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PSYCHOTHERAPIST-PATIENT SERVICES AGREEMENT

_____
Client Name

Welcome to my practice. This document (the Agreement) 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 law requires that I obtain your signature acknowledging that I have provided you with this information at the end of this session. Although these documents are long and sometimes complex, it is very important that you read them carefully before our next session. We can discuss any questions you have about the procedures 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. That revocation will be binding on me unless I have taken action in reliance on it; if there are obligations imposed on me by your health insurer in order to process or substantiate claims made under your policy; or if you have not satisfied any financial obligations you have incurred.

PSYCHOLOGICAL SERVICES

Psychotherapy is not easily described in general statements. It 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. Psychotherapy is not like a medical doctor visit. Instead, it calls for a very active effort on your part. In order for the therapy to be 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 uncomfortable feelings like sadness, guilt, anger, frustration, loneliness, and helplessness. On the other hand, 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. By the end of the evaluation, I will be able to offer you some first impressions of what our work will include and a treatment plan to follow, if you decide to continue with therapy. The treatment plan may include:

_____ Individual therapy for your child
_____ Parent sessions
_____ Conjoint sessions (sessions with the child and parent/parents)
_____ Adult individual therapy
_____ Family therapy
_____Referral for additional services (Occupational Therapy, Speech Therapy, Medication Evaluation, Psychoeducation/Neuropsychological evaluation).

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.

If at any point during psychotherapy either of us assess that I am not effective in helping you reach therapeutic goals, I am obligated to discuss it with you and I, if appropriate to terminate treatment. In such a case, I will refer you to other individuals or clinics that may be of help to you. If at any time you want another professional's opinion or wish to consult with another therapist, I will assist you in finding someone qualified, and if you provide a written consent, I will provide the essential information needed. You have the right to terminate psychotherapy with me at any time.

SESSIONS

I normally conduct a diagnostic evaluation that will last from 3 to 5 sessions. During this time, we can both decide on the issues of concern and if I am the best person to provide the services that your child/family need in order to meet your treatment goals. If psychotherapy is begun, I will usually schedule sessions (frequency and duration based on the treatment goals developed from the diagnostic phase) at a time(s) we agree on. Once an appointment session is scheduled, you will be expected to pay for it unless you provide 24 hours [1 day] advance notice of cancellation [unless we both agree that you were unable to attend due to circumstances beyond your control]. It is important to note that insurance companies do not provide reimbursement for cancelled sessions. [If it is possible, I will try to find another time to reschedule the appointment.].

PROFESSIONAL FEES

My fee per clinical hour (45 minutes) is $_____. If we need to meet longer than usual, I will charge accordingly. In addition to sessions in the office, I charge the same hourly rate for other professional services you many need such as school visits, team meetings, report/letter/written treatment summaries, etc., though I will prorate the hourly cost if I work for periods for less than one clinical hour. It is customary to be paid each session; however other arrangements can be negotiated. Phone calls in excess of 10 minutes will be subject to fees charged in ¼ hour increments.

BILLING AND PAYMENTS

You will be expected to pay for each session at the time it is held, unless we have agreed otherwise. [In circumstances of financial hardship I may be willing to negotiate a fee adjustment or payment installment plan.]

I will accept credit card payment for services. At the time a credit card payment is made, the card must be present. A copy will be made and secured under lock and key. For appointments that are missed or cancelled less that 24 hours in advance you authorize payment for the missed session on you credit card _____ (Initial for agreement of this provision)

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 payment. This may involve hiring a collection agency or going through small claims court. [If such legal action is necessary, tis costs will be included in the claim.] In most collection situations, the only information I will release regarding the patient's treatment is his/her name, the dates, times and nature of services provided, and the amount.

If you become involved in legal proceedings that require my participation, you will be expected to pay for any professional time I spend on your legal matter, even if the request comes from another party. [I charge $500 per hour for professional services I am asked or required to perform in relation to your legal matter. This includes preparation time. I also charge a copying fee of $.50/page for records requested plus a $50 record retrieval fee.]

CONTACTING ME

I am often not immediately available by telephone. When I am unavailable, my telephone is answered by voice mail that I monitor frequently. I will make every effort to return your call on the same day you make it with the exception of holidays and vacations (scheduled and discussed in advance). Since I am not immediately available, in the case of a true emergency, please call 911 and/or proceed to the nearest emergency room. If I am not available for an extended period of time, I will provide you with the name of a colleague to contact in case you need to consult a psychotherapist urgently.

INSURANCE REIMBURSEMENT

In order for us to set realistic treatment goals and priorities, It is I important to evaluate the resources you have available to pay for your treatment. I am a "fee for service" provider and therefore am not on any insurance panel. Therefore, it is very important that you find out exactly what "out of network" mental health services your insurance policy covers. You should carefully read the section in your insurance coverage booklet that describes mental health services. If you have questions about the coverage, call your plan administrator. Of course, I will provide you with whatever information I can based on my experience and will be happy to help you in understanding the information you receive from your insurance company.

