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Psychotherapist - Patient Services Agreement

Welcome! I am pleased to have you as a client. 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 for use and disclosure of PHI for treatment, payment and healthcare operations. The Notice of Privacy Practices, which is attached to this Agreement, explains HIPAA and its application to your personal health information in greater detail. The law requires that I obtain your signature acknowledging that I have provided you with this information.

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. It is a more active process, on your part. I have a broad base of experiences using multiple therapy modalities. These will be explored and mutually agreed upon during the evaluation process.

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, shame, 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 dis-ease. The capacity to tolerate an expanded array of affects (the painful ones above) plus more positive ones - love, faith, sensual feelings, exhilaration, productivity, renewed creativity, and spiritual growth - are also potential changes that may occur. However, there are no guarantees of what you will personally 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. 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 careful about the therapist you select. If you have any questions about my procedures, we should discuss them whenever they arise. If your doubts persist, I will assist you with finding another mental health professional for a second opinion. You may ask questions at any time about your treatment plan or any alternative treatments for your condition.

Meetings

I normally conduct an evaluation that will last from two to four sessions. During this time, we can both decide if I am the best person to provide the services that you need in order to meet your treatment goals. Psychotherapy sessions generally last 45-50 minutes. Once an appointment hour is scheduled, you will be expected to pay for it unless you provide 48 hours advanced notice of cancellation. It is important to note that insurance companies do not provide reimbursement for cancelled sessions.

Professional Fees

After the initial evaluation session (which costs $170), my hourly fee is $150. In addition to therapy or testing appointments, I charge this amount for any other professional services you may need, though I will break down the hourly cost if I work for periods of less than one hour. Other services include report writing, telephone conversations lasting longer than five minutes, consulting with other professionals with your permission, preparation of records 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 all of my professional time, including preparation and transportation costs, even if I am called to testify by another party.

Contacting Me

Due to my work schedule, I use voice mail to answer all calls. During office hours (Mon-Thurs 9am - 7pm, Fri 9am - 4pm) I monitor calls frequently. For calls received during office hours, I make every effort to return your call on the same day you make it, and if I am unable to do so, I will return your call by the next working day. On weekends, and on holidays and vacations, I pick up calls once per day. Only emergency calls are returned outside of office hours; non-

emergency calls are returned the next business day. If you are difficult to reach, please inform me of some times when you will be available. If you feel that you cannot wait for me to return your call, call the Crisis Hotline at 727-791-3131, or your psychiatrist if you have one, or contact your nearest emergency room. 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, a psychologist can only release information about your treatment to others if you sign a written Authorization Form that meets certain legal requirements imposed by HIPPA. There are other situations that require only that you provide written advanced consent. Your signature on this Agreement provides consent for those activities as follows:

1. 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. If you do not object, I will not tell you about these consultations unless I feel that it is important to our work together. I will note all consultations in your Clinical Record (which is called "PHI" in my Notice of Psychologists' Policies and Practices to Protect the Privacy of Your Health Information).

2. You should be aware that I employ administrative staff. In most cases, I need to share protected information with these individuals for both clinical and administrative purposes, such as scheduling, billing, and quality assurance. All staff members have been given training about protecting your privacy and have agreed not to release any information outside of the practice without my permission. I also have contracts with typing and billing services. As required by HIPAA, I have a formal business associate contract with these businesses in which they promise to maintain confidentiality of this data except as specifically allowed in the contract or otherwise required by law.

3. I may at times use various professional copying, test scoring, and other professional services and that may consult with other professionals as part of ongoing professional education, research, and workshop presentations. At all times, I will protect your privacy by not revealing your name or other unique identifying characteristics.

4. A limited exception to confidentiality exists for the purposes of treatment, payment, and healthcare operations (including, but not limited to, insurance companies, victims assistance programs, and billing companies) and will be limited to the minimum necessary information required in order to satisfy billing requirements and obtain payment including reporting session dates, account balances, diagnosis, and treatment reports.

5. I realize that certain types of information revealed during the course of these services may result in other agencies or people being notified, even though they are not directly involved in my psychological treatment. Examples of such instances are coved in the Notice of Privacy Practices, attached.

6. Disclosures required by health insurers to collect overdue fees are discussed elsewhere in this Agreement.

These are some situations where I am permitted or required to disclose information without either your consent or Authorization:

- Judicial or Administrative Proceedings: If you are involved in a court proceeding and a request is made for information about your diagnosis or treatment and the records thereof, such information is privileged under state law, and I will not release information without the written authorization of you or your legal representative, unless under subpoena of which you have been properly notified and you have not informed me that you are opposing the subpoena or court order. The privilege does not apply when you are being evaluated for a third party or where the evaluation is court ordered. You will be informed in advance if this is the case.

- Health Oversight: If a complaint is filed against me with the Florida Department of Health on behalf of the Board of Psychology, the Department has the authority to subpoena confidential mental health information from me relevant to that complaint.

- Worker's Compensation: If you file a worker's compensation claim, I must, upon request of your employer, insurance carrier, an authorized qualified rehabilitation provider, or the attorney for the employer or insurance carrier, furnish you relevant records to those persons.

- Other: I may disclose your health information to authorized federal officials who are conducting national security and intelligence activities or providing protective services to the President or other important officials. By law we cannot reveal when we have disclosed such information to the government.

These are some situations in which I am legally obligated to take actions, which I believe are necessary to attempt to protect others from harm, and I may have to reveal some information about a patient's treatment. These situations are unusual in my practice.

