ANNA M LUCCA PhD
LICENSED CLINICAL PSYCHOLOGIST

200 Park Avenue, Suite 304, Falls Church, VA 22046
(703) 672-0685 Phone (703) 852-7186 Fax
anna@amluccaphd.com www.amluccaphd.com

PSYCHOTHERAPIST-CLIENT SERVICE AGREEMENT

This document contains important information about my professional services and business policies. Please read it carefully and we can discuss any questions or concerns you might prior to signing. When you sign this document, it will represent an agreement between us.

Fee Schedule. The fee for the initial intake session is $250 per 60-75 minute visit and includes a thorough interview of your presenting issues and history as part of a diagnostic evaluation process. Fees for weekly services are $225 per 55 minute session and $200 per 45 minute session. I charge the same hourly rate for other professional services you may need on a prorated basis. Other services may include psychotherapy provided by telephone, preparation of records or treatment summaries, and the time spent performing any other service you may request of me. Typically, the charge for a treatment summary is $100 due at time of request. Photocopying of records is $35. Fees may increase periodically.

Billing and Payments. I am currently paneled with several insurance plans. If I am a preferred provider for your insurance, I will submit claims on your behalf. You will then be responsible for only the co-payment or co-insurance portion which will be collected at each session. Please be aware that you might also have a deductible which would make it your responsibility to pay the full amount of the negotiated rate that your insurance company would normally pay to me.

If I do not participate with your insurance but you would like to use your insurance to cover our sessions, your insurance company may reimburse you according to guidelines they have established for out of network providers. 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. You will be expected to pay for each session at the time it is held, unless we agree otherwise.

Cash, check, or electronic payment (Venmo, Zelle) is preferred, but I also accept major credit cards. Payment schedules for other professional services will be agreed to when they are requested. 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. If such legal action is necessary, its costs will be included in the claim. There will be a $30 charge for the return of a check from the bank. **By signing this agreement, you acknowledge responsibility for this account and guarantee payment of all charges against this account.**

Meetings/Cancellations. When a psychotherapy session is scheduled this hour is considered blocked for a particular client. Thus, a late cancellation results in an open hour, inconvenience, and a loss of revenue. **Once an appointment hour is scheduled, you will be expected to pay a $75 cancellation fee unless you provide 24 hours advance notice of cancellation.** Insurance companies

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will not reimburse for missed appointments. If there is an emergency, illness, or circumstance beyond your control, I will be flexible on a case-by-case basis. If it is possible, I will try to reschedule the appointment for later in the week. If you arrive late for a scheduled appointment, only the remainder of the session will be available. If I run late with a prior appointment, you will still receive the full session. If local schools (Fairfax county) are delayed or closed due to weather conditions, you can contact me via phone, text, or email about whether our appointment needs to be rescheduled.

Contacting Me. I am often not immediately available by telephone, text, or email. When I am unavailable, you may leave a message on my voicemail or send me a text or email. I will make every effort to return your message on the same day you leave it, with the exception of weekends and holidays. Specific policies about these modes of contact are elaborated below.

- **Telephone.** No charges will be assessed for brief or occasional telephone calls or for telephone conversations for the purpose of scheduling an appointment. However, if there are frequent telephone calls lasting more than 10 minutes, I will charge a prorated rate for the time based on my full fee of $225. I will return telephone calls as promptly as my schedule allows. Calls received on a Friday or during the weekend will be returned the following business day.
- **Texting.** Clients may use cell phone texting to contact me for scheduling purposes and for other non-clinical communications. Be advised that messaging platforms are not HIPAA compliant or secure. I do not use text messaging for discussion of clinical issues and it should not be used for communication in emergency situations.
- **Email**. The email address anna@amluccaphd.com is HIPAA compliant. This means that I have entered into a written agreement with my hosting service that they will appropriately safeguard electronic Protected Health Information (ePHI). Despite this protection, the possibility of email communications being accessed by unauthorized individuals is a real danger that can compromise the privacy and confidentiality of such communication. For these reasons, I only use email for setting up appointment times or contacting a client who has missed an appointment. I do not use it for discussion of clinical issues and it should not be used for communication in emergency situations. If you communicate confidential or private information via e-mail, I will assume that you have made an informed decision, and will honor your desire to communicate on such matters via e-mail. Please know that any e-mails I receive from clients and former clients along with any responses that are related to treatment and diagnosis may be kept in treatment records. Emails also become a part of your legal records and may be revealed in cases where your records are summoned by a legal entity. Please be assured that current and former client e-mail information is always kept secure and not shared with any third parties.

