Jennifer Wilcox PhD
3736 North High Street
Columbus OH 43214

Psychologist License No 6526
P 614.265.2530 F 614.265.2531

CLIENT AGREEMENT AND NOTIFICATION

Welcome! Thank you for entrusting my practice with your mental health care needs. I am pleased to have the opportunity to work with you. This document contains important information about my professional services and business practices. It also contains summary information about the Health Insurance Portability and Accountability Act (HIPAA), a federal law that provides privacy protection and patient rights regarding 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. This Notice, 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 receipt of this information. Your signature on this document represents an agreement between us. You may revoke this Agreement in writing at any time. That revocation will be binding unless I have acted in reliance on it; if there are obligations imposed by 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.

If you have any questions or concerns about these policies or any other aspect of my practice, please feel free to discuss them with me.

PROFESSIONAL SERVICES

Psychotherapy varies depending on the presenting concerns of the client, the theoretical orientation or therapeutic style of the therapist, and the personalities of the client and therapist. Research supports the effectiveness of psychotherapy for various behavioral and emotional concerns. There are multiple methods used to treat problems, and psychotherapy has benefits and risks. Treatment may include discussion of issues that are uncomfortable for you. As a result, you may experience unpleasant feelings during therapy such as sadness, anxiety, guilt, anger, frustration, and helplessness. You may also discover that therapy facilitates relief from distress and leads to more fulfilling relationships and solutions to specific problems. Early in therapy, I will discuss with you my impressions of what your work in therapy will involve. While I use my best professional judgment for your well-being, I cannot guarantee that you will obtain the results you seek. If at any time you feel you are not benefiting from treatment, please share your concerns with me so we can discuss alternatives including a referral to another provider, as indicated.

APPOINTMENTS

Appointments are typically 60 minutes in duration, however 45-minute sessions are also available depending upon the focus of treatment. We will discuss the length of sessions at the outset of treatment based upon your individual needs and presenting concerns. To schedule, cancel or change your appointment, please email me (drwilcox@drjenniferwilcox.com). You may also call/text me at 614.783.7128. Text and email should be used for scheduling and administrative matters only. Anything of a clinical nature should be discussed during your scheduled sessions.

EMERGENCIES

In the event you need urgent care between sessions, and you are unable to reach me, please contact:

Netcare Corp Crisis Hotline 614.276.CARE (2273) or OSU Harding Hospital 614.293.9600

FEES

All services are provided on a fee for service basis. I am out of network with all insurance plans. As such, clients are responsible for the full-service fee. A detailed fee scheduled will be provided prior to beginning treatment. If you

Jennifer Wilcox PhD
3736 North High Street
Columbus OH 43214
Psychologist License No 6526
P 614.265.2530 F 614.265.2531

have out of network coverage with your insurance plan and would like to submit claims to your insurance company for possible reimbursement, a super bill will be provided to you upon request.

In addition to therapy appointments, I charge the basic hourly session fee for other professional services you may need including telephone conversations of a clinical nature, report writing, consulting with other professionals at your request, preparation of records or treatment summaries, and the time spent performing any other services. In the unlikely event that I would be called into court to testify, for depositions, or if subpoenaed (even if called by another party), my fee is $400 per hour.

If you need to cancel your appointment, 24 hours' notice is required. If an appointment is missed or cancelled with less than 24 hours' notice, a late cancellation/no-show fee will be charged. For the first missed appointment, 50% of the session fee will be charged. For any late cancellations/no-shows thereafter, the full session fee will be charged.

Payment is expected at the time of service. I accept all major credit cards, health savings cards and cash as forms of payment. If you anticipate problems paying your bill, please discuss this with me as soon as possible to make a payment plan and to minimize any misunderstandings. A reasonable collections charge will be added to your balance should collections services be necessary to receive payment for your treatment. At that point, confidentiality regarding your name and involvement in therapy can be broken. To avoid this, please pay your bill at the time of service.

If you choose to place a credit card on file for payment, you are hereby authorizing my practice to charge the card on file for any services rendered or fees incurred.

CONFIDENTIALITY

In general, the law protects the confidentiality of all communications between a patient and a psychologist, and I can only release information about your treatment to others with your written permission. However, there are some situations in which I am legally entitled or even required to release patients' protected health information without their authorization. If you choose to submit claims to insurance, I am required to release clinical information on the super bill you will be provided. In some situations, I can also be compelled to release patient records by the courts and by the Board of Psychology.

In the following situations, I must take action to protect people from harm, even though that requires revealing some information about a patient's treatment. If I believe that a child, an elderly person, or a disabled person is being abused, I must file a report with the appropriate agency. If I believe that a patient is threatening serious bodily harm to him or herself or to another, I am required to take protective actions which may include contacting authorities, family members or others who can help provide protection. I may also be required to release confidential information under court order, although such an occurrence is unusual in my practice.

If such a situation arises, I will make every effort to fully discuss it with you and will limit my disclosure to what is necessary. It is important to discuss any questions or concerns you have regarding the limits to confidentiality now or in the future.

Your signature indicates that you have received a copy, read, understood, and are willing to abide by the above agreement.

____

Signature *Date*