patient's employer or the North Carolina Industrial Commission.

There are some situations 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. These situations are unusual in my practice.

- If I have cause to suspect that a child under 18 is abused or neglected, or if I have reasonable cause to believe that a disabled adult is in need of protective services, the law requires that I file a report with the County Director of Social Services. Once such a report is filed, I may be required to provide additional information.

- If I believe that a patient presents an imminent danger to the health and safety of another, I may be required to disclose information in order to take protective actions, including initiating hospitalization, warning the potential victim, if identifiable, and/or calling the police.

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.

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 / COMPLETION OF FORMS

The laws and standards of my profession require that I keep Protected Health Information about you in 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 danger to yourself and/or others or the record makes reference to another person (unless such other person is a health care provider) and I believe that access is reasonably likely to cause substantial harm to such other person, 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 charge a processing fee of $50.00 per request for medical records and $10.00 to complete forms (up to 2 pages) to schools, insurance companies, disability services, etc. A SEPARATE CONSENT TO RELEASE MEDICAL RECORDS form must be executed by the patient before we can release these records. If I refuse your request for access to your records, you have a right of review, which I will discuss with you upon request.

PATIENT RIGHTS

HIPAA 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 would be happy to discuss any of these rights with you.

BILLING AND PAYMENTS

Payment for services is the patient's responsibility and due at the time of service unless you have insurance coverage that requires another arrangement (see Insurance Reimbursement below). 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.] Any balances due in excess of 90 days are subject to interest being added.

INSURANCE REIMBURSEMENT

It is the patient's responsibility to verify the details of your mental health coverage with your insurance company(ies) and to determine if an authorization is required. (Note: Other information you may want to obtain from your insurance company might be: deductible amounts, reimbursement amounts, if authorization is required, number of visits allowed per benefit year, what are the dates of the benefit year, if a referral from your primary care physician or a psychiatrist is required, yearly and lifetime maximum reimbursement amounts, etc. When consulting with your insurance company, advise them that you are requesting out-of-network, mental health information.)   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 will be happy to help you in understanding the information you receive from your insurance company. Some insurance companies 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.

Please be advised that I am an "out-of-network" provider with insurance companies. I will provide you with the completed forms for you to file; however, you (not your insurance company) are responsible for full payment of my fees. It is <u>very</u> <u>important</u> that you find out exactly what mental health services your insurance policy covers. Any balances due in excess of 90 days are subject to interest being added. Please discuss the details of secondary or supplemental insurance reimbursement with me or the appropriate business associate that handles this for me.

It is your responsibility to advise us if you have a change of address, phone number(s), insurance coverage, and/or place of employment so that we can update our file for account accuracy. PLEASE BRING YOUR INSURANCE CARD TO YOUR FIRST APPOINTMENT.

You should also be aware that your contract with your health insurance company requires that I provide it with information relevant to the services that I provide to you. I am required to provide a clinical diagnosis. Sometimes I am required to provide additional clinical information such as treatment plans or summaries, or copies of your entire Clinical Record. 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. By signing this Agreement, you agree that I can provide requested information to your carrier.

It is important to remember that you always have the right to pay for my services yourself to avoid the problems described above [unless prohibited by contract].

REFERRALS

If you are referred to another provider (i.e., psychiatrist, psychological testing, career counselor), please contact your insurance carrier to verify coverage for that procedure. Payment for these procedures is your responsibility, and some insurance plans require primary doctor authorization.

CHILDREN

Our space is limited. Please make sure all children are supervised by an adult and not left unattended.

Should you have questions about any of our policies or procedures, I encourage you to ask me or one of my contracted business associates. We are always interested in any suggestions you may have on how we may improve our services to you or your family.

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.

Patient’s Name: ______________________________ Signature: ______________________________
(please print)

Relationship to patient: ______________________________ Date: ______________________________

Witness (if applicable) ______________________________