Emergencies. If you have a medical or mental health emergency and feel you are a danger to yourself or someone else, please go to your nearest emergency room or call 911. I do not have the ability to provide 24-hour emergency contact. If you believe that your situation will require a therapist that has a 24-hour support, please discuss this with me as soon as possible.

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Litigation Limitation. It is the stated philosophy of this practice that I do not participate in lawsuits of any type on a plaintiff's behalf, unless compelled to do so by subpoena or court order. It is agreed that should there be legal proceedings (such as, but not limited to divorce and custody disputes, injuries, lawsuits, etc...) neither you nor anyone else acting on your behalf will call me to testify in court or at any proceeding, nor will a disclosure of the psychotherapy records be requested unless otherwise agreed upon in advance. If agreed upon, additional fees will apply for testifying in legal proceedings.

Professional Records. The laws and standards of my profession require that I keep treatment records. You are entitled to receive a copy of your records, or I can prepare a summary for you instead. Because these are professional records, they can be misinterpreted by and/or upsetting to untrained readers. If you wish to see your records, I recommend you review them in my presence so that we can discuss the contents. Clients will be charged a fee for any professional time spent in responding to information requests.

Minors. If you are under 18 years of age, please be aware that the law may provide your parents the right to examine your treatment records. It is my policy to request that I provide parents only with general information about our work together, unless I feel there is a high risk that you will seriously harm yourself or someone else. In this case, I will notify them of my concerns. I will also provide them with a summary of your treatment when it is complete. Before giving them any information, I will discuss the matter with you, if possible, and do my best to handle any objections you may have about it.

Confidentiality. In general, the law protects the privacy of all communications between a client and a psychologist, and I can release information about our work to others only with your written permission. However, there are some situations in which I am legally obligated to take action to protect others from harm, even if I have to reveal some information about a client's treatment. For example, if I believe that a child, elderly, or disabled person is being abused, I am required to file a report with the appropriate state agency. If I believe that a client is threatening serious bodily harm to another, I may be required to take protective actions. These actions may include notifying the potential victim, contacting the police, or seeking hospitalization for the client. If the client threatens to harm himself or herself, I may be obligated to seek hospitalization for him or her or to contact family members or others who can help provide protection. I will make every effort to fully discuss it with you before taking any action.

You should also know that disclosure of some confidential information (typically your diagnosis and type of mental health service provided) may be required by your health insurance carrier in order to process the claims. I have no control or knowledge over what insurance companies do with this information.

I may occasionally find it helpful to consult other professionals about a case. During a consultation, I make every effort to avoid revealing the identity of my client. The consultant is also legally bound to keep the information confidential.

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Informed Consent to Treatment

I, _____(name of patient or guardian as applicable), agree and consent to participate in behavioral health care services offered and provided at/by Dr. Anna M. Lucca as described in the Psychotherapist-Client Service Agreement. If the patient is under the age of eighteen or unable to consent to treatment, I attest that I have legal custody of this individual and am authorized to initiate and consent for treatment and/or legally authorized to initiate and consent to treatment on behalf of this individual.

Your signature below indicates that you have read the information in this document and agree to abide by its terms during our professional relationship.

