**Cynthia R. Mathis, LMFT, PLLC**

**Lauren McBride, LPC**

**1483 Chain Bridge Road, Suite 301**

**McLean, VA 22101**

**703.401.5394**

**PSYCHOTHERAPIST-PATIENT SERVICES AGREEMENT**

Welcome to my practice. 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 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 I provide you with a Notice of Privacy Practices for use and disclosure of PHI for treatment, payment and health care operations. The law requires that I obtain your signature acknowledging that I have provided you with this information. 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 at any time. 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 me unless I have taken action in reliance on it; if you have not satisfied any financial obligations you have incurred.

**PSYCHOTHERAPY SERVICES**

Psychotherapy is not easily described in general statements. It varies depending on the personalities of the therapist and patient, and the particular problems you are experiencing. There are many different methods I may use to deal with the problems that you hope to address. Psychotherapy is not like a medical doctor visit. Instead, it calls for a very active effort on your part in order for the therapy to be most successful. You will have to work on things we talk about both during our sessions and at home.

Our first few sessions will involve an evaluation of your needs (or the needs or your child). By the end of the evaluation, I 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 own opinions of whether you feel comfortable working with me. Therapy involves a large commitment of time, money, and energy, so you should be very careful about the therapist you select. If you have questions about my procedures, we should discuss them whenever they arise. If your doubts persist, I will be happy to help you set up a meeting with another mental health professional for a second opinion.

**MEETINGS &** **CANCELLATIONS**

I normally conduct an evaluation that will last from 2 to 4 sessions. During this time, we can both decide if I am the best person to provide the services you (or your child) need in order to meet your treatment goals. If psychotherapy is begun, I will usually schedule one 45-minute session per week at a time we agree on, although some sessions may be longer or more frequent. Regular attendance is a critical factor of successful therapy. You are financially responsible for your appointments or for those of your child. Because unforeseen circumstances arise, however, the following policies have been adopted:

*Adults:* You may cancel two appointments each year without being charged if notice is given within **48 hours** of your scheduled appointment. Additional cancelled appointments must be rescheduled within one month of the cancellation or you will be charged for the missed session. You will be charged for all appointments that are not canceled prior to the session.

*Children:* You will not be charged for cancelled appointments due to your child's illness as long as you contact me before 8 a.m. the day of your scheduled appointment. If possible, an appointment will be offered for later in the week to reschedule the missed appointment. You will not be charged for sessions that your child misses due to family vacations as long as notice is provided at least one week in advance. More notice should be given for extended absences so that your child can be prepared for the break in treatment. Additional canceled appointments must be rescheduled within one month of the cancellation or you will be charged for the missed session. You will be charged for all of your child's missed appointments or appointments that are not cancelled **48 hours** prior to the session.

*Group Members:* You may cancel four appointments each school year (September through June) if you start group between September-December and two appointments if you start group after January 1st without being charged provided that you cancel 24 hours in advance. You will be charged for all missed appointments that are not cancelled prior to the session.

**PROFESSIONAL FEES**

I am available for child, adolescent and adult evaluation and treatment, school consultation and supervision. My fee is $195.00 per 45-minute and $260.00 per 60-minute individual therapy/evaluation session and $205.00 per 45-minute family therapy session. The fee for group psychotherapy is $120.00-$130.00 per group session. In addition, I charge $195.00 per 45-minutes for other professional services you may need, though I will break down the hourly cost if I work for periods of less than 45 minutes. Other services may include report writing, telephone conversations lasting longer than 15 minutes, consulting with other professionals with your permission, preparation of records or treatment summaries, and the time spent performing any other service you may request of me.

**COURT RELATED SERVICES**

**I do not offer court related services or evaluations.** If you foresee the courts being involved please discuss this with me at our initial meeting and I can provide contact information for professionals that would be better able to meet your needs. If you subpoena me in any type of legal proceedings I am required to respond. Per my Licensure Board and ethical obligations, it is my policy not to testify in court proceedings and I work to quash all subpoenas. My fee is $1500.00 per 60 minutes and you will be expected to pay for all of my professional time, including preparation, transportation costs, and any legal fees incurred, even if I am called to testify by another party. **Please note if I am subpoenaed all services must be terminated, as this is a breach in our agreement.**

**CONTACTING ME**

Due to my work schedule, I am often not immediately available by telephone. While I am usually in my office each day, the specific hours vary depending on the day. In addition, I will not answer the phone when I am with a patient. When I am unavailable, my telephone is answered by voice mail. I check messages regularly throughout the day. I will make every effort to return your call within 24 hours, with the exception of weekends and holidays. If you are difficult to reach, please inform me of some 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 and ask for the psychologist or psychiatrist on call. If I will be unavailable for an extended time, I will provide you with the name of a colleague to contact, if necessary.

