Audrey DuRoss, LCSW
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Professional Service Agreement

The Treatment Process

Therapy has the potential to offer personal benefits, such as a decrease in levels of distress and an increase in problem solving skills, communication effectiveness, and cultivation of meaningful relationships. Therapy involves a commitment on your part not only to keep scheduled appointments, but also to come to appointments prepared with meaningful topics to discuss. Much of the progress you make will take place when you are outside of the therapy appointment, reflecting on topics and putting into practice techniques we have discussed. The relationship between client and therapist is essential in regards to honesty, trust, and feeling safe. While therapy will be most effective when you "work" towards the change you would like to create, the work I do will be to create an environment that promotes self-awareness and growth. I believe that we all have the ability to change our perception, attitude, skills, or circumstance.

Confidentiality

In order to create a safe environment to share thoughts and feelings, it is a priority for me to ensure your confidentiality. The law protects the privacy of all communications between a client and a therapist, which is why the Release of Information form is included in this packet, in the event that you do wish for me to have communication with a family member, employer, professional, etc. for your benefit. By signing the ***Agreement***, you are giving consent for communication as follows:

- If you choose to use your insurance company to pay for a portion of your therapy. Insurance companies typically require that I provide information relevant to these services including diagnosis, treatment plans or treatment summaries. In such circumstances, I make every effort to release the minimum amount of information necessary while still complying with the insurance company's request. If you request, I will provide you with a copy of any report I submit. By signing the ***Agreement***, you agree that I can provide requested information to your insurance carrier.

- I may occasionally consult with other health and mental health professionals for the benefit of my clients and the care that I provide. During a consultation, I do not share any personal or identifying information regarding any specific client. I will share any consultations with you if I believe they are important to our work together.

- I may share confidential information in accordance with the terms and conditions of the ***Agreement*** on wireless or cellular phones.

There are some situations where I am permitted or required to disclose information without either your consent or Authorization. These are described in the ***HIPPA Privacy Notice*** and include threats to health and safety, judicial or administrative proceedings, specific, public health activities, worker's compensation claims and other disclosures required by law or law enforcement entities.

There are some situations in which I am legally obligated to take actions that I believe are necessary to protect others from harm, and I may have to reveal information about a client's treatment. Situations such as these are very rare in my practice and include the following:

- If I believe that a child, elderly person, or disabled person is being abused or neglected, I am required to report this to the appropriate authorities or the police; and,
- If I believe that you are threatening serious bodily harm to yourself or someone else, I am required to take protective actions, which may include notifying the potential victim or contacting the police.

Should a situation like this occur, I will make every effort to discuss it with you prior to taking any action, and I will limit my disclosure to what is necessary. I am happy to discuss with you any questions or concerns you may have now or in the future pertaining to confidentiality.

Client Rights

HIPPA provides you with several new or expanded rights with regard to your Clinical Record, and disclosures of PHI. These rights are described in the ***HIPPA Privacy Notice.*** I am happy to discuss any of these rights with you.

Professional Records

In accordance with HIPPA, I keep Protected Health Information (PHI) with regards to you and your treatment in two sets of professional records. One set constitutes your Clinical Record. It includes demographic and insurance information about you as well as information about your reasons for seeking therapy; a description of the ways in which your problem affects your life; your diagnosis; our treatment goals and progress towards them; your medical, social and treatment history, treatment records I receive from other providers; your billing records, documentation of any professional consultations, and any reports that have been sent to anyone, including your insurance carrier. In most circumstances, you may inspect and/or receive a copy of your Clinical Record, if you request it in writing. Upon your request, I will discuss with you the details of this process.

In addition, I will also write and keep progress notes regarding each session I have with every client. These notes are for my own use and are designed to assist me in providing you with the best treatment. While the contents of progress notes vary from client to client, they can include the content of our conversation, my analysis of those conversations, interventions used and progress regarding your goals. They can also contain particularly sensitive information that you may reveal to me that is not required to be included in our Clinical Record. These progress notes are kept separate from your Client

Record, are not available to you and cannot be sent to anyone else, including insurance companies without your written, signed authorization.

Contacting Me

I can be reached at 801-910-7193. See phone rates below that are outside of the initial and free 20 minute consultation. Phone calls often go directly to voicemail since I am usually meeting with other clients. Please feel free to leave a confidential message and I will return your call as soon as possible. Remember to leave your phone number each time you leave a message, even if you think I already have it. I will do my best to respond to you within the next business day. However, on the weekends or times when I am out of town, I will take longer to return your phone call. In the event of any emergency, call:

1. 911, or
2. The National Suicide Prevention Lifeline at 1-800-273-8255

Going to the nearest emergency room is also an option. If I am out of town or unavailable for an extended period of time, I will arrange for a licensed therapist to provide coverage for me in my absence.

