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# Practice and Policies

**Therapy Service Agreement:** *Please read over the following and discuss any questions you may have with me prior to signing this agreement for services.*

1. **Length of Sessions:** Sessions are typically scheduled for 45-50 minutes (coordinates with most insurance policies) unless arranged otherwise. Occasionally, services for children, families or special situations may require longer sessions and will be scheduled for 75 minutes or longer. Families are welcome to bring meals/snacks for the child depending on the timing of his/her appointment and I can offer select choices for snacks as long as I am made aware of any food sensitivities or allergies the child and/or caregiver may have at the beginning of services.

2. **Cancellations:** I ask that clients give a minimum of 24 hours notice if cancelling a session. The only exceptions will be if I am notified prior to the schedule appointment time of an emergency situation such as serious illness, accident or weather.

3. **Communication:** For reasons of privacy/confidentiality, I do not conduct treatment through email or texting. Conducting treatment via email violates my commitment to privacy and confidentiality, impinges natural conversation, and can be easily misconstrued. My preference is to meet to discuss issues and/or have a telephone conversation. I will use email only if I have specifically requested you send me specific information via email and suggest that any e-mail sent to me be accompanied with a voicemail message alerting me to the sent message. I rarely communicate via text as it can be intrusive during sessions with other clients and does not guarantee privacy/confidentiality.

1. **Inclement Weather:** I will make every effort to reach you by phone prior to our scheduled appointment if the office is closed due to inclement weather. Typically, the office will be closed on days when school is cancelled due to snow. However, I will contact you directly in the event of a snow day to confirm cancellation and schedule a make-up session.

2. **Emergency/Vacation Coverage:** As a private practitioner, I am not able to provide walk-in coverage or emergency coverage for unscheduled appointments. When unavailable, I will typically return urgent calls within 24 hours and scheduling or informational calls within 1-2 business days. Please bring it to my

attention if you feel you will need additional support so that we may make plans for emergency options as needed. I will give you advance notice of any scheduled vacations and provide information for emergency coverage options if we mutually decide that this would be helpful. If you are in significant crisis, have suicidal or homicidal thoughts, you can call HCRS Crisis Care Center (open Monday through Friday from 9am to 10pm) at 1-800-622-4235, call 911, or go to the nearest emergency room.

3. **Insurance Coverage:** It is your responsibility to understand what insurance coverage you have and to keep track of your benefits. While I may be able to assist you with this process, ultimately you are responsible for payment for sessions, even if your benefits change, run out without your knowledge, or if your insurance company chooses not to pay for services already provided. It is strongly suggested that you consult with your insurance provider prior to your first session to have a clear understanding of what mental health benefits your specific policy will cover. Additionally, if an insurance company should decide to deny benefits for therapy that has already been provided, they may request that fees already paid be refunded. Should this occur, you would be responsible for any outstanding bill.

4. **Payment of Fees:** Payment is due at the time of service unless arrangements have been made for billing insurance or other payment plans. In that case, I will bill your insurance company directly and you will be responsible for any co-pay fees at the time of your appointment. Please verify with your insurance company what the amount of your co-pay is prior to your visit. If you are unable to pay at the time of your visit, or monthly billing is more convenient, I will arrange to have you or the designated responsible party billed on a monthly basis.

5. **Confidentiality:** In accordance with the ethical guidelines of my profession and in compliance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA), any information discussed in our sessions will remain confidential with the following exceptions:

    a. I am a mandated to report in situations where I determine you to be in possible danger of harming yourself or someone else.

    b. Many insurance companies will authorize mental health benefits only if monitored through a utilization review process, requiring that details of your case and progress be provided to a case manager. While you are not required to authorize me to provide this information in order to receive therapeutic services, if you provide me with insurance information for billing purposes, I will take such provision as consent for providing information to your insurance company as requested.

    c. Children's Therapy: Children up through the age of 14 (or eighth grade) will be determined to be an integral part of the home or school system referring them for counseling. As such, the general content of therapy

sessions may be shared with parent(s) or school team as appropriate to assist a child in modifying undesirable behaviors, note progress and/or develop new educational/treatment plans. Should children over the age of 14 (or in high school) be referred by their parents, parents will be informed upon their request of general information consisting of attendance and progress. Specific content of sessions will not be disclosed without verbal consent of the child. Should any child disclose information that indicates that there may have been neglect or abuse, such information would be reported according to law. Should I determine that a child may be in danger of harming themselves or others, I will inform parents and/or other authorities as needed in order to ensure safety of the child.

d. Release of information: It may be helpful to authorize me to obtain/release information to/from other providers, agencies or individuals. Should we determine that this would be useful for your treatment, I will provide a release form for your consent for such contact. Please know that my primary professional dedication is to provide therapeutic services and support to clients. Efforts to compel me to testify in court proceedings have the potential to interfere adversely with the therapeutic process and maintain neutrality, which may likely result in a termination of therapeutic services.

e. Billing Service: I use a billing service to assist with insurance claims and tracking accounts. Information provided to this service includes intake information required for insurance reimbursement including diagnostic and billing codes. This service maintains such in accordance with the confidentiality requirements of my practice.

**Signing this document indicates that I have read the above Practice and Policies, have been given the opportunity to ask questions and have them answered to my satisfaction, and that I agree to accept these policies as stated.**

_____ _____

Client Signature Date

_____ _____

Parent/Guardian Signature Date

_____ _____

Witness Signature Date