**SOCIAL MEDIA AND ELECTRONIC COMMUNICATIONS**

I utilize email primarily for basic communication with parents, which might include coordinating schedules, providing brief updates, sending monthly invoices, or planning a phone session. If you choose to email, please understand that email is not completely confidential or secure. I do not use email as a means for extensive communication about clinical matters, and request that you call (rather than email) me for cancellations at least 48 hours before the scheduled appointment. In order to protect client confidentiality and to maintain the integrity and purpose of the therapist/client relationship, I do not “fan,” “friend,” “follow,” or interact with clients or clients’ family members through social media (i.e. Twitter, LinkedIn, Facebook, etc.). I utilize texts occasionally with clients or parents for scheduling purposes or brief communications. While I do secure my voicemail, email and phone through password protection, I ask that you do not communicate important personal or safety information through those means.

**LIMITS ON CONFIDENTIALITY**

The law protects the privacy of all communications between a patient and a psychotherapist. 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:

* 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 don't object, I will not tell you about these consultations unless I feel that it is important to our work together.

* You should be aware that I practice with other mental health professionals and that I may, at times, employ administrative staff. In most cases, I need to share protected information with these individuals for both clinical and 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.
* Disclosures required by health insurance or to collect overdue fees are discussed elsewhere in this Agreement.
* If a patient threatens to harm himself/herself, I may be obligated to seek hospitalization for him/her, or 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:

* If you are involved in a court proceeding and a request is made for information concerning your diagnosis and treatment, such information is protected by the psychologist-patient privilege law. I cannot provide any information without your (or your legal representative's) written authorization or court order, or if a subpoena is served on me with appropriate notices, I may have to release information in a sealed envelope to the clerk of the court issuing the subpoena. 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.
* If a government agency is requesting the information for health oversight activities, I may

be required to provide it for them.

* If a patient files a complaint or lawsuit against me, I may disclose relevant information

regarding that patient in order to defend myself.

* If a patient files a worker's compensation claim, I must, upon appropriate request, provide a copy of any mental health report.

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 patient's treatment. These situations are unusual in my practice.

* If I know or have reason to suspect that a child has been or is in immediate danger of being a mentally or physically abused or neglected child, the law requires that I file a report with the appropriate governmental agency, usually the Department of Social Services. Once such a report is filed, I may be required to provide additional information.
* If I have reason to suspect that an adult is abused, neglected, or exploited, the law requires that I report to the Department of Welfare or Social Services. Once such a report is filed, I may be required to provide additional information.
* If a patient communicates a specific threat of immediate serious physical harm to an identifiable victim, and I believe he/she has the intent and ability to carry out the threat, I am required to take protective actions. These actions may include notifying the potential victim or his/her guardian, contacting the police, or seeking hospitalization for the patient.

If such a situation arises, I will make every effort to fully discuss it with you before taking any action 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 now or in the future. The laws governing confidentiality can be quite complex, and I am not an attorney. In situations where specific advice is required, formal legal advice may be needed.

**PROFESSIONAL RECORDS**

The laws and standards of my profession require that I keep Protected Health Information about you in your Clinical Record. Except in unusual circumstances that involve a substantial risk of imminent psychological impairment or imminent serious physical danger to yourself and others, I must provide you with access to and/or a copy of your record if you request it in writing. I will notify you if anything is withheld. 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. If I refuse your request for access to your records, you have a right of review, which I will discuss with you upon request.

**PATIENT RIGHTS**

You have certain rights with regard 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 and my privacy policies and procedures. I am happy to discuss any of these rights with you.

**BILLING AND PAYMENTS**

You will receive a statement for professional services at the beginning of each month. You are expected to pay for these services upon receipt of your statement unless we agree otherwise. If your account balance has not been paid by the 30th of the month, a $25.00 late fee will be charged to your account for each month your account is past due. If your check for services is returned a $35 fee will be added to your account.

If your account has not been paid for more than 60 days and arrangements for payment have not been agreed upon, I have the option of using legal means to secure the payment. This may involve hiring a collection agency or going through small claims court which will require me to disclose otherwise confidential information. In most collection situations, the only information I release regarding a patient's treatment is his/her name, the nature of services provided, and the amount due. If such legal action is necessary, its costs will be included in the claim.

Please be advised that paying through back automatic payments may not be confidential, due to multiple payments being sent to our office in one envelope for multiple providers in our office. Please be aware that these payments may also take up to two weeks to receive.

**INSURANCE REIMBURSEMENT**

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 your insurance policy covers. If necessary, I will ask you to fill out an authorization so that I can provide information to your insurance company that will allow me to provide the information necessary to secure payment for the services I provide for you. This authorization will be in effect for one year, but can be revoked at any time. However, if revoked, I will continue to have the right to forward information necessary to process claims for services already provided.

You should also be aware that your contract with your health insurance company requires that I provide it with information relevant to the services that I provide to you. I am required to provide a clinical diagnosis and brief substantiation of that diagnosis. Sometimes I am required to provide additional clinical information. This information is limited to the dates of treatment and a brief description of the services provided, including the type of therapy provided. 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. I will provide you with a copy of any report I submit, if you request it. By signing this Agreement, you agree that I can provide requested information to your carrier.

YOUR SIGNATURE BELOW INDICATES THAT YOU HAVE READ THIS AGREEMENT AND AGREE TO ITS TERMS AND ALSO SERVES AS AN ACKNOWLEDGEMENT THAT YOU HAVE RECEIVED THE HIPAA NOTICE FORM DESCRIBED ABOVE.

**I have read and understand and agree to the structure as described above.**

**Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**