PSYCHOLOGIST PATIENT SERVICES AGREEMENT

Welcome to my practice.

This document contains important information about my professional services and business policies. This document contains a brief summary of information about the Health Insurance Portability and Accountability Act (HIPPA), a federal law that provides privacy protections and patient rights with regard to the use and disclosure of your protected health information (PHI). In compliance with HIPPA, I am providing you with a Notice of Privacy Practices that explains this in detail. It is very important that you read this document carefully and we can discuss questions you have any time. After reviewing this information, please sign this form, which constitutes an agreement between us. You can revoke this agreement at any time.

The information on these pages is made available that you are aware of some important matters concerning the psychologist-patient relationship and office policies. Read and sign one and keep a copy for your reference. Read it again in a day or two as there is typically much that occurs during your first visit.

Please note that I prefer to refer to my patients as clients, but in the eyes of the law, you may be considered my patient and that is why the word patient is used in this document.

PSYCHOLOGICAL SERVICES:

A therapeutic relationship does not exist between us until after the initial intake evaluation is complete and we have decided together to work together in a treatment relationship. It is important that we both agree we are a good therapeutic fit before establishing this relationship.

Therapy can have risks and benefits. Since therapy often involves discussing unpleasant aspects of your life, you may experience uncomfortable feelings or memories. On the other hand, therapy has been shown to have multiple benefits. Therapy often leads to better relationships, solutions to specific problems and significant reductions in feelings of distress. There are no guarantees of what you will experience. There may be alternative treatments or modes of therapy to consider. I encourage you to become aware of these options and to ask me any questions you have.

MEETINGS:

I usually schedule one 50 minute session per week at a time we agree on; sometimes we may schedule more than one session per week. This time is held for you each week.

If you are unable to attend an appointment, you must call and cancel this appointment 48 hours beforehand or more. If you call less that 48 hours before, you will be charged a late fee coverage of $75. If you no-show without calling, you will be charged the full session fee and this is never covered by insurance. My policy is that, when you see me, you pay me at the time of services. I do not provide billing statements for that reason and I will provide paperwork only for insurance claims. I may waive the late cancellation fees if we are able to reschedule the appointment within that same calendar week. It is important to
understand that research shows that people who are engaged in therapy, meaning that you attend and participate in appointments and complete homework are most likely to meet treatment goals.

PROFESSIONAL FEES FOR SELF-PAY CLIENTS:

For self-pay, initial intake fee is $250.

My 50 minute fee is $175.

The therapy fee includes very brief telephone calls (5 minutes), clinical paperwork for insurance purposes and consultations with other professional. If you require coaching during the week you will be billed at a prorated rate based on the session fee. If you become involved in legal proceedings that require my participation, you will be expected to pay for my professional time, including preparation and transportation costs to court.

My fees for legal proceeding are higher than therapy fees given the extensive preparation required. My hourly rate is $300/hour.

CONTACT:

You may call me at 804.938.4123 or send an email to: laurawagnerphd@gmail.com.

Email may not be a confidential form of communication.

I am often not available to immediately return calls, but my phone will be answered by a confidential voicemail. I will make every effort to call you back in 24 hours, with the exception of night time calls, weekends and holidays. Calls made at night time, weekends or holidays will be returned the next business day unless prior arrangements have been made. I do not provide formal emergency services.

In an emergency, you can call the National Suicide/Crisis Hotline at 1.800.273.TALK (open 24/7). In a psychological emergency, such as suicidal or homicidal ideation, or other emergency, you can call Region Ten at 434.972.1800 and clinicians can assist you. You can also call 911 or go to a local emergency room.

___Please initial here to indicate you will follow this crisis plan.

When I am on vacation, I will advise you in advance and I will generally cover all calls, but I may occasionally have another provider covering for me.

COMMUNICATION:

Email and text are not secure forms of communication. Please do not send me any clinical material such as essays, journal entries or other details about your mental state via those methods. I only communicate scheduling issues via email and text.

LIMITS ON CONFIDENTIALITY:
The law protects the privacy of all communications between a patient and a psychologist. 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 HIPPA and/or Virginia Law. I will always take every precaution and measure to ensure the privacy of your confidential information.

