Dr. Christopher Willard (Psy.D.)
One Washington Street Suite 305
Wellesley, MA 02481
617.383.9355

Outpatient Services Contract

Welcome. It is important that we have an understanding about the work we are about to begin together. Please review the following information carefully and feel free to raise any questions you may have with me.

Introduction

Psychotherapy can be a complex process not easily described in general statements. There is significant variability depending upon the personalities involved, the problems to be addressed and the goals. Often, psychotherapy calls for an active effort on the part of clients and their families and requires working on issues at home and between sessions. Psychotherapy can have benefits, as well as risks. At times when discussing difficult issues, you (and/or your child) may experience some uncomfortable feelings. At the same time, psychotherapy has also been shown to have benefits, such as solutions to specific problems, reduction of feelings of distress and improved coping skills. However, there are no guarantees of what you (and/or your child) will experience.

The initial sessions will involve an evaluation of your needs/your child's needs. By the end of the evaluation, I will offer feedback and recommendations for you and/or your child. The evaluation period is a time for you and I to decide if I am the most appropriate person to provide the services you need in order to meet your goals. It is also a time for you to evaluate your comfort level with me. If you have questions about my procedures, we should discuss them as they arise. If your doubts persist, I would be happy to facilitate a referral to another mental health professional for a second opinion.

Privacy and Confidentiality

Records

I am required by state law to keep a written record of your evaluation and treatment. In general, the law protects the confidentiality of all communications between a client and a mental health counselor. Information can only be shared with your written permission. There are a few notable exceptions in which I am legally obligated to disclose information even without your permission:

-If there is concern that you/your child is at risk for harming yourself/themselves or another person, I am required to take the appropriate measures that may include contacting a hospital, the police or potential victim.

-When I have reason to believe that a child, elderly, or disabled person is being abused or neglected, I am mandated to file a report with the appropriate state agency.

-When a judge issues an order requesting testimony or records.

Privacy Regarding Persons Under Eighteen Years of Age

Both parent(s)/ guardian(s) are required to give consent in order for a child to be in therapy, even if the parents are divorced and or separated. There are circumstances

during which both parents have equal access to their child's records, even if one parent has sole custody. As a psychotherapist invested in maintaining neutrality, I am not in the position of conducting custody evaluations. In families where there is a divorce or separation, it is also very important that we establish at the onset of therapy how communication will be handled with each parent.

As parent(s) and guardian(s), you are the most important people in your child's life and it is necessary for you to be a partner in your child's therapy. However, it may be difficult for a child, particularly an adolescent, to have a working relationship with any therapist if he or she feels that what they say in therapy will always be shared with their parents. Therefore, it is important at the onset of therapy that we establish how much information will be shared.

If you are in therapy as a couple, medical information cannot be released without the consent of both parties.

Consultation
As part of providing you with the highest possible quality of care, I will periodically consult with colleagues as part of supervision and/or quality assurance. The same laws of confidentiality bind the consultant.

Billing Policy
Payment is due at the time services are provided. Clients or parent(s)/guardian(s), are responsible for providing accurate health insurance information (including any changes in coverage) and for any balance due after insurance payment.

At times it is clinically beneficial or necessary for sessions to be supplemented by collateral services. These services may include, but are not restricted to: phone consultation to schools, adjunct mental health professionals, and physicians as well as report/letter writing. It is my policy to charge a prorated amount for these services. Should you become involved in legal proceedings that require my participation, even if another party other than yourself calls me to testify, payment for my time is your responsibility.

Cancellation Policy
If you need to cancel an appointment, I ask that you give at least 24 hours notice by leaving a message on my voicemail. There is a fee for late cancellations and missed appointments.

Dr. Christopher Willard (Psy.D.)
One Washington Street Suite 305
Wellesley, MA 02481
617.383.9355

Insurance Reimbursement
Should you decide to use your insurance, please be aware that your insurance company will typically require a diagnosis, treatment plan and on rare occasion, may ask for your full treatment record. Information that is submitted to your insurance company will become part of their records and probably be stored in a computer. Although insurance companies try to maintain confidentiality, they are not bound by the same laws that apply to mental health counselors.
I will provide you with assistance in helping you to receive the benefits to which you are entitled, however, it is ultimately your responsibility, not the insurance company's, for payment.

