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Therapy and Psychological Testing

PSYCHOTHERAPY SERVICE AGREEMENT FOR THE TREATMENT OF CHILD & ADOLESCENT CLIENTS

Welcome to my practice. This document contains important information about my professional services and business policies. It contains summary information about the Health Insurance Portability and Accountability Act (HIPAA), a federal law that provides privacy protections and patient rights about the use and disclosure of your Protected Health Information (PHI) for the purposes of treatment, payment, and health care operations. Although these documents are long and sometimes complex, it is very important that you understand them. When you sign this document, it will also represent an agreement between us. We can discuss any questions you have when you sign them or at any time in the future.

PSYCHOLOGICAL SERVICES

Psychotherapy varies depending on the personalities of the psychologist and client, and the particular issues your child is experiencing. I use many different methods depending on the problems that you hope to address. Psychotherapy is not like a visit to a medical doctor. Instead, it calls for a very active effort on your part and that of your child. In order for the therapy to be most successful, you and your child will have to work on things we talk about both during our sessions and at home.

Psychotherapy has potential benefits and risks. Since therapy often involves confronting unpleasant aspects of your child's life, he or she may experience uncomfortable feelings like sadness, guilt, anger, loneliness, and helplessness. His or her behavior may get worse before it gets better. On the other hand, psychotherapy has been shown to have many benefits. Therapy often leads to better relationships, solutions to specific problems, improved behavior, and significant reductions in feelings of distress. But there are no guarantees of what your child will experience.

APPOINTMENTS

I normally conduct a 1-3 session evaluation. During this time, we can both decide if I am the best person to provide the services you need to meet your treatment goals for your child. By the end of the evaluation, I will be able to offer you some initial impressions of what our work might include. Then we will discuss your goals and create an initial treatment plan. You should evaluate this information and make your own assessment about whether you feel comfortable working with me. If you have questions about my procedures, we should discuss them when 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.

I consider our meetings very important and ask you to respect them as well. Please try not to miss sessions if possible. When you must cancel, please give me at least 24 hours' notice. Your session time is reserved for you and I am rarely able to fill cancelled appointments on short notice. Without 24 hours' notice, you will be charged the full fee. For Monday appointments, I must receive notice by Friday at 5pm. Your insurance will not cover this charge.

PARENT UPDATES AND YOUR CHILD'S PRIVACY

Therapy is most effective when a trusting relationship exists between the psychologist and the client. 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 they feel free to discuss personal matters without fear that their thoughts and feelings will be immediately communicated to their parents. Naturally, the amount of privacy that is appropriate for a child in therapy depends on his/her developmental level. Adolescents who are developing a greater sense of independence and autonomy require a great deal of confidentiality.
I will periodically meet with you for one-on-one updates where we can discuss your child's progress. During these meetings, I will be happy to describe your child's work in therapy in general terms. However, while it is my policy to provide you with general information about your child's treatment, as a general rule, I do *not* share specific information your child has disclosed to me without your child's agreement. This includes activities and behavior that you would not approve of — or might be upset by — but that do not put your child at risk of serious and immediate harm. However, if your child's risk-

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taking behavior becomes more serious, then I will use my professional judgment to decide whether your child is in serious and immediate danger of harm. If I feel that your child is in such danger, I will communicate this information to you. You can always ask me questions about the types of information I would disclose. You can ask in the form of hypothetical situations, such as: "If a child told you that he or she were doing _____, would you tell the parents?"

Even when we have agreed to keep your child's treatment information private, I may believe that it is important for you to know about a particular situation that is going on in your child's life. In these situations, I will encourage your child to tell you, and I will help your child find the best way to do so.

CONFIDENTIALITY

My policies about confidentiality, as well as other information about your privacy rights, are fully described in a separate document titled Notice of Privacy Policies. You have been provided with a copy of that document and we have discussed those issues. Please remember that you may reopen the conversation at any time during our work together.

