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## Psychologist-Client Agreement

This document 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 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 health care operations. The Notice, which follows these Office Policies and is included as part of the services 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 at the end of our first session.

Although these documents are long and sometimes complex, it is very important that you read them carefully. We can discuss any questions you have about the procedures. When you sign the signature page of this form, your signature will 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 my 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.

## Client Rights and HIPAA

HIPAA provides you with several new or expanded rights with regards to your Clinical Record and disclosures of Protected Health Information. These rights include requesting that I amend your record; requesting restrictions on what information from your clinical record 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, the accompanying HIPAA Notice form, and my privacy policies and procedures. 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 allows parents to examine their child's treatment records unless I believe that doing so would endanger the child or we agree otherwise. Because privacy in psychotherapy is often crucial to successful progress, particularly with tweens and

teenagers, it is my policy to request an agreement from parents that they consent to give up their access to their child's records. If they agree, during treatment, I will provide them only with general information about the progress of the child's treatment, and his/her 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.

___ Parent/guardian initials ____ Parent/guardian initials ____ Child's initials

**Confidentiality**

All communications between a client and a psychologist are considered private and will be held in confidence. 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 HIPAA. **There are other situations that require only that you provide written, advance 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.

2. You should be aware that I at times work with trainees. In many cases, I need to share protected information with these individuals for both clinical and administrative purposes, such as scheduling, billing, quality assurance, and training. All of the mental health professionals are bound by the same rules of confidentiality. All trainees have been given training about protecting your privacy and have agreed not to release any information outside of the practice without my written permission.

3. Disclosures required by health insurers or to collect overdue fees are discussed elsewhere in this agreement.

4. If a client threatens to harm himself/herself, I may be obligated to seek hospitalization for him/her, or to contact family members or others who can help provide protection.

**There are some situations where I am permitted or required to disclose information without either your consent or authorization:**

1. If you are involved in a court proceeding and a request is made for information concerning my professional services, 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 be likely to order me to disclose information.

2. If a government agency is requesting the information for health oversight activities, I may be required to provide it for them.

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

4. If a client files a worker's compensation claim, and I am providing treatment related to the claim, I must, upon appropriate request, furnish copies of all medical reports and bills.

5. There 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 client's treatment.

6. If I have reason to believe that a child has been abuse, the law requires that I file a report with Child Protective Services (in Hawaii) or appropriate government agency (elsewhere). Once such a report is filed, I may be required to provide additional information.

7. If I have reasonable cause to believe that a disabled adult or elder person has had a physical injury or injuries inflected upon him/her, other than by accidental means, or has been neglected or exploited, I must report to Adult Protected Services (in Hawaii) or appropriate government agency (elsewhere). Once such a report is filed, I may be required to provide additional information.

8. If I determine that a client presents a serious danger of violence to another, I may be required to take protective actions. These actions may include notifying the potential victim, and/or contacting the police, and/or seeking hospitalization for the client.

If such a situation arises, I will make every effort to fully discuss it with you before taking any actions, and I will limit 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 not or in the futures.

**Client Records**

The laws and standards of my profession require that I keep Protected Health Information (PHI) about you in your clinical record. Except in unusual circumstances that involve danger to yourself and others or makes reference to another person (unless such other person is a health care provider) and I believe that access is reasonably

likely to cause substantial harm to such other person or where information has been supplied to me confidentially by others, 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 situations, I am allowed to charge a copying fee of 50 cents per page (and for certain other expenses like postage). If I refuse your request for access to your records, you have a right of review (except for information provided to me confidentially by others) which I will discuss with you upon request.

**Limitations in Forensic Settings**

My practice is a clinical psychology practice aimed at providing psychological healing services. I do not specialize in forensic evaluations (child custody evaluations, other evaluations requested by courts). Although I may be required by a court to provide records or testify (via a valid court order), forensic evaluations are not a part of my regular practice. If I do provide letters for submission to the court, the content will only be about psychological evaluation results of testing, treatment attendance, and treatment compliance. I do not provide opinions on where a child should be placed and/or other information that parents and/or their counsel may desire.

____ Patient/parent/guardian initials _____ Patient/parent/guardian initials

**Emergencies and After-Hour Calls**

I schedule appointments and am in my office from 8am to 5:30pm Tuesdays and Thursdays, and 8am-3pm on Sundays. I also have a dedicated phone line with voice mail for my practice. I may not be able to answer the phone, even during office hours, as I may be with a client. I will make every effort to return your call on the same day you make it, with the exception of Saturdays and holidays. If you are difficult to reach, please inform me of times when you will be available. If you are unable to reach me and feel that you can't wait for me to return your call, contact your family physician or the nearest emergency room. If I will be unavailable for an extended period of time, I will provide you with the name of a colleague to contact, if necessary.

**Reminder calls/texts/e-mails**

Normally, reminder calls for appointments will be made a few days before the appointment. Unless authorized below, these calls will be by phone to the phone number indicated as the primary contact number (or numbers) by patient/parent/guardian. Text and e-mail are not HIPAA compliant ways to communicate, and thus not secure forms of communication. If indicated below, the patient/parent/guardian is requesting that reminder calls be made in another format and understands that these transmissions may not be fully secure. The minimum information required for the

reminder will be used (usually just date and time of appointment, with initial of the patient/child if there are more than one patient per family).

I hereby agree that Stephanie Dodge, PhD may contact me by the following means of communication for appointment reminders/schedule changes only.

_____ text _____

_____e-mail _____

other _____

**Missed Appointments and No-Show Policy**

If you are unable to make an appointment, please call to let me know at least 24 hours in advance of your scheduled appointment. If you do this, the cancelled appointment will not be counted a "no-show." If you do not cancel in advance (per above), and miss an appointment or are more than 15 minutes late for an appointment, the appointment will be considered a "no-show" for that appointment. If you accrue more than 2 "no-show" appointments in any given 2 month period, or out of any 8 consecutive appointments, you will be able to continue receiving services, but may be put on the waiting list and not able to get your next appointment as quickly as if you regularly keep (or give 24-hour notice for cancellation) you appointments.

**Professional Fees**

My hourly fee is $170. In addition to scheduled appointments, I charge this amount for 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 may include report writing, telephone conversations lasting longer than 10 minutes, attendance at meetings with other professionals you have authorized, preparation of records or treatment summaries, and the time spent performing any other service you request of me. If you become involved in legal proceedings that require my participating, you will be expected to pay for my professional time even if I am called to testify by another party. Because of the difficulty of legal involvement, I charge $325 per hour for preparation and attendance at any legal proceeding.

**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.

**Insurance Reimbursement**

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. If you have a health insurance policy, it will usually provide some coverage for mental health treatment. I will fill out forms and provide you with whatever assistance I can in helping you receive the benefits to which you are entitled; however, you (not your insurance company) are responsible for full payment of my fees. It is very important that you find out exactly what mental health services you insurance policy covers.

You should be aware that most insurance companies require you to authorized me to provide them with a clinical 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 and will probably be stored in a computer. Though all insurance companies claim to keep such information confidential, I have no 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 report I submit if you request it.

Once we have all of the information about your insurance coverage, we will discuss what we can expect to accomplish with the benefits that are available and what will happen if they run out before you feel ready to end our sessions. It is important to remember that you always have the right to pay for my services yourself to avoid problems described above (with exceptions for some insurers).

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

Signature: _____ (parent/guardian)

Name (printed): _____ (parent/guardian)

Signature: _____ (parent/guardian)

Name (printed): _____ (parent/guardian)

Signature: _____ (child)

Name (printed): _____ (child)

Date: _____

Provider's Signature: _____