Contacting Me
If you need to contact me between sessions, please leave a message on my voicemail. I check my voicemail regularly. I will make every effort to return your call in a timely fashion; calls received on Friday may not be returned until Monday. If it is an emergency situation that cannot wait, please seek services at your local hospital emergency room or call 911.

I have read and understood the information outlined. My signature indicated my agreement with these terms.

_____ _____
Client Signature Date

_____ _____

Parent/Legal Guardian Date

_____ _____

Parent/Legal Guardian Date

_____
_____
Witness Date

Dr. Christopher Willard (Psy.D.)
One Washington Street Suite 305
Wellesley, MA 02481
617.383.9355

Registration Form

Date _____/_____/_____

Client's Name _____Date of Birth _____/_____/_____

Parent(s) Name
_____

Street Address
_____

Town _____Zip Code _____

Home Telephone (_____) _____Work (_____) _____

Pediatrician/Physician _____Tele. (_____) _____

Referred By _____

In Case of Emergency, please notify
_____

Tele. (_____) _____Relationship _____

This section to be completed by clients using insurance:

Policy Holder's Name _____Date of Birth
_____/_____/_____

Soc Sec Number _____-_____-_____ Employer
_____

Subscriber Number _____Group Number
_____

Referral Number _____

Subscriber's Address (if different from above)

_____

Dr. Christopher Willard (Psy.D.)
One Washington Street Suite 305
Wellesley, MA 02481
617.383.9355

RELEASE OF INFORMATION TO INSURANCE COMPANY

Client's Name _____ Date of Birth ____/____/____

I hereby authorize Christopher Willard, PsyD to release from my medical records to my health insurance company information necessary for processing my claims, administering benefits, and managing care, including but not limited to diagnosis and treatment plan.

Name of Insurer _____

Please note any restrictions on type of information to be released:

_____

_____

This information is not to be re-released to any person or agency, except as provided by law.

This release shall expire one year after the completion of my treatment with Christopher Willard, PsyD unless otherwise specified. I understand that I may revoke this consent at any time.

I also understand that any release that was made prior to my revocation that was made in reliance upon this authorization shall not constitute a breach of my right of confidentiality. I also understand that Federal Regulation 42CFR Part 2, Confidentiality of Alcohol and Drug Abuse Treatment Record may protect the above information.

_____ _____ ____/____/____
Signature of Client/Parent Relationship Date

_____ ____/____/____
Witness Date

Dr. Christopher Willard (Psy.D.)
One Washington Street Suite 305
Wellesley, MA 02481
617.383.9355

NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you may be used and disclosed and how you can gain access to this information. Please review it carefully. If you have any questions about this Privacy Notice, please feel free to ask me.

PLEASE REVIEW THIS NOTICE CAREFULLY.

Understanding Your Health Record/Information

Each time you visit a hospital, healthcare provider, or mental health clinician, a record of your visit is made. Typically, this record contains your symptoms, evaluation and test results, diagnoses, treatment, and a plan for future care or treatment. This information, often referred to as your health or medical record, serves as a:

- basis for planning your care and treatment;
- means of communication among the many health professionals who contribute to your care;
- legal document describing the care you received;
- means by which you or a third party payer can verify that services billed were actually provided;
- tool in educating health professionals;
- source of information for public health officials charged with improving the health of the nation;
- source of data for facility planning and marketing;
- tool with which we can assess and continually work to improve the care we render and the outcomes we achieve.

Understanding what is in your record and how your health information is used helps you to:

- better understand who, what, when, where and why others may access your health information;
- make more informed decisions when authorizing disclosure to others;
- ensure its accuracy.

Your Privacy Rights

You have the following rights regarding the health information that your provider has about you.

- **Your Right to Inspect and Copy:** You have the right to inspect and/or receive a copy of your Private Health Information (PHI) record unless it is legally determined that it would adversely affect your well-being or you are a minor. You may be charged a fee for the cost of copying your records. (You may need to make an appointment to look at your record to assure that we will have it available for you.)
- **Your Right to Amend:** You have the right to request to amend information, but not expunge information from your record if you feel that there is a mistake. Your

provider can deny your request, but he/she must give you a written reason for the denial.