PROFESSIONAL FEES

The fee for a psychotherapy session is $175.00. You are responsible for paying at the time of your session unless prior arrangements have been made. Payment may be made by check, cash, or credit card. I accept MasterCard or Visa; I do not accept American Express or Discover. Returned checks are subject to an additional fee of $35.00. If you refuse to pay your debt, I reserve the right to use an attorney or collection agency to secure payment; I am permitted under law to disclose limited PHI to obtain payment. In addition to weekly appointments, I charge this amount on a prorated basis (I will break down the hourly cost) for other professional services you may require such as report writing, telephone conversations that last longer than 15 minutes, attendance at meetings or consultations which you have requested (including travel time), or the time required to perform any other service which you may request of me. If you anticipate becoming involved in a court case, I recommend that we discuss this fully before you waive your right to confidentiality. If your case requires my participation, you will be expected to pay for the professional time required even if another party compels me to testify. If 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 reimburse me at the rate of $450 per hour for time spent traveling, speaking with attorneys, reviewing and preparing documents, testifying, being in attendance, and any other case-related costs.

INSURANCE

In order to set realistic treatment goals and priorities, it is important to evaluate what resources you have available to pay for your treatment. If you have a health insurance policy, it will usually provide some coverage for mental health treatment.

I am not in-network with any insurance carriers. If you have a PPO or POS plan, your insurance plan will likely reimburse you for some portion of my fee. You are responsible for paying my full fee at the end of each session and submitting a claim with to your insurance carrier for reimbursement. I am not responsible for obtaining coverage for my services on your behalf.

Due to the rising costs of health care, insurance benefits have become increasingly complex. It is sometimes difficult to determine how much mental health coverage is available. Managed Health Care plans such as HMOs often require advance authorization, without which they may refuse to provide reimbursement. These plans are often limited to short-term treatment approaches designed to address specific problems interfering with a person's usual level of functioning. It may be necessary to seek approval after a certain number of sessions. While a lot can be accomplished in short-term therapy, some clients feel they need more services after insurance benefits end. Some managed-care plans will not allow me to provide services to your child once your benefits end. If this is the case, I will do my best to find another provider to continue your child's therapy.

Most insurance companies require me to provide them with a clinical diagnosis. Diagnoses are technical terms describing the nature of your child's problems and whether they are short-term or long-term. (Diagnoses come from a book entitled the *DSM-V*. There is a copy in my office which I am glad to let you see to learn more about your child's diagnosis.) Sometimes I have to provide additional clinical information such as treatment plans or summaries, or copies of the entire record (in rare cases). This information will become part of the insurance company files, probably stored digitally. All insurance companies claim to keep such information confidential, but I have no control over what they do with it. In some cases, they may share it with a national medical information databank. I will provide you with a copy of any report I submit, if you request it. By signing this Agreement, you agree that I can provide requested information to your carrier if you plan to pay with insurance. If you plan to use insurance, authorization from the insurance company may be required before they will cover therapy fees. If you do not obtain authorization and it is required, you may be responsible for full payment. Some insurance plans also have a deductible, an out-of-pocket amount that must be paid by the client before the insurance company begins paying any

amount for services. This typically means that you are responsible for paying 100% of initial sessions until your deductible has been met. The deductible amount may also need to be met at the start of each calendar year. Once you have all of the information about your coverage, we will discuss what we can reasonably expect to accomplish with the available benefits and what will happen if coverage ends before you feel ready to end your child's sessions. You always have the right to pay for my services yourself to avoid the problems described above and not file claims with your insurance carrier at all.

CONSULTATIONS

If your child could benefit from a treatment I can't provide, I will help you to get it. You have a right to ask me about such treatments, their risks, and their benefits. Based on what I learn about your child, I may recommend a medical exam or a medication consult. If so, I will discuss my reasons with you, so you can make an informed decision. If you are treated by another professional, I will coordinate with them and with your child's pediatrician. If for some reason treatment is not going well, I might suggest your child see another therapist or professional, in addition to me. As an ethical therapist, I cannot continue to treat your child if my treatment is not working. If you wish for another opinion at any time, or wish to talk with another therapist, I will help you find a qualified person and will provide him or her with the information needed.

