OUTPATIENT SERVICES CONTRACT

Welcome to Child & Adolescent Psychology Associates (CAPA) and thank you for choosing us to work with you and your family. This document provides important information about our business policies and professional services. Please read this carefully and if you have any questions discuss them with your provider.

PROFESSIONAL SERVICES AND APPOINTMENTS

Our providers are not employed by CAPA, rather we are all self-employed psychologists who work collaboratively within CAPA. As such each provider is responsible for their own practice including what services they offer, insurances they are paneled with, and hours of availability. The information provided in this contract applies to all providers working within CAPA.

Your appointment time with CAPA is protected for you, we take great efforts to be ready for you in a timely manner and ask that you arrive at least 5 min prior to your appointment time. If you arrive more than 15 minutes late, we may not be able to see you that day. We ask that you email your provider directly or call 513-589-0900 to cancel an appointment at any time. **We ask that you cancel appointments in advance at least 24 hours for therapy and 48 hours for testing/assessment. Monday appointments must be cancelled by the previous Friday at 5pm. Failing to do so will be considered a no-show. No-shows cannot be billed to insurance and will be billed to the family at a rate of $250 for testing/assessment and $60 for therapy.**

BILLING, PAYMENT, AND INSURANCE

You have the right to use insurance benefits if you have an insurance carrier that is accepted by your provider and if your policy provides benefits that cover the services being provided by your provider. As policies vary, it is your responsibility to contact your health insurance carrier prior to your appointment in order to understand your benefits and coverage. It is also your responsibility to obtain any needed authorizations prior to your appointment. Failure to do so may result in reduced or non-payment and you will be responsible for the full balance. Having health care insurance does NOT guarantee coverage of our services by your carrier.

Self-pay appointments are also available if our providers are not on your insurance panel or you do not have insurance coverage. For these appointments, our providers will not submit any information to your insurance carrier. If requested, the provider can provide documentation of your out of pocket expenses for you to submit to your insurance carrier for possible out of network reimbursement.

Fees (e.g., self-pay costs, co-pays, deductibles) are due at the time of services. We accept cash, checks and credit cards for payment. There will be a $25 fee for any returned checks. Balances not paid within 60 days will be considered delinquent and will incur a $25 fee. Please note that a collection agency is used for any bills over 90 days past due. The collection agency fee is charged directly to the client's delinquent account. Please understand that the collection agency may release information related to unpaid balances to third parties including attorney's and credit reporting agencies.

EMERGENCIES

Your provider will review with you their individual availability. They are typically not immediately available by telephone due to being in session with other patients but do monitor their voicemail regularly. In the event of an emergency and you feel you cannot wait for a return call, please contact your primary care physician or the nearest emergency room. Crisis lines are also available 24 hours a day (Butler County 844-427-4747; Hamilton County 281-CARE; Warren County 877-695-633).

CONFIDENTIALITY

Patient information is always held confidential by both ethical and legal standards. However, there are certain circumstances in which your provider is legally obligated to breach confidentiality.

1. Situations in which the provider must take action to protect others from harm.
    a. If the patient is assessed to be at a clear and substantial risk for imminent suicide, contact responsible family member to help provide protection and seek hospital evaluation.
    b. If a child, vulnerable elderly adult or disabled person is being abused, by Ohio law a report must be filed with the appropriate state agency.
    c. If the patient is threatening imminent bodily harm to another, protective actions are required. This may include contacting the potential victim, contacting the police or seeking hospitalization of the patient.
2. Your insurance carrier may require confidential patient information in order to authorize treatment or obtaining payment for services.
3. Court mandated subpoenas ordered by a judge.
4. Parents have the legal rights to their minor's treatment records. When working with a minor, the confidentiality of the minor is critical in order to have an effective therapeutic relationship. Your provider will speak with parents to try and ensure that minors experience the same degree of confidentiality as adults.

In an effort to coordinate care, providers within CAPA may share pertinent clinical information about a patient with each other. You may revoke this right for providers to share information with one another but will need to do so in writing.

TELEPSYCHOLOGY

Telepsychology refers to services or communication through electronic means (e.g., phone, video, email, text). These types of communications will be determined by you and your provider. Patient

reports and billing can also be sent via email. If you request, information may be faxed to referring physician, agency or any company you request we send information. Please know that our phone, fax, email and internet are all secure and HIPAA compliant. However, security breaches are possible with any system and you need to be aware that there is some degree of risk, no matter how minimal, associated with any electronic communication. If there is any form of communication you wish to prohibit, please discuss this with your provider.

Your signature below indicates agreement with the following:

1. You have read this outpatient services contract and agree to its terms.
2. You consent to treatment for you or your dependent child or adult
3. If you are seeking services for a dependent, you are a biological parient, adoptive parent, or legal guardian with full rights to make health care decisions for your dependent listed below.
4. You authorize your insurance company to reimburse your provider directly for services provided. You accept personal financial responsibility for any services rendered.

_____ _____

Name of Patient (please print) Patient Date of Birth

_____ _____

Signature of patient or legal guardian Date

9200 Montgomery Rd
Unit 17A
Montgomery, OH 45242

8050 Beckett Center Dr
Suite 225
West Chester, OH 45069

Phone: (513) 589-0900