If you choose to submit for reimbursement, I will provide you with an invoice that has the information you well need to complete the forms for your insurance company. Please be aware that most insurance companies require your clinical diagnosis be included on any reimbursement form. Sometimes your insurance company request I submit additional clinical information, such as treatment plans, progress notes or summaries, or copies of the entire record (in rare cases). This information will become pat of the insurance company files. Although all insurance companies claim to keep such information confidential, I have not control over what they do with it once it is in their hands. In some cases, they may share the information with a national medical information databank. I will provide you with a copy of any records I submit if you request it.

You understand that, by using your insurance, you authorize me to release such information to your insurance company. I will try to keep that information limited to the minimum necessary.

It is important to remember that paying for services yourself, without the use of insurance, avoids the problems described above

SERVICE DELIVERY

Modalities of services delivered are on based treatment goals developed from the diagnostic process. In general there are several principles that underlay the approach to treatment.

*Children are not typically treated in isolation; therefore parent involvement is often part of the intervention plan. Sessions will be scheduled based on need and may either be conjoint (with the child) or separate in parenting sessions.

* This practice includes the use of nurturing touch for young children when appropriate to child's diagnosis and to promote eye-contact, shared attention and/or reciprocal interaction. Touch provided may include tickling, light and deep pressure touch and is directed by the child's experience of comfort. Touch provided in the course of treatment is consistent with the goals of promoting in the child physiological regulation, comfort, stress reduction, reciprocal interaction and/or playfulness.

*Parents must accompany minors to and from sessions.

I am often not available immediately by telephone. Though I am usually in the office between 9am and 9pm, I won't answer the phone when I am with a patient. When I am unavailable, my telephone is answered by voicemail that I monitor frequently. I will make every effort to return your call on the same day you make it, with the exception of weekends and holidays. If you are difficult to reach, please inform me of some times when you will be available. If you are unable to reach me and feel that you cannot wait for me to return your call, contact your family physician or the nearest emergency room and ask for the psychologist or psychiatrist on call. If I will be unavailable for an extended time, I will provide you with the name of a colleague to contact if necessary

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. But, there are some situations where I am permitted or required to disclose information without either your consent or Authorization:

- I may occasionally find it helpful to consult other health and mental health professionals about a case. During a consultation, I make every effort to avoid revealing the identity of my patient. The other professionals are also legally bound to keep the information confidential. Ordinarily, I will not tell you about these consultations unless I believe that it is important to our work together.

- If I believe a patient is threatening serous bodily harm to another, I am required to take protective actions. These actions may include notifying the potential victim, contacting the police, or seeking hospitalization for the patient. If the patient threatens to harm himself/herself, I may be obligated to seek for him/her or to contact family members or others who can help provide protection. In a similar situation occurs on the course of our work together, I will attempt to fully discuss it with your before taking any action.

- In most legal proceedings, you have the right to prevent me from providing any information about your treatment In some legal proceedings a judge may order my testimony if he/she determines that the issues demand it, and I must comply with the court order.

- 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 uses health insurance HMO/PPO/EAP/MCO, disclosure of confidential information may be required by your health insurance carrier in order to process the claims. I will provide only the minimum necessary information. I have no control or knowledge over what insurance companies do with information that is submitted. You must be aware that submitting a mental health invoice of reimbursement carries a certain amount of risk of confidentiality, privacy or future capacity to obtain health or life insurance.

- If I observe or have knowledge of an incident that reasonably appears to be physical abuse, abandonment, abduction, isolation, financial abuse or neglect of an elder or dependent adult, or if an elder or dependent adult credibly reports that he or she has experienced behavior including an act or omission constituting physical abuse, abandonment, abduction, isolation, financial abuse, or neglect, or reasonably suspects that abuse, the law requires that I report to the appropriate government agency. Once such a report is filed, I be may be required to provide additional information.

TECHONOLOGY LIMITATIONS OF CONFIDENTIALITY

In order to maintain clarity regarding our use of electronic modes of communication during your treatment, I have prepared the following policy. This is because the use of various types of electronic communications is common in our society, and many individuals believe this is the preferred method of communication with others, whether their relationships are social or professional. Many of these common modes of communication, however, put your privacy at risk and can be inconsistent with the law and with the standards of my profession. Consequently, this policy has been prepared to assure the security and confidentiality of your treatment and to assure that it is consistent with ethics and the law.

If you have any questions about this policy, please feel free to discuss this with me.

