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Psychologist – Client Agreement

Welcome to my practice. This Psychologist-Client Agreement contains important information about my professional services and business policies. Please read over the document carefully. The signature page at the end of this document (Consent to Treatment), when signed, represents contractual agreement between us. I will provide you with a copy of this agreement and your signed consent. You may revoke this Psychologist-Client Agreement in writing at any time.

This document also contains summary information about the Health Insurance Portability and Accountability Act (HIPAA), a federal law that provides privacy protections and patient rights with regard to the use and disclosure of your Protected Health Information (PHI). HIPAA requires that I provide you with a Notice of Policies and Practices to protect the privacy, use, and disclosure of PHI for treatment, payment, and health care operations. The law requires that I obtain your signature acknowledging that I have provided you with this information. Both the Notice and the Signature Page are attached to this document, and explain HIPAA and its application to your personal health information in greater detail. Although these documents are long and can be complex, it is very important that you read them carefully before our next session. For both the Psychologist-Client Agreement and the HIPAA forms – please bring any questions or concerns to our next meeting so that we can discuss them.

Purpose of the Intake Interview/Evaluation

The function of this first meeting is for me to learn more about you, your history, and your wish for treatment. A second purpose includes you asking any questions about my background and my approach to treatment. We will discuss whether my background and style fits your needs, explore how further therapy/work together could be appropriate, and if so, set preliminary treatment goals. I will offer you my impressions about the scope of our work, my thoughts about treatment goals, and may ask for other assessments (e.g., physical exam, psychiatric evaluation for medication). Occasionally, if there is a great deal of information to be covered, the intake evaluation could extend to another one or two sessions.

Confidentiality

The privacy of almost all communication between a patient and a psychologist is protected by law. It is your legal right that our sessions and my records about them are kept private, and I can only release information to others about you and your therapy with your written consent. The

consent form usually remains in effect for 60 days, though you may specify a shorter length, and you may withdraw your permission at any time. Washington DC law and HIPAA limit what information can be released, even to insurance companies. Please note that once any information is released I cannot guarantee that it will remain confidential.

However, there are some situations in which I am legally obligated to take action to protect you or others from harm. These circumstances require revealing information about a patient's condition, mental status, and symptoms; and disclosing that the patient is in treatment with me. These situations include:

(1) ***Child Abuse***. If, during the course of therapy, I learn that a child or vulnerable adult is being abused, neglected or exploited, I must file a report with the appropriate protective services agency. Once such a report is filed, I may be required to provide additional information.
(2) ***Harm to Others.*** If I know that a patient has propensity for violence and the patient indicates that s/he has the intention to inflict imminent physical injury upon specified victim(s), I am required to take protective actions. These actions can include establishing and undertaking a treatment plan that is calculated to eliminate the possibility that the patient will carry out the threat, notifying the potential victim(s), notifying the police, and/or seeking appropriate hospitalization for the patient. Whenever possible, I will discuss these with you before taking any action.
(3) ***Harm to Self.*** If I believe there is an imminent risk that a patient will inflict serious physical harm or death on her/himself, or that immediate disclosure is required to provide for the patient's emergency health care needs, I may be required to take appropriate protective actions, including initiating hospitalization and/or notifying family members or others who can protect the patient.

Additionally, in the following situations no authorization is required:

(1) Sometimes I might find it helpful to consult with other health or mental health professionals about a case. During such a consultation, I do not reveal the identity of the patient. Consultants are legally bound to keep all information confidential.
(2) If I am away from the office for more than a few days, I will have another therapist provide coverage for you should you want to speak or meet with someone during my absence. Because this therapist will be available to you, s/he needs to know about you. This therapist is bound by the same privacy rules and laws as I am.
(3) Disclosures required by health insurers or to collect over fees (discussed further in this document, under Billing and Payments).
(4) If a government agency requests information for health oversight activities, I may be required to provide it for them.
(5) 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

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 likely order me to disclose information.

(6) If a client files a complaint or lawsuit against me, I may disclose relevant information regarding that patient in order to defend myself.

If such a situation arises, I will make every effort to discuss with it with you before taking any action and to limit my disclosure to what is necessary. Please discuss with me any questions or concerns about exceptions to confidentiality as they arise.