_____ _____
Print Client Name Date Signed

_____ _____
Signature of Client /or Legal Representative Date of Birth

_____ _____
Print Name of Legal Representative Relationship to Client

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PERSONAL INFORMATION

Today's Date:

Client Name:	DOB & Age:
Address (please include zip code):	Phone – best number(s) to reach you:
Email Address:	Marital Status:
Highest Degree Received and Area of Study:	Employer:
Emergency Contact Person:	Relationship to Client:

INSURANCE INFORMATION (if applicable)

Insurance Company:	Phone #:
Insurance ID #:	Group #:
Subscriber Name and DOB:	Client Relationship to Subscriber:

Cancellation Policy

A 24-hour advance notice is required for cancellation of your scheduled appointment or a missed appointment fee of $75 will be charged.

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Certification and Authorization

I certify that the above information is correct. I authorize the release of any medical information necessary to process this claim. I request that payments be made directly to Anna M Lucca, PhD on my behalf, therefore, my signature will be on file to file with my insurance company. I understand that I am financially responsible for all charges whether or not paid by the insurance.

Signature of Patient (or Parent): _____ **Date:** _____

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OTHER HEALTH PROFESSIONALS Please provide information about other health professionals that you are currently seeing (as applicable).

Primary Care Physician (Name/Contact information):
Psychiatrist (Name/Contact information):
Other Mental Health Professional (Name/Contact information):
Other Professional (Name/Contact information):

FAMILY INFORMATION Please provide information about family members that are living with you or with whom you maintain regular contact (as applicable).

Name of Spouse or Significant Other:
Names and Ages of Children:
Names of Parents (if you are under 18):
Names and Ages of Sibling(s):

Please answer the following questions that may be relevant to therapy:

1. What are the main reasons you are seeking psychotherapy at this time?

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2. Are you currently experiencing depressed mood, sadness, or grief? ____yes____no
If yes please describe your depressive symptoms and for how long you've had them.

3. Are you currently experiencing worry, anxiety, panic, or have any phobias? ____yes____no
If yes, please describe your anxiety symptoms and for how long you've had them.

4. Do you have any medical conditions that are being treated by a physician? ____yes____no
If yes, please describe.

5. Are you currently taking any prescribed medications? ____yes____no
If yes, please specify type and dosage.

6. Have you previously been involved in mental health therapy or treatment? ____yes____no
If yes, please describe.

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7. Do you have any history of suicidal ideation or suicide attempt? ____yes____no
If yes, please explain.

8. Do you (or others in your life) have any concerns about your alcohol use? ____yes____no
If yes, please explain.

9. Do you (or others in your life) have any concerns about your drug use? ____yes____no
If yes, please explain?

10. Do you have current legal problems or previous legal history? ____yes____no
If yes, please explain.

11. Have you experienced any significant life changes or stressful events recently or in the past that you would like me to know about?___yes____no If yes, please describe.

12. Is there anything else you would like me to know about you?

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NOTICE OF PRIVACY PRACTICES
Effective February 16, 2026

This information is being provided as required by the federal Health Insurance Portability and Accountability Act of 1996.

This notice describes how medical/mental health information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

This Notice describes how your medical and mental health information may be used and disclosed and how you can access this information. Please review it carefully.

I am required by law to maintain the privacy of your Protected Health Information ("PHI") and to provide you with this Notice of my legal duties and privacy practices.

HOW I MAY USE AND DISCLOSE YOUR INFORMATION

1. Treatment, Payment, and Health Care Operations

Once you sign the Consent for Treatment, I may use or disclose your PHI for:

Treatment – To provide, coordinate, or manage your mental health care.

Payment – To obtain reimbursement (for example, submitting claims to your insurance company).

Health Care Operations – For practice management, quality improvement, compliance, and administrative activities.

If you choose to use insurance, I must share certain information with your insurance company to obtain payment.

2. Substance Use Disorder (SUD) Treatment Information

If your treatment involves diagnosis, assessment, referral, or treatment related to Substance Use Disorder (SUD), federal law provides additional protections under 42 C.F.R. Part 2.

Where permitted by law, I may use and disclose SUD treatment information for treatment, payment, and health care operations. In certain circumstances, your written authorization may be required before disclosure.