Email Communications

I use email communication and text messaging only with your permission and only for administrative purposes unless we have made another agreement. That means that email exchanges and text messages with my office should be limited to things like setting and changing appointments, billing matters and other related issues. If you need to send me information over email, please use the link provided on my webpage on the **contact** page to send an encrypted email. Otherwise, please do not email me about clinical matters because email is not a secure way to contact me. If you need to discuss a clinical matter with me, please feel free to call me so we can discuss it on the phone or wait so we can discuss it during your therapy session. The telephone or face-to-face context simply is much more secure as a mode of communication.

Text Messaging

Because text messaging is a very unsecure and impersonal mode of communication, I do not text message to nor do I respond to text messages from anyone in treatment with me. So, please do not text message me unless we have made other arrangements.

Social Media

I do not communicate with, or contact, any of my clients through social media platforms like Twitter, Facebook or Linkedin. In addition, if I discover that I have accidentally established an online relationship with you, I will cancel that relationship. This is because these types of casual social contacts can create significant security risks for you.

I participate on various social networks, but not in my professional capacity. If you have an online presence, there is a possibility that you may encounter me by accident. If that occurs, please discuss it with me during our time together. I believe that any communications with clients online have a high potential to compromise the professional relationship. In addition, please do not try to contact me in this way. I will not respond and will terminate any online contact no matter how accidental.

Websites

I have a website that you are free to access. I use it for professional reasons to provide information to others about me and my practice. You are welcome to access and review the information that I have on my website and, if you have questions about it, we should discuss this during your therapy sessions.

Web Searches

I will not use web searches to gather information about you without your permission. I believe that this violates your privacy rights; however, I understand that you might choose to gather information about me in this way. In this day and age there is an incredible amount of information available about individuals on the internet, much of which may actually be known to that person and some of which

may be inaccurate or unknown. If you encounter any information about me through web searches, or in any other fashion for that matter, please discuss this with me during our time together so that we can deal with it and its potential impact on your treatment.

Recently it has become fashionable for clients to review their health care provider on various websites. Unfortunately, mental health professionals cannot respond to such comments and related errors because of confidentiality restrictions. If you encounter such reviews of me or any professional with whom you are working, please share it with me so we can discuss it and its potential impact on your therapy. Please do not rate my work with you while we are in treatment together on any of these websites. This is because it has a significant potential to damage our ability to work together.

I may use a bill assistant to generate and track basic billing information. Only the billing assistant and I will have access to your billing records from which invoices are generated. The psychotherapy notes are NOT a part of this record.

PATIENT RIGHTS

HIPAA provides you with several new or expanded rights with regard to your Clinical Records and disclosures of protected health information. These rights include requesting that I amend your record; requesting restrictions on what information from your Clinical Records 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. I am happy to discuss any of these rights with you.

This agreement provides that during treatment, I will provide parents with only general information about the progress of the treatment, and the patient's attendance at scheduled sessions. I will also provide parents with a summary of their child's treatment when it is complete when requested to do so. 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.

Your signature below indicates that you have read the information in this document and agree to abide by its terms during our professional relationship.

PARENT AUTHORIATION FOR MINOR'S MENTAL HEATH TREATMENT

In order to authorize mental health treatment for your child, you must have either sole or joint legal custody of your child. If you are separated or divorced from the other parent of your child, please notify me immediately. I will ask you to provide me with a copy of the most recent custody decree that establishes custody rights of you and the other parent or otherwise demonstrates that you have that you have to authorize treatment for your child.

If you are separated or divorced from the other child's other parent, please be aware that it is my policy to notify the other parent that I am meeting with your child. I believe it is important that all parents have the right to know, unless there are truly exceptional circumstances, that their child is receiving mental health evaluation or treatment.

One risk of child therapy involves disagreements among parents and/or disagreements between parents and the therapist regarding the child's treatment. If such disagreements occur, I will strive to listen carefully so that I can understand your perspectives and fully explain my perspective. You can resolve such disagreements or we can agree to disagree, so long as this enables your child's therapeutic progress. Ultimately, parents decide whether therapy will continue. If either parent decides that therapy should end, I will honor that decision unless there are extraordinary circumstances. However, in most cases, I will as that you allow me the option of having few closing sessions with your child to appropriately end the treatment relationship.

INDIVIDUAL PARENT/GUARDIAN COMMUNICATIONS WITH ME

In the course of my treatment of your child, I may meet with the child's parent' guardians either separately or together. Please be aware, however, that at times, my patient is your child – not the parents/guardians nor any siblings or other family members of the child. If I meet with you or other family members in the course of your child's treatment, I will make notes of that meeting in your child's records. Please be aware that those notes will be available to any person or entity that has legal access to your child's treatment record.

