Maria T. Aranda, Ph.D., LLC

Licensed Psychologist #PY5983

Psychology Service Agreement
Scheduling and Billing Policies
New Patients
Effective January 2017

Welcome to my practice. This form serves to outline my general office policies. It also contains information about the Health Insurance Portability and Accountability Act (HIPAA), certain Florida laws and professional ethical codes relevant to therapy. Please read it carefully, and if you feel comfortable with the content, please sign at the bottom. When you sign this document, it will represent an agreement between us. You may revoke this agreement in writing any time, which will mean you no longer consent to treatment. I will provide you with a copy to retain for future reference.

PSYCHOLOGICAL SERVICES: Psychotherapy is not easily described in general statements. There are many different methods that may be used to deal with the problems you, your child or your family is experiencing. Psychotherapy is different from a medical visit. It calls for a very active effort on your part.

Psychotherapy can have both benefits and risks. The therapy process may include discussions of you, your child or your family's personal challenges and difficulties, which can elicit discomfort, sadness, guilt, anger or frustration. However, therapy has been shown to have many benefits. It can often lead to better interpersonal relationships, improved work/academic performance, solutions to specific problems, and an increased capacity to manage intense feelings. But there are no guarantees to what you will experience.

The first few sessions will involve an assessment of your needs. By the end of the assessment, I will be able to offer you some first impressions of what our work will include and a treatment plan to follow. You should evaluate this information along with your own opinions of whether you feel comfortable working with me. Therapy involves a commitment, so you should feel careful about the therapist you select. If you have questions about my procedures, we should discuss them whenever they arise. If your doubt persists, I will be happy to help you set up a meeting with another mental health professional for a second opinion.

Therapy is usually most effective on a consistent and weekly basis; thus, my clients usually see me once a week for approximately three to six months. After that, we may meet less often for several more months. Therapy then usually comes to an end, but this can vary per person. The process of ending therapy is called termination and this can be a very valuable part of our work. Stopping therapy should not be done casually and should be discussed. If you wish to stop therapy at any time, I ask that you meet with me for at least one more session to review our work together.

SCHEDULING: Psychotherapy services are provided on a regular schedule, weekly in most cases, unless therapeutic needs dictate a more or less frequent schedule. I request as much notice as possible in order to fill your appointment if you are unable to make it. **You are responsible for the session fee if less than 48 hours' notice is given.** You can leave a message on my voicemail (813) 431-2798 at any time, 24 hours a day**. I reserve the right to terminate services after two missed appointments in one month (less than 24-hour notice).**

CONFIDENTIALITY: Psychological services are confidential as provided by Federal and Florida laws. I comply with all regulations regarding the privacy of psychological information and comply with the HIPAA law. I will provide you with a separate form regarding privacy policies as required by HIPAA.

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. There are other situations that require that you provide written, advance consent. **Your signature on this agreement provides consent for the following activities:**

- I may occasionally find it helpful to consult other mental health professionals about a case. During this consultation, I avoid revealing the identity of my patient. The other professional is also legally bound to keep the information confidential. The consultations will be recorded in your clinical record.
- Disclosures required by health insurers or to collect overdue fees are discussed elsewhere in this agreement.

There are some situations where I am permitted or required to disclose information **without** either your consent or authorization:

- If federal officials are conducting national security and intelligence activities or providing protective services to the President or other important officials. By law I cannot reveal when I have disclosed such information to the government.
- 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, and I am providing necessary treatment related to that claim, I must, upon appropriate request, submit treatment reports to the appropriate parties, including the patient's employer, the insurance carrier or an authorized qualified rehabilitation provider.

There are other situations that I **require** you consent or authorization to disclose information:

- 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 psychologist-patient privilege. I cannot provide any information without your written authorization or a court order. If you are involved in/or contemplating litigation, you should consult with your attorney to determine whether a court would be likely to order the release of information.