Professional Fees, Billing and Payment

My current professional fees are:

- $180 per 45 to 50 minute individual therapy session. I do not charge differently for intake evaluations that run for a typical 50 minute session.
- $270 per 75 to 90 minute individual therapy or intake session. These are not typical and may be scheduled on an as-needed basis.
- $85 to $95 per group counseling session. Groups typically run for 75 minutes.

My fee structure will be reassessed at the start of the calendar year. You will be given ample notice of any increase in fees. In addition to weekly appointments, I charge for additional services that include: report writing, telephone conversations lasting longer than 15 minutes, consultations with other professionals (with your signed permission) that last longer than 15 minutes, preparation of letters 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 my professional time, including preparation and transportation costs, even if I am called to testify by another party. In circumstances of unusual financial hardship I may be willing to negotiate a fee adjustment. The possibility of reduced fees due to need is negotiated on an individual basis.

Payment expected at time the session is held, unless we agree otherwise. Check, cash or credit card (Visa, MasterCard, American Express, Discover) are accepted forms of payment. There will be an additional $5 charge for each declined credit card because it costs me about $5 per declination. A payment schedule for other professional services will be discussed when they are requested. I am not a participating provider with any insurance companies and do not belong to any managed care panels. I will provide you with a statement at the end of each month that includes information you need to submit your insurance forms. Please discuss your needs with me, as different insurance companies have different requirements for submission. Additionally, all insurance companies require a diagnosis on any bill submitted for reimbursement. I am happy to discuss the diagnosis given on the monthly statement.

Scheduling, Cancellations and Rescheduling

Please provide ***at least 24 hours notice*** to cancel a session. Once a given session time is booked, it usually cannot be filled on short notice. Therefore, *fees will be charged* for all missed sessions or for sessions cancelled less than 24 hours in advance of the session. However, I will first make every attempt to reschedule your appointment within the same week. Please note that I may not be able to find a mutually convenient time with little notice so I cannot guarantee that we can reschedule. Exceptions include "snow days" or other weather/environmental conditions beyond our mutual control. Please discuss any questions or concerns about this policy with me. Please also note that insurance companies cannot be billed for missed sessions.

Vacations and Absences

If I will be away for more than 4 to 5 days I will provide you with the name and contact information of a colleague to contact, if necessary. We will discuss the need for a planned phone call or meeting with the clinician who will be providing emergency coverage for me.

Contacting Me

Please contact me by either by phone or via email.

- *Phone:* When I am unavailable by phone, my telephone is answered by an answering machine. I will usually return all phone calls within one business day unless otherwise specified on my voice mail. If you are difficult to reach, please leave a message indicating your availability. If you are unable to reach me and feel that you cannot wait for me to return your call, please contact your family physician, your psychiatrist, or the nearest emergency room and ask for the psychologist or psychiatrist on call.
- *Email:* You are welcome to contact me by email between sessions. Please be advised that I cannot safeguard the confidentiality of electronic communication. I will respond to your email and your concerns, but please be advised that I do not discuss clinical matters or conduct therapy over email.
- *Other forms of electronic communication:* Please note that it is impossible to protect the confidentiality of many forms of electronic communication. In addition to email, information stored on computers linked to the internet, and material discussed on cordless and cell phones may not be secure.

Professional Records

The laws and standards of my profession require that I keep professional treatment records. Typically such treatment records include information about your reasons for seeking therapy, a description of the ways in which your problem has an impact on your life, your diagnosis, your treatment history, and any past treatment records that I receive from other providers, reports of professional consultations, your billing records, and any reports that have been sent to anyone, including reports to your insurance carrier. I will release information about your treatment to another professional with a release of information form signed by you. I can also review your

treatment records with your at your request. 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.

Patient Rights

You have the following rights in therapy: (1) To ask questions about my background training and experience, my treatment approach, your treatment plan and the procedures used, (2) To ask questions at any time about any information contained in this contract or to bring up for discussion any other issue or matter that comes up for you, (3) To seek consultation with another credentialed mental health professional regarding your treatment, and (4) To end therapy at any time without obligation beyond payment due for completed sessions. Should you decide between sessions to withdraw from therapy, I ask that you agree to attend at least one additional session to discuss your reasons with me. Please ask for further clarification of this stipulation.