ADDITIONAL LIMITS ON CONFIDENTIALITY RELATED TO MINORS

<u>Confidentiality cannot be maintained when:</u>

- Child patients tell me they plan to cause serious harm or death to themselves, and I believe they have the intent and ability to carry out this threat in the very near future. I must take steps to inform a parent or guardian or others of what the child has told me and how serious I believe this treat to be and to try to prevent the occurrence of such harm

- Child patients tell me they plan to cause serious harm or death to someone else, and I believe they have the intent and ability to carry out this threat in the very near future. In this situation, I must inform the person who is the target of the threatened harm [and the police].

- Child patients are doing things that could cause serious harm to them or someone else, even if they do not intend to harm them selves or another person. In these situations, I will need to use my professional judgment to decide whether a parent or guardian should be informed.

- Child patients tell me, or I otherwise learn that, it appears that a child is being neglected or abused—physically, sexually or emotionally—or that it appears that they have bee neglected or abused in the past. In this situation, I may be required by law to report the alleged abuse to the appropriate state child-protective agency.

●I am ordered by a court to disclose information

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.

DISCLOSURE OF MINOR'S TREATMENT INFORMATION TO PARENTS

When doing individual child therapy is most effective when a trusting relationship exits between the psychologist and the patient. Privacy is especially important in earning and keeping that trust. As a result, it is important for children to have a "zone of privacy" where children feel free to discuss personal matters without fear that their thoughts and feelings will be immediately communicated to their parents. This is particularly true for adolescents who are naturally developing a great sense of independence and autonomy.

It is my policy to provide you with general information about your child's treatment, but NOT to share specific information your child has disclosed to me without your child's agreement. This includes activities and behavior you would not approve of – or might be upset by – but that do not put your child at risk of serous and immediate harm. However, if your child's risk-taking behavior becomes more serious, then I will need to use my professional judgment to decide whether your child is in serious and immediate danger or harm. If I feel that your child is in such danger, I will communicate this information to you.

> ***Example:*** If your child tells me that he/she has tried alcohol at a few parties, I would keep this information confidential. If your child tells me that he/she I drinking and driving or is a passenger in a car with a driver who is drunk, I would not keep this information confidential form you. If your child tells me, or if I believe based on things I learn about your child, that your child is addicted to drugs or alcohol, I would not keep that information confidential
> ***Example:*** If your child tells me that he/she is having voluntary, protected sex with a peer, I would keep this information confidential. If your child tells me that, on several occasions, the child has engaged in unprotected sex with strangers or in unsafe situations, I will not keep this information confidential.

You can always ask me questions about the types of information I have to disclose. You can ask in the for of "hypothetical situations"' such as" "if a child told you that he or she were doing _____, would you tell parents?"

Even when we have agreed to keep your child's treatment information confidential from you, I may believe that it is important for you to know about a particular situation that is going in your child's life. In these situations, I will encourage your child to tell you, I may sometimes describe your child's problems in general terms, without using specifics, in order to help you know how to be more helpful to your child.

DISCLOSURE OF MINOR'S TREATMENT RECORDS TO PARENTS

Although the laws of California may give parents the right to see any written records I keep about your child's treatment, by signing this agreement, you are agreeing that your child o teen should have a "one of privacy" in their meetings with me, and you agree not request access to your child's written treatment records.

PARENT/GUARDIAN AGREEMENT NOT TO USE MINOR'S THERPAY INFORMATION/RECONDS IN CUSTODY LITIGATION

When a family is in conflict, particularly conflict due to parental separation or divorce, it is very difficulty for everyone, particularly for children. Although my responsibility to your child may require my helping to address conflicts between the child's parents, my role will be strictly limited to providing treatment to your child. You agree that in any child custody/visitation proceedings, neither of you will seek to subpoena my records or ask me to testify in court, whether in person or by affidavit, or to provide letters or documentation expressing my opinion about parental fitness or custody/visitation arrangements.

Please note that your agreement may not prevent a judge from requiring my testimony, even though I will not do so unless legally compelled. If I am requested to testify, I am ethically bound not to give my opinion about either parent's custody, visitation suitability, or fitness. If the court appoints a custody evaluator guardian ad litem, or parenting coordinator, I will provide information as needed, I appropriate releases are signed or a court order is provided, but I will not make any recommendations about the final decision(s). Furthermore, if I am required to appear as a witness or to otherwise perform work related to any legal matter, the party responsible for my participation agrees to reimbursement at the rate of $500 per hour for time spent traveling, speaking with attorneys, reviewing and preparing documents, testifying, being in attendance, and any other case-related costs.

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PSYCHOTHERAPIST-PATIENT SERVICES AGREEMENT
SIGNITURE PAGE
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Your signature below indicates that you have read the information in the Psychotherapist-Patient Agreement and agree to abide by its terms during our professional relationship.

ACKNOWLDGING SIGNATURES

_____	_____
Patient Signature (13 years of age or older)	Date
_____	_____
Parent or Legal Guardian Signature	Date
_____	_____
Therapist Signature	Date