PROFESSIONAL RECORDS

I am required to keep appropriate records of the services that I provide. Your records are maintained in a secure location in the office. You should be aware that, pursuant to HIPAA, I may keep Protected Health Information about your child in two sets of records. One set constitutes your Clinical Record. It includes information about your reasons for seeking therapy for your child, a description of the ways in which your child's problem impacts his/her life, your child's diagnosis, the goals that we set for treatment, his/her progress towards those goals, your child's medical and social history, treatment history, any treatment records that I receive from other providers, reports of any professional consultations, billing records, and any reports that have been sent to anyone, including reports to your insurance carrier. Except in unusual circumstances, you may examine and/or receive a copy of your child's Clinical Record if you request it in writing. If your child is at least fourteen years old, he/she can also request a copy of his or her Clinical Record. Because these are professional records, they can be misinterpreted and/or upsetting to untrained readers. For this reason, I recommend that you or your child initially review them in my presence or have them forwarded to another mental health professional so the contents can be discussed. In most circumstances, I am allowed to charge an appropriate copying fee (and for certain other expenses). The exceptions to this policy are contained in the Notice of Privacy Policies. If I refuse your child's or your request for access to the Clinical Record, you or your child have a right of review, which I will discuss with you or your child upon your request.

In a few cases, I may also keep a set of Psychotherapy Notes. These are for my own use and are designed to assist me in providing your child with the best treatment. These may include the contents of our conversations, my analysis of those conversations, and how they impact your child's therapy. They also contain particularly sensitive information that your child may reveal to me that is not required to be included in the Clinical Record. These are kept separate from the Clinical Record. While insurance companies can request and receive a copy of your child's Clinical Record, they cannot receive a copy of the Psychotherapy Notes without signed, written authorization. Insurance companies cannot require your authorization as a condition of coverage, nor penalize you in any way for refusal. You may examine and/or receive a copy of the Psychotherapy Notes unless I determined that such information does not exist or cannot be found, or such disclosure would be injurious to your health or well-being or that of your child. If your child is at least fourteen years old, he or she may also examine and/or receive a copy of the Psychotherapy Notes, under these same conditions.

If I meet with you or other family members in the course of your child's treatment, I will take notes of that meeting in the treatment records. Those notes will be available to any person or entity that has legal access to your child's treatment record.

Although the law may give you the right to see written records about your child's treatment, by signing this agreement, you agree that your child should have privacy in therapy, and you agree not to request access to written treatment records.

CLIENT RIGHTS

HIPAA provides you with rights regarding to your Clinical Record and disclosures of protected health information (PHI). These include requesting that I amend your child's record; requesting restrictions on what information from your child's Clinical Record is disclosed to others; requesting an accounting of most disclosures of PHI that was neither consented to nor authorized; determining the location to which PHI disclosures are sent; having any complaints made about my policies and procedures recorded in your child's records; and the right to a paper copy of this Agreement, the Notice of Privacy Policies, and my privacy policies and procedures. I am happy to discuss any of these rights with you.

CONTACTING ME

I am often not immediately available by phone, as I do not answer when I am with clients and I am often otherwise unavailable. At these times, you may leave a message on my confidential voicemail and I will return your call when possible. It may take a day or two for non-urgent matters. Even for urgent matters, there may be any number of unforeseen reasons that you do not hear from me or I am unable to reach you. If you cannot wait for my call or if you feel unable to stay safe, you or someone close to you should call 911 or go to the emergency room. I will make every attempt to inform you in advance of planned absences and provide you with the name and phone number of the mental health professional covering my practice.

PARENT AUTHORIZATION FOR TREATMENT

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, please notify me immediately. I will ask you to provide me with a copy of the most recent custody decree establishing custody rights or otherwise demonstrating that you have the right to authorize treatment for your child.