If you sign a written authorization allowing disclosure of SUD treatment information, that authorization may allow future uses and disclosures for treatment, payment, and health care operations as permitted by law.

You may revoke your authorization at any time in writing, except to the extent action has already been taken in reliance on it.

3. Redisclosure of Health Information

If your health information (including Substance Use Disorder treatment information) is disclosed in accordance with HIPAA and other applicable laws, the information may no longer be protected by federal privacy laws once it is received by the recipient, depending on the circumstances.

I will disclose your information only as permitted or required by law. However, once information leaves this practice, I cannot control how it is used or protected by others.

OTHER USES AND DISCLOSURES PERMITTED OR REQUIRED BY LAW

Abuse or Neglect – If I suspect abuse or neglect of a child, elder, or vulnerable adult, I am required to report it to the appropriate authorities.

Serious Threat to Health or Safety – If I believe you present a serious and imminent threat of harm to yourself or others, I may disclose information to appropriate individuals or authorities.

Legal Proceedings – I may disclose PHI in response to a court order, subpoena, or other lawful process.

Public Health Activities – As required by law for certain public health reporting purposes.

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ELECTRONIC COMMUNICATION

I may communicate with you via phone, email, text message, secure portal, or telehealth platform. While reasonable safeguards are used, electronic communications carry some risk of unauthorized access.

You may request limitations on electronic communication methods.

YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION

Right to Inspect and Copy – You may inspect and request copies of records used to make decisions about your care (excluding psychotherapy notes). Requests must be in writing. A reasonable fee may be charged. I will respond within the timeframe required by law.

Right to Amend – If you believe your record is incorrect or incomplete, you may request an amendment in writing with a reason for the request.

Right to an Accounting of Disclosures – You may request a list of certain disclosures made in the past six (6) years (not including disclosures for treatment, payment, and operations).

Right to Request Restrictions – You may request restrictions on certain uses or disclosures. While I am not required to agree to all restrictions, I will consider your request.

Right to Confidential Communications – You may request that I contact you at a specific address or phone number.

Right to a Paper Copy – You may request a paper copy of this Notice at any time.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with:

Anna M. Lucca, Ph.D.
200 Park Avenue, Suite 304
Falls Church, VA 22046
(703) 672-0685

Or with:

U.S. Department of Health and Human Services
Office for Civil Rights
200 Independence Avenue SW
Washington, DC 20201

You will not be retaliated against for filing a complaint.

CHANGES TO THIS NOTICE

I reserve the right to change this Notice. The revised Notice will apply to all information I maintain and will be posted on my website and available in my office.

Signature of Client or Custodial Parent/Guardian: _____

Date: _____

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Consent for Release of Information

I, _____, DOB:_____, authorize Anna M. Lucca, Ph.D. to disclose and/or received protected information as described below. Fill in all that apply.

		Telephone/Email:
Primary care physician:	_____	_____
Psychiatrist:	_____	_____
Family/couples therapist:	_____	_____
Other:	_____	_____

This authorization may include verbal communication and/or written documentation, including treatment summaries, diagnostic information, progress notes (excluding psychotherapy notes unless specifically authorized), assessment results, billing information, and other clinically relevant materials. The purpose of disclosure may be for coordination of care, continuity of treatment, and insurance/billing purposes.

I understand that I may revoke this authorization at any time by submitting a written request to Dr. Lucca, except to the extent that action has already been taken in reliance on this authorization. I understand that once information is disclosed pursuant to this authorization, it may no longer be protected by federal privacy laws (HIPAA) and may be subject to redisclosure by the recipient.

If this authorization includes Substance Use Disorder (SUD) treatment information, federal law (42 C.F.R. Part 2) prohibits the recipient from using or disclosing that information to investigate or prosecute me for a substance use disorder, except as permitted by law.

I understand that signing this authorization is voluntary and that my treatment will not be conditioned upon signing this form. This authorization will expire upon termination of treatment.

_____ _____
Signature of Client or Legal Representative Date Signed

_____
Print Client Name

_____ _____
Print Name of Legal Representative Relationship to Client