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PSYCHOTHERAPIST-PATIENT SERVICES AGREEMENT

Welcome to my practice. This document 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 explains HIPAA and its application to your personal health information in greater detail. The law requires that I obtain your signature acknowledging that I provided you with this information.

It is very important that you read these documents carefully before our next session. We can discuss any questions you have at that time. When you sign this document, it will also represent an agreement between us. You may revoke this Agreement in writing at any time, and the revocation will be binding on me unless I have taken action as a result of it, or if it is needed to process or substantiate claims made under your insurance policy; or if you have not satisfied any financial obligations you have incurred.

PSYCHOLOGICAL SERVICES

I am a clinical psychologist licensed in Oregon to provide services to individuals, families, and couples in need of help for life problems. I received a doctorate from the University of Connecticut in 1987, and completed an internship and two year post-doctoral residency in Medical Psychology at Oregon Health Sciences University. I have been in private practice since 1989.

Psychotherapy is a process that 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. It is important for you to know that psychotherapy requires an investment of your time and energy to make the process 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 periods of emotional discomfort, changes in relationships, or temporary

worsening of symptoms. This should subside as treatment progresses. 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.

Our first few sessions will involve an evaluation of your needs. Following this, I will be able to offer you some first impressions of what our work will include and a treatment plan. 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.

APPOINTMENTS AND FEES

Therapy typically involves an initial evaluation and follow-up treatment sessions. He first session lasts one hour after which sessions typically last for 45 minutes. The fee for the first session is $250. This covers the costs of the evaluation and generating the chart with treatment plan. The fee for a 45 minute session is $150. If a therapy session is extended to an hour, the fee is $180.

I ask that you avoid missing appointments. If you must cancel, you will not be charged for the appointment if you give 24 hour notice. Cancellations can be phoned into my office at any time day or night (503-466-2846). If you do not show up for your appointment, you may be charged full fee and this will be noted on your billing statement. If you cancel with less than 24 hour notice, you may be charged one-half the session fee. **It is important to note that insurance companies do not provide reimbursement for cancelled sessions.**

Please note that fees may be charged for any additional time that I may need to spend on your behalf, such as prolonged phone calls (over 15 minutes), preparing letters, conferring with other professionals, evaluation of psychological data, preparing psychological reports, etc. If I am required to be in court on your behalf, a fee of $250 per hour will be charged for preparation and review, meetings and conversations with your attorney, any time I am required to be out of my office, and testimony. I will negotiate a retainer and contract with your attorney and you prior to any legal work I do on your behalf. These fees apply even if I am called by another party to be involved in your behalf.

INSURANCE REIMBURSEMENT

In order for us to set realistic treatment goals and priorities, it is important to evaluate what resources you have available to pay for your treatment. If you have a health insurance policy, it will usually provide some coverage for mental health treatment. I will fill out forms and provide you with whatever assistance I can in helping you receive the benefits to which you are entitled; however, 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.

Some plans may require authorization before they provide reimbursement for mental health services. It is your responsibility to make sure sessions are preauthorized. It may be necessary to seek approval for additional sessions after the preauthorization, which is typically my responsibility.

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. If you have an Oregon insurance policy, by state law when you accept policy benefits, you are deemed to have consented to examination of your Clinical Record for purposes of utilization review, quality assurance and peer review by the insurance company. I may provide clinical information to your insurer for such purposes. 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. 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.

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 [unless prohibited by contract].

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 state law and/or HIPAA. With your signature on a proper Authorization form, I may disclose information for consultation with other health care professionals or for other purposes (e.g., legal) as you deem necessary.

If a session involves more than one person, and that other person is present as an adjunct to therapy, the second person is not considered to be a patient and are therefore not subject to confidentiality or privilege. The records may be released with consent from the identified patient. Accordingly, information about the adjunct person may be released without their consent. If a person is involved in couples therapy or family therapy and is considered to be a patient, then the record may not be released without the consent of all people involved.

Please note that I have a contract with a billing service that will be given information pertinent to billing you and your insurance agency. As required by HIPAA, I have a formal business associate contract with this business in which they promise to maintain the confidentiality of this data except as specifically allowed in the contract or otherwise required by law.

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 in which a court order is made for me to release your records.
- 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, he/she automatically authorizes me to release any information relevant to that claim.
- Disclosures required by health insurers or to collect overdue fees. This is discussed elsewhere in this agreement.

There are some instances in which I may be ethically and/or legally obligated to take actions necessary to attempt to protect others from harm which require revealing some information about a patient's treatment. In all cases, I will use my professional judgment to determine whether it is appropriate to disclose PHI to prevent harm. These include the following:

- If I have reasonable cause to believe that a child with whom I have had contact has been abused I may be required to report that abuse. Additionally, if I have reasonable cause to believe that an adult with whom I have had contact has abused a child, I may be required to report the abuse. In any child abuse investigation I may be compelled to turn over PHI.
- If I have reasonable cause to believe that a mentally ill adult or developmentally disabled adult , who receives services from a community program or facility has been abused, I may be required to report the abuse. Also, if I come in contact with any person whom I believe may have committed such abuse, I may be required to report the abuse.
- If I believe that a patient presents a clear and substantial risk of imminent, serious harm to another person, 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 I believe that a patient presents a clear and substantial risk of imminent, serious harm to him/her self, I may be obligated to seek hospitalization for him/her, or to contact family members or others who can help provide protection.

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

You should be aware that, pursuant to HIPAA, I keep Protected Health Information about you in my professional records. This 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. Pursuant to HIPAA, I may use or disclose this PHI with your written authorization.

You may examine and/or receive a copy of your Clinical Record, if you request it in writing, and obtain the release from any other patient who holds confidentiality with the record. In the unusual circumstance that involves danger to yourself and others, I may not release the full record but will provide an accurate and representative written summary of the record. 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 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 Clinical Record, 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 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 happy to discuss any of these rights with you.

MINORS & PARENTS

Patients under 14 years of age (not emancipated) and their parents should be aware that the law may allow parents to examine their child's treatment records. Because privacy in psychotherapy is often crucial to

successful progress, particularly with teenagers, for children between 14 and 18, it is sometimes my policy to request an agreement from parents that they consent to give up their access to their child's records. If they agree, during treatment, I will provide them only with general information about the progress of the child's treatment, and his/her 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 your copay for each session at the time it is held, unless we agree otherwise or unless you have insurance coverage that requires another arrangement. Payment schedules for other professional services will be agreed to when they are requested. [In circumstances of unusual financial hardship, I may be willing to negotiate a fee adjustment or payment installment plan.]

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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YOUR SIGNATURE BELOW INDICATES THAT YOU HAVE READ THE PSYCHOTHERAPIST-PATIENT AGREEMENT AND AGREE TO ITS TERMS. IT ALSO SERVES AS AN ACKNOWLEDGEMENT THAT YOU HAVE RECEIVED THE HIPAA PRIVACY PRACTICES NOTICE FORM DESCRIBED ABOVE.

_____ _____

Client signature Date

_____ _____

Client signature Date

_____ _____

Client signature Date

_____ _____

Legal representative of the client Date

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