If you are separated or divorced, be aware that it is my policy to notify the other parent that I am meeting with their child. I believe it is important that all parents know that their child is receiving mental health evaluation or treatment, except in exceptional circumstances.

One risk of child therapy involves disagreement among parents and/or disagreement between parents and the therapist regarding the child's treatment. If such this occurs, I will try to understand your perspectives and fully explain mine. We can resolve such disagreements, or we can agree to disagree, as 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, except in extraordinary circumstances. However, in most cases, I will ask that you allow me the option of having a few closing sessions with your child to appropriately end the treatment relationship.

CUSTODY DISPUTES

If you ever become involved in a divorce or custody dispute, I ask that you understand and agree that I will not provide evaluations or expert testimony in court. You should hire a different mental health professional for any evaluations or testimony you require. The testimony will damage my relationship with your child, and I must put this relationship first.

By signing this agreement, 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.

Your agreement may not prevent a judge from requiring my testimony, even though I will not do so unless legally compelled. If I am required 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, if appropriate releases are signed or a court order is provided, but I will not make any recommendation 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 reimburse me at the rate of $450 per hour for time spent traveling, speaking with attorneys, reviewing and preparing documents, testifying, being in attendance, and any other case-related costs.

OTHER POINTS

If, as part of our therapy, your child creates and provides to me records, notes, artworks, or any other documents or materials, I will return the originals to you at your written request but will retain copies.

If you are unhappy with what is happening in therapy, I hope you will talk with me so that I can respond to your concerns. These comments will be taken seriously and handled with care and respect. You may also request that I refer your child to another therapist, and you are free to end therapy at any time. You have the right to considerate, safe and respectful care, without discrimination as to race, ethnicity, color, gender, sexual orientation, age, religion, national origin, or source of payment. You have the right to ask questions about any aspects of therapy and about my specific training and experience. You have the right to expect that I will not have social or sexual relationships with clients or with former clients.

OUR AGREEMENT

Please initial each statement and sign below.

PLEASE NOTE: If your child is 14 years old or older, therapy cannot begin without both parents' initials/signature.

_____ _____ I (parent/guardian) understand I have the right not to sign this form.

_____ _____ I have read and discussed this agreement. It does not indicate that I am waiving any of my rights. I understand I can choose to discuss my concerns with you, the therapist, before my child starts formal therapy. I also understand that any of the points mentioned above can be discussed and may be open to change. If at any time during treatment I have questions about any of the subjects discussed in this brochure, I can talk with you about them, and you will do your best to answer them.

_____ _____ I understand that after therapy begins, I have the right to withdraw my consent to therapy at any time, for any reason. However, I will make every effort to discuss my concerns about my progress with you before ending therapy with you.

_____ _____ I understand that no specific promises have been made to me by this therapist about the results of treatment, the effectiveness of the procedures used by this therapist, or the number of sessions necessary for therapy to be effective.

_____ _____ I have read, or had read to me, the issues and points in this document, discussed the points I did not understand, and have had my questions answered. I agree to act according to the points covered here. I agree to have my child enter into therapy with this therapist, and to cooperate fully and to the best of my ability, as shown by my signature here.

_____ _____ I will refrain from requesting detailed information about individual therapy sessions with my child. I understand that I will be provided with periodic updates about progress, and/or may be asked to participate in therapy sessions as needed.

_____ _____ Although I may have the legal right to request written records/session notes since my child is a minor, I agree *not* to request these records in order to respect the confidentiality of my child's/adolescent's treatment.

_____ _____ I understand that I will be informed about situations that could endanger my child. I know this decision to breach confidentiality in these circumstances is up to the therapist's professional judgment, unless otherwise noted above.

MY SIGNATURE INDICATES THAT I HAVE READ THIS AGREEMENT AND AGREE TO ITS TERMS DURING OUR PROFESSIONAL RELATIONSHIP.

_____ _____

Signature of Parent/Guardian Date

_____

Printed Name

_____ _____

Signature of Parent/Guardian Date

_____

Printed Name

_____

Child's Name