Benefits and Risks of Therapy

Psychotherapy can vary due to a number factors including the fit of the client and therapist, the quality of the therapy relationship, the therapist's experience and level of training for the presenting problem, the presenting problems/issues themselves, the treatment approach used, and the history, depth, and severity of the problems being addressed. Psychotherapy has both benefits and risks. Risks may include experiencing difficult and uncomfortable feelings when exploring painful life events. Sometimes a client's problems may temporarily worsen at the beginning of treatment, particularly if the issues discussed have not been explored before. However, psychotherapy is designed to reduce distress, build healthy coping skills, lead to improved relationships, and enhance general life satisfaction. To maximize the benefits you can receive from therapy, it's important that you participate as much as possible in your treatment. I ask that you commit to self-reflection and self-exploration and to work actively on our established treatment goals both during and outside of session.

Consent to Treatment

Your signature below indicates that you have read this agreement, have had the opportunity to ask questions, and agree to abide by its terms during our professional relationship. Additionally, I understand that:

- I have the right to ask questions about my treatment at any time during the therapy process.
- My therapist may suggest additional treatment modalities and/or suggest outside consultation, and I have the right to consent to or refuse such recommendations.
- No promises have been made as to the success of this treatment.
- I may stop treatment at any time, but agree to discuss this decision first with my therapist, and to have a final session where we discuss my decision in person.
- I have been informed that I must give 24 hours notice to cancel and appointment and that I will be charged if I do not come or if the time cannot be rescheduled.

Signature: ____

Name (printed): ____

Date: _____________________

_____________________________________ __________________

Suzanne Friedman, Ph.D. Date

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Notice of Psychologist's Policies and Practices to Protect the Privacy of Your Patient's Health Information

THIS NOTICE DESCRIBES HOW PSYCHOLOGICAL AND MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

I. Uses and Disclosures for Treatment, Payment, and Health Care Operations

I may *use* or *disclose* your *protected health information* (*PHI*), for *treatment, payment, and health care operations* purposes with your *written authorization*. To help clarify these terms, here are some definitions:

- "*PHI*" refers to information in your health record that could identify you.
- "*Treatment, Payment, and Health Care Operations*"
  – *Treatment* is when I provide, coordinate, or manage your health care and other services related to your health care. An example of treatment would be when I consult with another health care provider, such as your family physician or another psychologist.

  – *Payment* is when I obtain reimbursement for your healthcare. Examples of payment are when I disclose your PHI to your health insurer to obtain reimbursement for your health care or to determine eligibility or coverage.

  – *Health Care Operations* are activities that relate to the performance and operation of my practice. Examples of health care operations are quality assessment and improvement activities, business-related matters such as audits and administrative services, and case management and care coordination.

- "*Use*" applies only to activities within my office such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.
- "*Disclosure*" applies to activities outside of my office, such as releasing, transferring, or providing access to information about you to other parties.
- "*Authorization*" is your written permission to disclose confidential mental health information. All authorizations to disclose must be on a specific legally required form.

II. Other Uses and Disclosures Requiring Authorization

I may use or disclose PHI for purposes outside of treatment, payment, or health care operations when your appropriate authorization is obtained. In those instances when I am asked for information for purposes outside of treatment, payment, or health care operations, I will obtain an authorization from you before releasing this information. I will also need to obtain an authorization before releasing your Psychotherapy Notes. "*Psychotherapy Notes*" are notes I have made about our conversation during a private, group, joint, or family counseling session, which I have kept separate from the rest of your medical record. These notes are given a greater degree of protection than PHI.

You may revoke all such authorizations (of PHI or Psychotherapy Notes) at any time, provided each revocation is in writing. You may not revoke an authorization to the extent that (1) I have relied on that authorization; or (2) if the authorization was obtained as a condition of obtaining insurance coverage, law provides the insurer the right to contest the claim under the policy.