- **Your Right to Request Confidential Communications by Alternative Means and at Alternative Locations:** You have the right to ask that your provider share information with you in a certain way or in a certain place. For example, you may ask him to send information to your work address instead of your home address. Your provider will do their best to accommodate such a request.
- **Your Right to Request Restrictions on the Use or Disclosure of Information:** You can ask for limits on how your information is used or disclosed. Your Provider is not required to agree to such requests, but can if he/she believes it is reasonable to do so.
- **Your Right to a List of Disclosures:** You have the right to ask for a list of certain disclosures made after April 14, 2003. This list will not include the times that information was disclosed for treatment, payment, or health care operations. The list will not include information provided directly to you or your family, or information that was sent with your permission. It will not include information released without your name or other data that would identify you. The first accounting you request within a twelve month period will be free, but there is a fee for additional requests during the same 12 month period.
- **Your Right to a Paper Copy of this Notice**. You have the right to obtain a paper copy of this Notice of Privacy Practices at any time.

As additional HIPAA regulations are mandated and clarified, this office will be altering its policies and procedures to be in compliance.

If this office is found to be in violation of the Primary Standards put forth in HIPAA, you ~~am~~are urged to speak with your~~my~~ therapist and if not resolved, you have a right to file a formal complaint with the Office of Civil Liberties.

Your Providers' Responsibilities:

- maintain the privacy of your health information
- provide you with a notice as to our legal duties and privacy practices with respect to information collected and maintained about you
- abide by the terms of this notice
- notify you if he/she is unable to agree to a requested restriction
- accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations.

Dr. Christopher Willard (Psy.D.)
One Washington Street Suite 305
Wellesley, MA 02481
617.383.9355

How Your Provider Will Use and Disclose Your Health Information

Your provider will use your health information for treatment.

For example: Information obtained by your therapist, physician or other member of your healthcare team will be recorded in your record and used to determine the course of treatment that should work best for you. The provider will document in your record your evaluation and treatment plan. Your provider will then record the actions they took and their observations. In that way, we will know how you are responding to treatment.

When your provider makes disclosures to a third party (other than your health plan) for coordination or management of your health care, your provider will obtain your written authorization prior to the disclosure. A third party is a person or entity who is not affiliated with our organization. In addition, with your authorization, he will disclose your health information to another health care provider (e.g., your primary care physician or a laboratory.)

Your provider will use your health information for payment.

For example: A bill may be sent to you or your health insurance company. The information on or accompanying the bill may include information that identifies you, as well as your diagnosis, and the type of visit. Or, as part of the prior approval process, your health insurance company may request information regarding your current clinical status.

Your provider will use your health information for regular health operations.

Your provider may use and share your health information for activities that are known as health care operations. These are activities that are needed to operate his/her private practice. Some of the information is shared with outside parties who perform these health care operations or other services on behalf of your provider. These are called "business associates". Business associates must also take steps to keep your health information private. Examples of activities that make up health care operations include:

- contacting you at the address and telephone numbers you give to us (including leaving messages on answering machines) about:
    - scheduled or cancelled appointments, registration/insurance updates, billing or payment matters, or test results
    - information on patient care issues, treatment choices and follow up care instructions
    - other health-related benefits and services that may be of interest to you
- monitoring the quality of care and making improvements where needed
    - reviewing medical records for completeness and accuracy
    - meeting standards set by regulating agencies

- using outside business services; such as storage, auditing, legal or other consulting services
- storing your health medical information
- information on computers managing and analyzing

Uses and Disclosures (Sharing) of Your Health Information Without Your Specific Permission:

Your provider may legally use and/or share your health information with others in the following areas without your specific permission. In such cases, your provider will disclose the minimum amount of information necessary to fulfill his/her obligation.

