FRANCO PSYCHOLOGICAL ASSOCIATES

Psychotherapist Patient Services Agreement

CONFIDENTIALITY AND PRIVACY: Welcome to Franco Psychological Associates (FPA). This 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 provides you privacy protections 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.

All of the staff of Franco Psychological Associates are required by law to safeguard the information they learn about a patient through the course of treatment. As a patient of FPA, relevant treatment information may be discussed between the professional staff involved in your care to insure the best care, including supervision, consultation, and referrals between FPA therapists (treatment).

HIPAA requires that we provide you with an Explanation of Privacy Practices (the Notice), which is attached. If you choose to use your health care insurance to pay for psychotherapy services, you are giving your consent for us to disclose the minimum necessary PHI to your health insurer to determine your benefits and obtain reimbursement (payment).

OFFICE HOURS AND APPOINTMENTS: Our office is staffed from Monday through Thursday, 8 A.M. until 8 P.M. and Friday 9 A.M. to 4:30 P.M. At other times, a 24-hour "live" answering service will take messages. In case of emergency, the answering service will attempt to contact your therapist. If they are unable to be reached, you should contact your local crisis intervention office. We make every effort to provide appointments at convenient hours, however, there is an especially high demand for evening times. We appreciate your cooperation in arranging daytime appointments whenever possible.

FEES AND INSURANCE COVERAGE: The fee for a 50 minute session of psychotherapy is $110 which is payable at the time of service unless your insurance company has a specific contract with Franco Psychological Associates (FPA). A one time fee of $150 is charged for the initial evaluation session. Most health insurance plans cover part of the cost of psychotherapy provided by licensed professionals. Some insurance and all HMO's require pre-certification for services. All insurance copays are expected to be paid at the time of service. Non-payment of fees may result in termination of professional services and collection activity for the amounts owed by the patient.

CANCELLATION POLICY: A charge of $55 will be made for sessions that are cancelled with less than 24 hours notice except in cases of emergency. Since insurance companies will not pay for missed appointments, it is the patient's responsibility to pay our established fee for a late cancellation or a no show.

RESPONSIBILITY FOR PAYMENT OF SERVICES: My signature below acknowledges my agreement to the following:
1) I request that payment of insurance benefits for services I have received be paid directly to FPA when assignable.
2) I authorize FPA to release to my insurance carrier and its agents any PHI (Protected Health Information) needed to determine these benefits.
3) I realize that the services to be provided have not been guaranteed for payment under my health benefit program and therefore I agree to be responsible for fees not covered by my insurance carrier or HMO.

FOR PARENTS OF MINORS: In cases of divorce or separation of parents, the law requires us to take steps to ensure both parents have been notified of the child's arrangements and visitation. There is one exception: when a parent has sole legal custody, and we have evidence of that arrangement, treatment can commence without requiring an attempt to contact the other parent.

When a child is age 14 to 17, she or he may consent to treatment themselves; however, if the absent parent's insurance will be billed, we need the information noted below.

Please provide the name and contact information for your child's other parent if he/she is not living in the home:

Name _____

Address _____

_____

_____

Telephone _____

If you have sole legal custody of your child, please initial here _____. We will need you to provide legal documentation of the custody arrangement.

Court Appearances: As the parent, you agree that the therapist's role is limited to providing treatment and that you will not involve your child's therapist in any legal dispute, especially a dispute concerning custody or custody arrangements (visitation, etc.).

If you have any concerns, questions or objections to the above, please discuss them with your therapist.

I have read the PROFESSIONAL SERVICES AGREEMENT and consent to receive psychotherapy services under the terms outlined.

_____ _____

Client Signature Date

(If Client is 14 or older)

_____ _____

Client Signature (or Responsible Party) Date

(If Client is under 18)

_____ _____

Witness Signature Date