There are some situations in which a psychologist is legally obligated to take some action that will likely involve revealing information to an outside party, possibly without your consent. These situations are limited as follows:

- Cases in which a psychologist is ordered by a judge to release therapy records.
- Cases in which a psychologist has reason to believe, or suspects, that a child under 18 may be abused or neglected.
- Cases in which a psychologist has reason to believe, or suspects, an adult has been abused or neglected.
- Cases in which you have made a specific threat to harm yourself and you are in clear and imminent danger, as determined by my clinical judgment.
- Cases in which you have made a threat of violence to others, as determined by my clinical judgment.
- Cases in which a health care provider is deemed to be incapacitated due to mental health or substance abuse. You can be reported to your board.
- In the event of an emergency, Dr. Wagner also has the right to consult with another mental health provider in order to provide you the best care.

If such a situation arises, I will make every effort to fully discuss it with you before taking any action or releasing any information about you, and I will limit disclosure of information as deemed clinically appropriate. Confidentiality is complicated, so please ask me questions.

In addition, I want to protect your privacy if I happen to run into you in a public setting. If this occurs, I will not acknowledge you. This will give you the option of remaining anonymous. If you speak first, I will greet you as well.

PATIENT RIGHTS:

HIPAA provides you with a number of rights, which briefly include the right to amend the information in your record, to limit what information is disclosed to whom, to request restrictions as to how you are contacted, and to receive an Accounting of Disclosures, or a list of all information that has been released about you. You can also file a complaint about policies or procedures regarding your records with the federal Department of Health and Human Services.

SOCIAL MEDIA:

If you access to any social media associated with Dr. Wagner, it is your right to determine the level of disclosure that you are comfortable with but your confidentiality could be limited on these sites. I will take all precautions not to disclose your status as a patient or previous patient. If you choose to follow or like a page, please consider the confidentiality or disclosure risk to you. The law and my ethical code prohibit me from
being friends with you on social media platforms so please do not send connection request.

BILLING AND PAYMENTS:

If you are self-pay, you are responsible for the fees for your therapy and are expected to pay for each session at the time of the session unless other arrangements have been made. In the event that you encounter some unusual financial hardship, such as losing your job, I might be willing to negotiate a payment plan so you can continue to receive therapy during that specific difficult time, but not for the duration of your treatment. The original fees may resume.

If I am an in-network provider or out of network provider for your insurance, I will provide you the documentation to file a claim. Full payment is due at the time of services.

If your balance due becomes very large, or if no payments are made for more than 3 weeks, I have the option of resorting to legal means to obtain payment if we cannot work out a payment plan. This could mean involvement of a collections agency or small claims court, and the cost of this collection effort will be passed on to you at my same hourly rate. Such efforts also require the disclosure of confidential information but I will limit this to minimum information necessary. I also have the right to terminate therapy if you are unable to pay, although I will provide you referrals if needed.

I accept cash, but cannot make change, checks and most major credit cards and HSA cards. If you choose to use a card instead of cash or check to pay, you will be assessed an additional 3% swipe fee to cover the fees required for credit cards. You can avoid this fee by paying in cash or check or pre-paying.

_____ Initial here to accept the 3% processing fee when using credit/debit/HSA card for payments.

_____ Initial here for the cancellation policy. Returned checks will incur a $50 returned check fee. Late cancellations will be billed $75 and no-shows billed the full session fee.

TERMINATION:

Ending relationships can be difficult. Therefore, it is important to have a termination process in order to achieve some closure. The appropriate length of the termination depends on the length and intensity of the treatment. I may terminate treatment after appropriate discussion with you and a termination process if I determine that the psychotherapy is not being effectively used or if you are in default on payment. I will discuss termination with you before ending treatment. If I terminate treatment, you can request another therapist and I will provide you with a list of qualified psychotherapists. You can also choose someone from another referral source.

Unless arrangements have been made in advance, for legal and ethical reasons, I must consider the professional relationship discontinued.
Your signature below indicates that you have read the information in this document, and agree to abide by its terms during our professional relationship and consent to treatment with Dr. Laura Wagner, Ph.D., LCP of Wagner Psychological and Consulting Services, LLC.

SUICIDALITY OR HOMICIDALITY

I request that you report all suicidal or homicidal thoughts to me. Please do not delay in this process, so that I can aim to keep you safe and meet ethical and legal guidelines regarding these issues. Your confidentiality may be limited if you are in imminent risk of harming yourself or someone else.