- As required by state and federal laws and regulations
- When your provider believes you might be in danger of harming yourself or other persons or are at risk because of being unable to take care of yourself
- When your provider believes that a child, elderly person, or disabled person in your care is, or has been abused or neglected
- Your insurance company requests information relative to payment of your claim, or another process is required to collect unpaid fees.
- Your provider may disclose health information about you to a court when a judge orders to do so.
- Your provider may disclose health information about you in legal proceedings without your permission when:
    - your health information involves communications made during a court-ordered psychiatric examination;
    - you introduce your mental or emotional condition in evidence in support of your claim or defense in any proceeding and the judge approves the disclosure of your health information;
    - you file a claim against any clinician or staff affiliated with this practice for malpractice or initiate a complaint with a licensing board against a clinician affiliated with this practice;
    - a judge approves the disclosure of your health information in a legal proceeding that involves child custody, adoption or dispensing with consent to adoption;
    - a provider affiliated with this office brings a proceeding, or is asked to testify in a proceeding, involving foster care of a child or commitment of a child to the custody of the Massachusetts Department of Social Services.
- For law enforcement purposes under specific conditions such as reporting when someone is the victim of a crime. Other conditions include
    - when the information is provided in response to an order of a court;
    - when you agree to the disclosure

  - when it is determined that the law enforcement purpose is to respond to a threat of an imminently dangerous activity by you against yourself or another person; or
  - the disclosure is otherwise required by law.
- With regard to people who have died, to coroners, medical examiners and funeral directors, or for organ, eye or tissue donation at death
- To avert a serious threat to health or safety
- For specialized government operations
- As authorized by and as necessary to comply with workers compensation laws

Uses And Disclosures (Sharing) Of Your Health Information That You May Ask To Be Limited, Or Request Not Be Made

In general, your provider will not give out any information to family or friends without an authorization signed by you. Your provider does not have a patient directory and will not give out any information regarding your care.

In an emergency situation, if you are present and are able to make health care decisions, your provider will try to find out if you want him/her to share this information with your family members or others. If you are not able to make your wishes known, your provider will use his/her best judgment to decide whether to share information. If it is thought to be in your best interest, your provider will only share information that others really need to know.

If you are not in an emergency situation but are unable to make health care decisions, your provider will disclose your health information to: your health care agent if he has received a valid health care proxy from you, your guardian or medication monitor if one has been appointed by a court, or if applicable, the state agency responsible for consenting to your care.

Uses And Disclosures Of Information That Require Your Written Permission.

- Sharing information about genetic testing (as defined by state law) or genetic test results
- Sharing information about HIV testing or test results
- Sharing information from substance abuse rehabilitation treatment programs
- Sharing information about treatment for sexually transmitted diseases
- Information which state law recognizes as “privileged” (sensitive) information can only be shared in administrative and judicial proceedings if you give written permission.
  - Privileged (sensitive) information includes information that relates to domestic violence, sexual assault counseling, confidential communications

between a patient and a social worker, or confidential details of psychotherapy (from a psychiatrist, psychologist, licensed mental health counselor, or licensed mental health nurse clinical specialist)
    - such proceedings may include civil or criminal trials and their preliminary proceedings, or hearings before a state, county or local administrative agency
- Using and sharing psychotherapist notes (notes maintained outside of the medical record for the therapist's own use); however, specific permission is not required for use or sharing of these notes for your therapist to treat you, for legal defense in an action you bring, or for oversight of the therapist.

Withdrawing Permission:

If you have given permission for your medical information in the above categories to be used or shared, you may withdraw your permission in writing at any time and except to the extent that your provider has already acted on it, he/she will not make any further disclosures of your information.

Complaints

If you believe your privacy rights have been violated, you may file a complaint with your provider or with the Secretary of the U.S. Department of Health and Human Services.

Acknowledgement and Agreement of Privacy Policy

My signature is provided in acknowledgement that Christopher Willard, PsyD has informed me of his~~her~~ privacy policy and of my rights and ~~her~~his obligations regarding the handling of clinical information under the HIPAA law. Christopher Willard, PsyD, has presented me, in writing, with a summary of the HIPAA law and his~~her~~ privacy policy as it relates to the law and his~~her~~ handling of information regarding my child, family or myself. I have reviewed these materials, understand them and hereby accept the conditions for information management outlined in this policy and the HIPAA law.

Signature: _____ Date: _____

Print Name: _____

Witness Signature: _____ Date: _____