

SCOTTSDALE PSYCHOLOGICAL ASSOCIATES, LLC

OUTPATIENT SERVICES AGREEMENT

Welcome to our practice. This document contains important information about our professional services and business policies. It also contains summary information about the Health Insurance Portability and Accountability Act (HIPAA), a federal law that provides privacy protection and patient rights with regard to the use and disclosure of your Protected Health Information (PHI). If requested our front office will provide you with a notice explaining in greater detail HIPAA and its application to your personal health information. You may also review this notice on our practice website.

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 us unless we have taken action in reliance on it; if there are obligations imposed on us 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 provider and the patient, and the particular problems you are experiencing. In order for 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, solution to specific problems, and significant reductions in feelings of distress. 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, we 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 opinions of whether you feel comfortable working with us. If you have questions about our procedures, we should discuss them whenever they arise. If your doubt persists, we will be happy to help you set up a meeting with another mental health professional for a second opinion.

Providers in this practice limit our services to treatment and not forensic/legal work, which requires different training, ethics and focus. Therefore we will not write letters, consult with your attorneys or release records in any legal dispute. If requested by a judge to provide services, you will be charged for our professional time required, including but not limited to, review of records, copying of documents, travel time, and testimony. Pre-payment is expected.

If psychotherapy is begun, scheduling can be flexible although we often will see someone on a once per week basis. Once an appointment is made and you need to cancel it, please contact the office **at least 24 business hours in advance to cancel an appointment**. Insurance does not cover missed appointments and late cancellations. Therefore, the responsible party will be billed for 50% of the provider's billable hourly rate. Any check which is received back from the bank is subject to a \$35.00 processing fee or the bank fee, whichever is larger.

MEDICATION SERVICES

Our medication provider's goal is to prescribe medication in the most effective manner and to appropriately monitor patient response, including potential side effects. They will evaluate a patient before prescribing any new medications, or refilling existing prescriptions. The office will refill prescriptions during regular office hours only. No prescriptions will be authorized after hours or on weekends. Please plan ahead (3-5 days is advisable). **The provider may not be in the office the day you request your medication refill and will not be paged for refill requests.** If the medication is a controlled substance, the law requires written prescriptions. You will need to set up a follow up appointment or make arrangements to pick up the prescription at the office. If you need to cancel an appointment, please contact the office **at least 24 business hours in advance to cancel an appointment**.

_____ Initials

PROFESSIONAL FEES AND BILLING

Our initial consultation fee is \$ _____ and our regular hourly fee is \$ _____. You are responsible for the entire amount billed for our services. We will bill your insurance as a courtesy to you. You are responsible for any co-pays or deductibles at the time of service. Many insurance companies have additional stipulations that may affect your coverage. You are responsible for any amount not covered or denied by your insurer. The responsible party also agrees to notify the office of changes in coverage within 10 days and is responsible for all charges not covered by insurance as allowed by third party payor agreements.

You should also be aware that your contract with your health insurance company requires that we provide the company with information relevant to the services that we provide to you, including a clinical diagnosis. Sometimes we are required to provide additional clinical information such as treatment plans or summaries. We will make every effort to release only the minimum information about you that is necessary for the purpose requested. Your signature on this document acknowledges your consent for us to provide this information to your insurance company.

Insurance companies do not pay for many services that require the provider's time, such as the completion of non-insurance forms, writing letter, non-routine telephone calls, and the copying and release of charts. As a result, you will be billed directly for those services, based on the provider's hourly rate. Pre-payment is expected for letters, the completion of forms, and the copying and the release of charts.

If your account has not been paid for more than 60 days and arrangements for payment have not been agreed upon, we have the option of using legal means to secure the payment. This may involve hiring a collection agency, although we will make every attempt to avoid this action. In most collections situations, the only information we release regarding a patient's treatment is his/her name, the nature of services provided and the amount due. Any fee incurred in the collection of this account becomes the responsibility of the patient/ guardian. Such fees may range up to 30% of the amount owed. **If your account is sent to collections, no further services will be provided until that balance is paid in full.**

MINORS AND PARENTS

It is our office policy not to treat patients under the age of 18 without the written permission of both parents and/or legal guardians. Parents will be asked to sign an additional treatment consent by your child's therapist.

Patient's under 18 years of age who are not emancipated will be told that the law does allow parents to examine their treatment records. Because privacy in psychotherapy is often crucial to successful progress, particularly with adolescents, often before giving parent s any information we will discuss the matter with the child and if possible do our best to handle any objections he/she may have.

CONTACTING YOUR THERAPIST

Due to our work schedule, we are often not immediately available by telephone. When unavailable, our telephone is answered by either our front office, or our answering service. You may also leave a confidential voice mail message. We 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 us of some times when you would be available. If it is an emergency situation please call 911 or go to your nearest emergency room. If your therapist will be unavailable for an extended period of time, the front office or answering service will relay your message to a provider who is on call during their absence.

LIMITS ON CONFIDENTIALITY

The law protects the privacy of all communications between a patient and a therapist. In most situations, we 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:

- We may occasionally find it helpful to consult other health and mental health professionals about a case. During a consultation, we make every effort to avoid revealing the identity of our patient. The other professionals are also legally bound to keep the information confidential.

_____ Initials

- You should be aware that SPA therapists practice with other mental health professionals and that we employ administrative staff. In most cases, we need to share protected information with these individuals for either clinical or administrative purposes, such as scheduling, billing and quality assurance. All of the mental health professionals are bound by the same rules of confidentiality. All staff members have been given training about protecting your privacy and have agreed not to release any information outside of the practice without the permission of a professional staff member.
- We have formal business contracts with any businesses we utilize, such as our answering service, to maintain the confidentiality of our clients.
- If a patient threatens to harm herself/himself, we may be obligated to seek hospitalization for her/him, or to contact family members or others who can help provide protection.

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

- If we have reason to believe that a child under 18 who we have examined is or has been the victim of injury, sexual abuse, neglect or deprivation of necessary medical treatment, the law requires that we file a report with the appropriate government agency. Once such a report is filed, we may be required to provide additional information.
- If we have reason to believe that any adult patient who is either vulnerable and/or incapacitated and who has been the victim of abuse, neglect or financial exploitation, the law requires that we file a report with the appropriate government agency. Once such a report is filed, we may be required to provide additional information.
- You should be aware that the law is evolving and that there may be other circumstances when we are required by law to reveal information about a patient’s treatment.

PROFESSIONAL RECORDS

Our clinical records include 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 and your billing records.

Except in unusual circumstances that involve danger to yourself and others or where information has been supplied to us by others confidentially, 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, we recommend that you initially review them in our presence, or have them forwarded to another mental health professional so you can discuss the contents. We will charge a reasonable fee for the copying of records.

The above is a summary of our office policies and your rights and obligations as a patient of Scottsdale Psychological Associates. Your signature below indicates that you have read the information in this document and agree to abide by its terms during our professional relationship. If you have additional questions, please feel free to discuss them with your individual provider.

Printed Name of Patient

Signature

Printed Name of Parent/Guardian

Signature of Parent/Guardian

Printed Name of Parent/Guardian

Signature of Parent/Guardian

Date

Signature of Provider