III. Uses and Disclosures without Authorization

I may use or disclose PHI without your consent or authorization in the following circumstances:

- *Child Abuse* – If I have reason to believe that a child has been subjected to abuse or neglect, I must report this belief to the appropriate authorities.

- *Adult and Domestic Abuse* – I may disclose protected health information regarding you if I reasonably believe that you are a victim of abuse, neglect, self-neglector exploitation.

- *Health Oversight Activities* – If I receive a subpoena from the Maryland Board of Examiners of Psychologists because they are investigating my practice, I must disclose any PHI requested by the Board.

- *Judicial and Administrative Proceedings* – If you are involved in a court proceeding and a request is made for information about your diagnosis and treatment or the records thereof, such information is privileged under state law, and I will not release information without your written authorization or a court order. The privilege does not apply when you are being evaluated or a third party or where the evaluation is court ordered. You will be informed in advance if this is the case.

- *Serious Threat to Health or Safety* – If you communicate to me a specific threat of imminent harm against another individual or if I believe that there is clear, imminent risk of physical or mental injury being inflicted against another individual, I may make disclosures that I believe are necessary to protect that individual from harm. If I believe that you present an imminent, serious risk of physical or mental injury or death to yourself, I may make disclosures I consider necessary to protect you from harm.

IV. Patient's Rights and Psychologist's Duties

Patient's Rights:

- *Right to Request Restrictions* – You have the right to request restrictions on certain uses and disclosures of protected health information. However, I am not required to agree to a restriction you request.

- *Right to Receive Confidential Communications by Alternative Means and at Alternative Locations* – You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations. (For example, you may not want a family member to know that you are seeing me. On your request, I will send your bills to another address.)

- *Right to Inspect and Copy* – You have the right to inspect or obtain a copy (or both) of PHI in my mental health and billing records used to make decisions about you for as long as the PHI is maintained in the record. I may deny your access to PHI under certain circumstances, but in some cases you may have this decision reviewed. You have the right to inspect or obtain a copy (or both) of Psychotherapy Notes unless I believe the disclosure of the record will be injurious to your health. On your request, I will discuss with you the details of the request and denial process for both PHI and Psychotherapy Notes.

- *Right to Amend* – You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. I may deny your request. On your request, I will discuss with you the details of the amendment process.

- *Right to an Accounting* – You generally have the right to receive an accounting of disclosures of PHI. On your request, I will discuss with you the details of the accounting process.

- *Right to a Paper Copy* – You have the right to obtain a paper copy of the notice from me upon request, even if you have agreed to receive the notice electronically

<u>Psychologist's Duties:</u>

- I am required by law to maintain the privacy of PHI and to provide you with a notice of my legal duties and privacy practices with respect to PHI.

- I reserve the right to change the privacy policies and practices described in this notice. Unless I notify you of such changes, however, I am required to abide by the terms currently in effect.

- If I revise my policies and procedures, I will provide you with a revised notice in writing at a session or at your last provided mailing address.

V. Questions and Complaints

If you have questions about this notice, disagree with a decision I make about access to your records, or have other concerns about your privacy rights, you may contact me.

If you believe that your privacy rights have been violated and wish to file a complaint with me, you may send your written complaint to me at the above address or by e-mail.

You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services. I can provide you with the appropriate address upon request.

You have specific rights under the Privacy Rule. I will not retaliate against you for exercising your right to file a complaint.

VI. Effective Date, Restrictions, and Changes to Privacy Policy

This notice will go into effect on October 15, 2003.

I reserve the right to change the terms of this notice and to make the new notice provisions effective for all PHI that I maintain. I will provide you with a revised notice in writing at a session or by mail to your last provided mailing address.

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGMENT

I have received the Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information will be used to conduct, plan, and direct my treatment and follow-up.

Your signature below serves as an acknowledgment that you have received this HIPAA notice form described above.

Client Name: ____

Signature**: ____

Date: ____

**You have the right to refuse to sign this form.

For professional use only.

No signature may be for the following reasons (if so, check)

____ Individual refused to sign

____ Communication barrier prohibited obtaining a signed acknowledgment

____ Emergency services prohibited obtaining signed acknowledgment

____ Other reason (specify) ____________________________________