Cancellations

The appointment time you have scheduled is yours. If you need to cancel an appointment, ***please call 48 hours in advance*** so that the time can be rescheduled for someone else. Since I only have a limited number of treatment hours available during the week, ***you will be charged $150 for missed appointments or those not cancelled 48 hours in advance.***

Financial Policy

You are financially responsible for all charges, whether or not paid for by insurance or HSA. If you choose to use an insurance policy to pay for a portion of your care as stated above, I am required to submit certain information about you in order to obtain partial reimbursement. I will discuss this with you when necessary, so that you may be aware of the type of information being requested. Please ask me if you have questions or concerns about your specific insurance policy.

In many cases, you are under no obligation to use your insurance. You may prefer to avoid filing insurance, having your diagnosis disclosed or having your care reviewed by a managed care organization. *I am pleased to discuss self-pay as an alternative to using insurance and in fact, I am not accepting insurance at this time, though I will provide a receipt of service that you can submit to your insurance company or HSA for reimbursement based on your plan.*

Fees for professional services are charged as follows:

- $150/1 hour for initial psychosocial evaluation
- $150/50 minutes for individual sessions, 13 and up only
- $75/person for group sessions

- $120/hour for document preparation
- $150/hour prorated for phone calls that exceeds 10 minutes of contact time.
- $150 cancellation fee if not notified 48 hours in advance.

Alpha-Stim (Free in-session use):

- $100/monthly rental
- $840/Purchase
- $100/month rent-to-own available
- Non-client $50/30 minute instruction

Student discount, sliding scale, and insurance or HSA reimbursement statements available.

Payment is due at time of service through Venmo, Paypal, check, or cash.

If your evaluation or session exceeds the allotted time, your final rate will be billed in 15-minute increments. Appointments not kept and not canceled at least 48 hours in advance will be charged to you at the rate of $75. Insurance will not cover these charges.

You are expected to:

- Pay the amounts not covered by your insurance plan, e.g., copayments, unpaid deductibles, missed appointment fees, request for written documents at the time of service unless other arrangements have been made.
- Pay the entire bill at the end of each session.
- If your account is overdue and sent to an attorney or collection agency to pursue collection, you will pay any collection fees, court costs, attorney fees, and filing fees.
- Pay a $35 charge on any returned checks.
- Pay a 1.5% interest charge on unpaid balances over 30 days.

If you have any questions or concerns about the fee policy or your fee, I am happy to address them with you.

Please check one of the following:

□ **I will NOT be using my insurance to pay for any part of my care. I will pay the full amount of each session at the time of service.**

□ **I want to use my insurance benefits to pay for a portion of my care.**

If I am using my insurance carrier(s) to partially pay for my care, I give permission to Audrey DuRoss, LCSW to release all necessary diagnostic and treatment information to the insurance carrier(s), and authorize my insurance carrier(s) to pay policy benefits directly to Audrey DuRoss, LCSW. I request that this assignment remain on file with my insurance carrier(s). If a family member, or other party, is paying my fees, I give permission to Audrey DuRoss, LCSW, to request payment or explain the charges. No further information about care will be provided unless I sign a Release of Information. I understand that I am financially responsible for all charges whether or not paid for by my insurance, including missed appointments and sessions not canceled more than 48 hours in advance. I authorize the release of necessary information to a collection agency if that should become necessary. I permit a copy of this signed ***Agreement*** *to be used in place of the original. I may revoke this* ***Agreement*** *in writing at any time. That revocation will be binding on Audrey DuRoss, LCSW (1) unless she has taken actions in reliance on it; (2) if there are obligations imposed on Audrey DuRoss, LCSW by my health insurer in order to process or substantiate claims made under my policy; or (3) if I have not satisfied any financial obligations I have incurred.*

I UNDERSTAND THAT MY SIGNATURE BELOW INDICATES THAT I HAVE READ THIS AGREEMENT AND AGREE TO ITS TERMS.

Client's Name – Please print

_____ _____

Date

Signature of Client

X_____ _____

Date

Signature of Parent or Guardian (if client is a minor)

X_____ _____

Date

Provider Signature

_____