INFORMED CONSENT AGREEMENT:

Full Printed Name: ____________________________

Signature of Client: ____________________________

Date: ____________________________

PATIENT EMAIL AND TEXT MESSAGE INFORMED CONSENT

Wagner Psychological and Consulting Services and its affiliates, agent, independent contractors and any covered entity or business associate, as defined in HIPPA, with which your information may be shared under HIPPA may communicate with you by email, text message or other forms of unencrypted electronic communication (called Electronic Messaging) to the telephone numbers, email addresses and other locations reflected on your account or as otherwise provided below. This form provides information about Wagner Psychological and Consulting Services use, risk and conditions of Electronic Messaging. It will also be used to document your consent for Wagner Psychological and Consulting Services communication with you by Electronic Messaging.

Electronic Messaging Use

Dr. Wagner may use electronic messaging to communicate with you regarding a wide range of care related issues, including but not limited to:

- Reminders of appointments or actions to take before an appointment
- Follow ups from an appointment
- Notices about preventive services, treatment options, coordination of your care and other available health services;
- Information regarding payments and account balances or eligibility for services and fees charged.
Risks of using electronic messaging

Electronic messaging has a number of risks that you should consider.

- Electronic messaging can be circulated, forwarded, sent to unintended recipients and stored electronically or on paper.
- Senders can easily misaddress electronic messaging and send the information to an unintended recipient.
- Backup copies may exist even after deletion.
- Electronic messaging may not be secure and can possibly be intercepted, altered, forwarded or used without authorization or detection.
- Electronic messaging service providers may charge for calls or messages received.
- Employers and online providers have a right to inspect electronic messaging through their company systems.
- Electronic messaging can be used as evidence in court so I require that no clinical material be sent via this route.

Conditions for the use of electronic messaging

Dr. Wagner cannot guarantee but will use reasonable means to maintain security and confidentiality of the messages we send. By signing where indicated below, you acknowledge your consent to the use of electronic messaging on the following conditions.

- In a medical emergency, do not use electronic messaging, call 911 or go to the emergency room.
- Urgent messages or needs should be relayed by telephone.
- Electronic messaging may be placed in your medical records.
- Dr. Wagner is not responsible for breaches of confidentiality caused by you or any other party.
- You are solely responsible for any charges incurred under your agreement with your electronic messaging service provider (such as per-minute, per-message, per-unit of data received basis or otherwise).

Expiration and Withdrawal of Consent

Unless you either withdraw your consent, this consent will expire upon the ending of our treatment relationship. You may choose to stop participating in electronic messaging at any time by informing me in writing as described herein. You further understand that withdrawing this consent will not cause you to lose any benefits or rights to which you are otherwise entitled, including continued treatment, payment, or enrollment or eligibility for use of insurance. To withdraw consent and stop participating in electronic messaging, please do so in writing.

Patient acknowledgement and consent

I have read and fully understand this consent form. I understand the risks associated with the use of electronic messaging between Dr. Wagner and me, and I
consent to the conditions and instructions outlined, as well as with any other instructions that Dr. Wagner may impose to communicate with me by electronic messaging.

I understand that Dr. Wagner may send electronic messages to numbers on my account:

___ I request to receive text messages
___ I request to receive email messages
___ I request either email or text messages, based on Dr. Wagner’s discretion

Release

In consideration of Dr. Wagner’s services and my request to receive electronic messaging as described herein, I hereby release Dr. Wagner and Wagner Psychological and Consulting Services from any and all claims, causes of action, lawsuits, injuries, liabilities, or other harms resulting from or relating to the violation of the law (including without limitation the Telephone Consumer Protection Act, the Truth in Caller ID Act, the CAN-SPAM Act, the Fair Credit Reporting Act, the HIPPA act, and any similar state and local acts or statutes, and any federal or state tort or consumer protection laws).

Patient Printed Name: ___________________________

Patient signature: ___________________________

Date: ___________________________

CANCELLATION AND NO-SHOW POLICY

Your appointment time is reserved especially for you!

When you call late to cancel or reschedule, or no-show without calling, it delays our work together and impacts my practice. Dr. Wagner will do what she can to make your appointment convenient for you.

You can request an appointment time change request if Dr. Wagner has that available, which is not guaranteed.

**When you must cancel, please do so at least 48 hours in advance.** There may be people on a wait-list who need an appointment, so it is important that you advise me 48 hours in advance. Sufficient notice allows Dr. Wagner to use that hour for other clients who may be on a waiting list, experiencing a crisis, or looking for the opportunity to reschedule their own appointment for a different time.
If you call to cancel less than 48 hours in advance of your session starting, you will be charged a $75 late fee. If you call to cancel after the start of the session or no-show without calling, Dr. Wagner may charge the full session fee.