- Child Abuse: If I know, or have reasonable cause to suspect, that a child is abused, abandoned, or neglected by a parent, legal custodian, caregiver or other person responsible for the child's welfare, the law requires that I report such knowledge or suspicion to the Florida Department of Child and Family Services.

- Adult and Domestic Abuse: If I know, or have reasonable cause to suspect, that a vulnerable adult (disabled or elderly) has been or is being abused, neglected, or exploited, I am required by law to immediately report such knowledge or suspicion to the Central Abuse Hotline.

- Serious Threat to Health or Safety: When you present a clear and immediate probability of physical harm to yourself, to other individuals, or to society, I may communicate relevant information concerning this to the potential victim, appropriate family member, or law enforcement or other appropriate authorities.

If such a situation arises, I will make every effort to fully discuss it with you before taking any action and I will limited my disclosure to what is necessary.

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 no 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.

Professional Records

You should be aware that, pursuant to HIPAA, I keep Protected Health Information about you in two sets of professional records. One set constitutes your Clinical Record. It includes information about your reasons for seeking therapy, a description of the ways in which your problem impacts on your life, your diagnosis, the goals that we set for treatment, your progress towards those goals, your medical and social history, your treatment history, any past treatment records that I receive from other providers, reports of any professional consultations, your billing records, and any reports that have been sent to anyone, including reports to your insurance carrier. Except in unusual circumstances through which disclosure would physically endanger you and/or others, or makes reference to another person (other than a health care provider) and I believe access is reasonably likely to cause substantial harm to such other person, you may examine and/or receive a copy of your Clinical Record, if you request it in writing. 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. In most circumstances, I am allowed to charge a reasonable fee for these records. I may withhold copies of your records until payment of these fees has been made. The exceptions to this policy are contained in the attached Notice Form. If I refuse your request for access to your Clinical Records, you have a right of review, which I will discuss with you upon request.

In addition, I also keep a set of Psychotherapy Notes. These notes are for my own use and are designed to assist me in providing you with the best treatment. While the contents of Psychotherapy Notes vary from client to client, they can include the contents of our

conversations, my analysis of those conversations, and how they impact on your therapy. They also contain particularly sensitive information that you may reveal to me that is not required to be included in your Clinical Record. These Psychotherapy Notes are kept separate from your Clinical Record. Your Psychotherapy Notes are not available to you and cannot be sent to anyone else, including insurance companies, without your written, signed Authorization. Insurance companies cannot require your authorization as a condition of coverage no penalize you in any way for your refusal to provide it.

If I should become incapacitated due to illness, injury, or death, your records will be transferred to Ben Cohen, Clinical Psychologist, at 905 E Martin Luther King Dr, Ste 211, Tarpon Springs, FL 34689.

Patient Rights

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

Minors and Parents

Patients under 18 years of age who are not emancipated, and their parents, should be aware that the law may allow parents to examine their child's treatment records. Children between 13 and 17 may independently consent to (and control access to the records of) diagnosis and treatment in a crisis situation. Because privacy in psychotherapy is often crucial to successful progress, particularly with teenagers a, and parental involvement is also essential, it is usually my policy to request an agreement with minors (developmentally over 13 years of age) and their parents about access to information, 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. 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.

Billing and Payments

You will be expected to pay for each session at the time it is held, unless we agree otherwise or unless you have insurance coverage that requires another arrangement. Payment schedules for other professional services will be agreed to when they are requested.

Payment is expected at the beginning of each session unless other arrangements have been made with me. Make you check payable to "Diane Hahn." Personal checks, business checks, and cash are accepted. A $25 charge will be applied for all returned checks.

In the event of late cancellations (less than 48 hours notices) or missed sessions, you will be charged half fee for the time you reserved. Exceptions may be made in the case of illnesses and emergencies, after discussion with me. Insurance policies usually do not reimburse for sessions missed or cancelled late.

In order for us to set realistic treatment goals and priorities, it is important to evaluate what resources you have available to pay for your treatment, I do not typically bill any insurance companies. If you have out of network options I will furnish "super bills" - a receipt that provides a diagnosis, CPT codes, my license information, and all the necessary information that your insurance copay may need. You are responsible for finding out what deductible and co-pay or reimbursement you may receive, so that you have a good idea of what to expect, if you should receive reimbursements for your therapy sessions. If family members or third parties are helping you with the costs we will discuss the complexities, regarding boundaries and any other therapeutic complications that may potentially occur.

I cannot guarantee reimbursement by insurance companies or protect the confidentiality of information given to them, although I am willing to talk with them on your behalf, as necessary.

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 the payment. This may involve hiring a collection agency or going through small claims court which will require me to disclose otherwise confidential information. In most collection situations the only information I release regarding a patient's treatment is his/her name, the nature of services provided, and the amount due. If such legal action is necessary its costs will be included in the claim.

I have read, or have had read to me, the information in this Agreement and I have asked questions about everything I have not understood. I understand that I may revoke this Agreement in writing at any time. That revocation will be binding on Dr. Diane Hahn unless she has taken action in reliance on the Agreement; if there are obligations imposed on Dr. Diane Hahn by my health insurer in order to process or substantiate claims made under my policy; or if I have not satisfied any financial obligation I have incurred.

By signing this form I freely acknowledge my willingness to undergo the psychological treatment to be performed by Dr. Diane Hahn and release her of any liability that might directly or indirectly result from the release or exchange of any information covered by this form. If I wish it, I will be provided with a copy of this form,

I further acknowledge that I have been provided with a copy of the Notice of Privacy Practices.

Please check one box below:

☐ I am the patient

☐ I am the legal representative for the patient: _____

Please print the patient's name in the space above.

Print Your Name: _____

Sign Your Name: _____

Today's Date: _____