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PSYCHOLOGIST-CLIENT SERVICES AGREEMENT

This document (the Agreement) is intended to give you a better sense of your rights and responsibilities as a client as well as important information about 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 protections and 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 you are provided with a Notice of Privacy Practices (the Notice) for use and disclosure of PHI for treatment, payment and health care operations. The Notice, available with this Agreement, explains HIPAA and its application to your PHI in greater detail.

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 unless action is taken in reliance on it, if there are obligations imposed on me by your health insurer, or if you have not satisfied any financial obligations you have incurred. It represents a contract for services and, when signed, indicates you agree to the conditions herein. Please read it carefully and ask any questions you have with me when we meet in person.

SERVICES PROVIDED

I provide individual and couples psychotherapy services to adult clients (18+), as well as clinical supervision and consultation to mental health professionals at all levels of experience.

FEES / PAYMENTS

My fee is $160 for a 50 minute session. I accept cash, checks, and most major credit cards, including Health Saving Account (HSA) cards. Payment is required at the time of the initial consultation session as well as the start of each individual or couples counseling session. I am an in-network provider with Blue Cross Blue Shield (Blue Choice PPO, BlueOptions, and ParPlan). My office will submit claims for clients with these insurance policies. If you plan to use your health insurance coverage for your treatment you should contact your insurance company before our initial meeting to determine your coverage benefits for behavioral health providers. I am considered an out-of-network provider for health insurance plans other than Blue Cross Blue Shield. Your insurance carrier will be able to inform you about whether or not your sessions will be covered, what percentage will be covered, and their procedures for reimbursement. If you plan to file a claim for reimbursement with your insurance company I am happy to provide you with a copy of an itemized statement and receipt for services provided.

CANCELLATION / NO SHOW POLICY

I require 24 hours notice for cancellation or rescheduling of an appointment. No shows or cancellations within 24 hours of our appointment time will be billed to the client at the full session rate. If, after a period of a month, you have not rescheduled an appointment and I have not heard from you regarding needing additional services I will no longer consider you an active client and will close your client file.

CONTACT

I check my voicemail and email throughout the day on weekdays and will respond to messages as soon as possible. Messages left on weekends, holidays, or after 5 pm on weekdays will not be returned until the next business day. If you are in crisis and need to talk with a mental health professional outside of the hours stated above please contact the 24 hour Hotline for Help at 512-472-4357 (512-472-HELP). If you are at any risk of harming yourself or someone else (or you believe your life is at risk) please call 911 or proceed to the nearest hospital emergency room.

PRIVACY POLICIES / LIMITS ON CONFIDENTIALITY

You can expect that I will treat you and your personal concerns with the greatest of sensitivity, particularly when it comes to

keeping your information confidential. The law protects the privacy of all communications between a client and a psychologist. This means that anything you share with me during counseling sessions stays strictly between us with a few important exceptions outlined below.

In most situations, information about your treatment may only be released 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:

- Case consultation with other professionals to ensure you are receiving the best care. In these circumstances, all identifiable information will be omitted to protect your confidentiality.
- Disclosures required by health insurers or to collect overdue fees are discussed elsewhere in this Agreement.

In the following instances I will not be able to keep your information confidential:

- If you demonstrate intent to physically harm yourself or another individual, I may need to involve others (e.g., police, EMS) to ensure your safety or the safety of others.
- If you report risk of ongoing abuse or neglect to a minor under the age of 18, an individual with a disability, or an elder adult, I am responsible for reporting this to authorities to ensure the safety of vulnerable individuals.
- If you report a history of abuse perpetrated by a mental health professional or clergy, I am responsible for reporting this to licensing agencies and authorities.
- If a judge orders your records released, I need to comply with that request. If I receive a subpoena for your records from a lawyer or another party, rather than an order from a judge, I am not obligated to respond or release information and will attempt to contact you regarding the request. In such instances, I only release information with a client's written permission.
- There may be other rare situations in which I am required to share confidential information (e.g., to a health oversight or national security agency). In such instances it is my policy to attempt to contact the client to inform them I am required to disclose confidential information and will attempt to share the least amount of information necessary.

RECORDS

Your records are maintained electronically on a secure server. If you have reason to request a copy of your records, I require you to sign a release of information. If you are requesting I release the records directly to you, typically I will request you set an appointment with me to review your records and ensure you understand what is included.

ELECTRONIC COMMUNICATION

Email communication, once sent, resides on the server of the recipient and the sender. Additionally, I may not readily access electronic communication so urgent needs may not be addressed immediately. With these considerations in mind, due to my desire to protect your confidentiality and meet your needs in a timely manner if you have consented to electronic communication I try to refrain from using electronic communication with the exception of scheduling purposes. I discourage any contact via social media networks or text messaging.

A paper copy of this consent form is available to you at any time upon request. Your signature below indicates receipt of and agreement to this Psychologist-Client Services Agreement.

_____ _____

Signature Date

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Printed Name

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* This notice will go into effect on August 1, 2016