___I understand that I must call to reschedule or cancel any appointment with Dr. Wagner at least 48 hours in advance or I will be charged $75.

___If I call to reschedule or cancel my appointment after the start of my session or no-show without calling, I understand that I will be charged the full session fee.

Printed name: ____________________________________________
Signature: ______________________________________________
Date: __________________________________________________

AGREEMENT FOR CONFIDENTIALITY OF INDIVIDUAL TREATMENT

I understand that it is Dr. Wagner’s role to provide therapeutic services so that I might feel better and/or improve my functioning, including as it relates to my family. Dr. Wagner’s role is not intended to gather information for the courts or to make judgements related to my family.

Therefore, I agree that I will not call upon Dr. Wagner to provide treatment records or to testify in a future divorce or custody action. I understand that courts can appoint professionals who have had no prior contact with my family to conduct independent evaluations and make recommendations to the court.

I understand that it is Dr. Wagner’s policy to have no court involvement in my case because that could harm our professional relationship and the ability to achieve my goals. My goals include resolving personal concerns so that I might preserve my marriage and/or be a better parent.

By signing this form I am agreeing not to use any of my psychotherapy records or testimony in any future court proceedings.

Signature: ______________________________________________
Date: __________________________________________________
“Notice of Privacy Practices”

THIS NOTICE INVOLVES YOUR PRIVACY RIGHTS AND DESCRIBES HOW INFORMATION ABOUT YOU MAY BE DISCLOSED, AND HOW YOU CAN OBTAIN ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

I. Confidentiality

As a rule, I will disclose no information about you, or the fact that you are my patient, without your written consent. My formal Mental Health Record describes the services provided to you and contains the dates of our sessions, your diagnosis, functional status, symptoms, prognosis and progress, and any psychological testing reports. Health care providers are legally allowed to use or disclose records or information for treatment, payment, and health care operations purposes. However, I do not routinely disclose information in such circumstances, so I will require your permission in advance, either through your consent at the onset of our relationship (by signing a general consent form), or through your written authorization at the time the need for disclosure arises. You may revoke your permission, in writing, at any time, by contacting me.

II. “Limits of Confidentiality”

Possible Uses and Disclosures of Mental Health Records without Consent or Authorization

There are some important exceptions to this rule of confidentiality – some exceptions created voluntarily by my own choice, [some because of policies in this office/agency], and some required by law. If you wish to receive mental health services from me, you must sign the attached form indicating that you understand and accept my policies about confidentiality and its limits. We will discuss these issues now, but you may reopen the conversation at any time during our work together.

I may use or disclose records or other information about you without your consent or authorization in the following circumstances, either by policy, or because legally required:

· Emergency: If you are involved in in a life-threatening emergency and I cannot ask your permission, I will share information if I believe you would have wanted me to do so, or if I believe it will be helpful to you.

· Child Abuse Reporting: If I have reason to suspect that a child is abused or neglected, I am required by Virginia law to report the matter immediately to the Virginia Department of Social Services.
· Adult Abuse Reporting: If I have reason to suspect that an elderly or incapacitated adult is abused, neglected or exploited, I am required by Virginia law to immediately make a report and provide relevant information to the Virginia Department of Welfare or Social Services.

· Health Oversight: Virginia law requires that licensed psychologists report misconduct by a health care provider of their own profession. By policy, I also reserve the right to report misconduct by health care providers of other professions. By law, if you describe unprofessional conduct by another mental health provider of any profession, I am required to explain to you how to make such a report. If you are yourself a health care provider, I am required by law to report to your licensing board that you are in treatment with me if I believe your condition places the public at risk. Virginia Licensing Boards have the power, when necessary, to subpoena relevant records in investigating a complaint of provider incompetence or misconduct.

· Court Proceedings: If you are involved in a court proceeding and a request is made for information about your diagnosis and treatment and the records thereof, such information is privileged under state law, and I will not release information unless you provide written authorization or a judge issues a court order. If I receive a subpoena for records or testimony, I will notify you so you can file a motion to quash (block) the subpoena. However, while awaiting the judge’s decision, I am required to place said records in a sealed envelope and provide them to the Clerk of Court. In Virginia civil court cases, therapy information is not protected by patient-therapist privilege in child abuse cases, in cases in which your mental health is an issue, or in any case in which the judge deems the information to be “necessary for the proper administration of justice.” In criminal cases, Virginia has no statute granting therapist-patient privilege, although records can sometimes be protected on another basis. Protections of privilege may not apply if I do an evaluation for a third party or where the evaluation is court-ordered. You will be informed in advance if this is the case.

· Serious Threat to Health or Safety: Under Virginia law, if I am engaged in my professional duties and you communicate to me a specific and immediate threat to cause serious bodily injury or death, to an identified or to an identifiable person, and I believe you have the intent and ability to carry out that threat immediately or imminently, I am legally required to take steps to protect third parties. These precautions may include 1) warning the potential victim(s), or the parent or guardian of the potential victim(s), if under 18, 2) notifying a law enforcement officer, or 3) seeking your hospitalization. By my own policy, I may also use and disclose medical information about you when necessary to prevent an immediate, serious threat to your own health and safety. If you become a party in a civil commitment hearing, I can be required to
provide your records to the magistrate, your attorney or guardian ad litem, a CSB evaluator, or a law enforcement officer, whether you are a minor or an adult.

· Workers Compensation: If you file a worker’s compensation claim, I am required by law, upon request, to submit your relevant mental health information to you, your employer, the insurer, or a certified rehabilitation provider.

· Records of Minors: Virginia has a number of laws that limit the confidentiality of the records of minors. For example, parents, regardless of custody, may not be denied access to their child’s records; and CSB evaluators in civil commitment cases have legal access to therapy records without notification or consent of parents or child. Other circumstances may also apply, and we will discuss these in detail if I provide services to minors.

*Other uses and disclosures of information not covered by this notice or by the laws that apply to me will be made only with your written permission.*

III. Patient’s Rights and Provider’s Duties:

· Right to Request Restrictions-You have the right to request restrictions on certain uses and disclosures of protected health information about you. You also have the right to request a limit on the medical information I disclose about you to someone who is involved in your care or the payment for your care. If you ask me to disclose information to another party, you may request that I limit the information I disclose. However, I am not required to agree to a restriction you request. To request restrictions, you must make your request in writing, and tell me: 1) what information you want to limit; 2) whether you want to limit my use, disclosure or both; and 3) to whom you want the limits to apply.

· Right to Receive Confidential Communications by Alternative Means and at Alternative Locations — You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations. (For example, you may not want a family member to know that you are seeing me. Upon your request, I will send your bills to another address. You may also request that I contact you only at work (or that I do not leave voice mail messages.) To request alternative communication, you must make your request in writing, specifying how or where you wish to be contacted.

· Right to an Accounting of Disclosures – You generally have the right to receive an accounting of disclosures of PHI for which you have neither provided consent nor authorization (as described in section III of this Notice). On your written request, I will discuss with you the details of the accounting process.
· Right to Inspect and Copy – In most cases, you have the right to inspect and copy your medical and billing records. To do this, you must submit your request in writing. If you request a copy of the information, I may charge a fee for costs of copying and mailing. I may deny your request to inspect and copy in some circumstances. I may refuse to provide you access to certain psychotherapy notes or to information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative proceeding.

· Right to Amend – If you feel that protected health information I have about you is incorrect or incomplete, you may ask me to amend the information. To request an amendment, your request must be made in writing, and submitted to me. In addition, you must provide a reason that supports your request. I may deny your request if you ask me to amend information that: 1) was not created by me; 2) is not part of the medical information kept by me; 3) is not part of the information which you would be permitted to inspect and copy; 4) is accurate and complete.

· Right to a copy of this notice – You have the right to a paper copy of this notice. You may ask me to give you a copy of this notice at any time. Changes to this notice: I reserve the right to change my policies and/or to change this notice, and to make the changed notice effective for medical information I already have about you as well as any information I receive in the future. The notice will contain the effective date. A new copy will be given to you or posted in the waiting room. I will have copies of the current notice available on request.

Complaints: If you believe your privacy rights have been violated, you may file a complaint. To do this, you must submit your request in writing to my office. You may also send a written complaint to the U.S. Department of Health and Human Services.

EFFECTIVE DATE: 04.07.2018

Patient’s Acknowledgement of Receipt of Notice of Privacy Practices

Please sign, print your name, and date this acknowledgement form.

I have been provided a copy of Dr. Wagner’s Notice of Privacy Practices.

We have discussed these policies, and I understand that I may ask questions about them at any time in the future.

I consent to accept these policies as a condition of receiving mental health services.