There are some situations in which I am **legally obligated** to take actions, such as situations where I believe it is necessary to protect others from harm. In these situations, I may have to reveal some information about a patient's treatment. These situations are unusual in my practice and can include the following:

- If I know or have reason to suspect, that a child under 18 is abused, abandoned, or neglected by a parent, custodian, or caregiver or any other person responsible for the child's welfare, the law requires that I file a report with the Department of Child and Family Services. Once a report is filed, I may be required to provide additional information.
- If I know or have reasonable cause to suspect that a vulnerable adult has been or is being abused, neglected, or exploited, the law requires that I file a report with the central abuse hotline. Once a report is filed, I may be required to provide additional information.
- If I believe there is a clear and immediate probability of physical harm to the patient, to other individuals, or to society, I may be required to disclose information to take protective action and seek hospitalization of the patient and/or communicate information to a potential victim and/or appropriate family member.

If one of these situations arises, I will make every effort to fully discuss it with you before taking any action and I will limit my disclosures 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 questions or concerns that you may have now or in the future. The laws governing confidentiality are quite complex, and I am not an attorney. In situations where confidentiality is unclear, formal legal advice may be needed.

WORKING WITH MINORS: Treatment of minors is a collaborative process and open lines of communication with parents and guardians help move the pace of treatment along. In the case of divorce or separation, it is also important that all individuals who have custody provide consent for treatment in writing. Treatment or evaluation cannot commence without said consent.

Patients under 18 should be aware that the law might allow parents to examine their child's treatment records. Children between 13 and 17 may independently consent to (and control access to the records of) diagnosis and treatment in a crisis situation. Because privacy in therapy is crucial to treatment, particularly with teenagers, and parental involvement is also essential, it is usually my policy to request an agreement with minors over 12 and their parents about access to information. This agreement provides that during treatment, I will provide parents only with general information about the progress of the treatment, and the patient's attendance at scheduled sessions. Any other communication will require the child's authorization, unless I feel that the child is in danger or is a danger to someone else, in which case, I will notify the parents of my concern. Before giving parents information, I will discuss the matter with the child, if possible, and do my best to handle any objections he/she may have.

CLINICAL EMERGENCIES: **My practice does not include a back-up answering service.** If you or I believe that your mental health needs requires this type of service, I reserve the right to transfer you to a practice or agency with such said services. I check my messages regularly Monday through Friday between 8 AM and 5PM. I make all efforts to respond to crises and emergencies as promptly as possible. **If an emergency is life-threatening and requires immediate attention that I am unable to provide, assistance can be sought from the nearest hospital emergency room or by calling 9-1-1.** The Crisis Center can also be reached at 813-234-1234. After-hours non-emergency phone calls will be returned during regular office hours.

PROFESSIONAL FEES/BILLING/INSURANCE: I currently am on the provider list for Tricare insurance and Woods & Associates. I do not use any business associates and perform all billing myself. Although your insurance carrier may pay for claims on your behalf, **all unpaid claims are the member's responsibility**. All co-pays are required at the time of service. When providing information to your insurance, I will only give the required information so as to protect your privacy.

If you decide to not utilize your insurance for payment, the fee for individual psychotherapy is $180 for an initial consultation and $160 for subsequent sessions. Sessions are 50 minutes long. I do expect payment for each session to be made at the time of the appointment. If a large unpaid bill is accrued (more than 2 sessions), I may decide to discontinue treatment until the balance is paid or payment arrangements have been made, as is clinically appropriate. In addition, during instances where a client is refusing to pay for services already rendered, I may involve the use of collection agencies if payment arrangements cannot be agreed upon. Please note that I review my service fees at the beginning of each year, and I may increase your fee at a minimal percentage. I provide complimentary telephone consultations that are 15 minutes or less. If such telephone consultation is longer than 15 minutes, my hourly rate will apply on a prorated basis. **Letters are also subject to prorated hourly rates ($160/per hour) as is time spent preparing records or treatment summaries and other services you request**. If records are requested, I charge $1 for each page (up to 25 pages) and then .25 cents for each page after.

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, even if I am called to testify by another party. **Because of the difficulty of legal involvement, I charge $250.00 per hour for preparation and attendance at any legal proceeding**. A $25 service fee is assessed for returned checks.

PATIENT RIGHTS: HIPAA provides you with rights. These include: amending your clinical record and 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 record; and the right to a paper copy of this agreement and the additional HIPAA notice form. I am happy to discuss an of these rights with you.

FORMS OF COMMUNICATION: You are welcome to contact me via telephone at 813.431.2798; all voice mail messages are confidential and only heard by Dr. Aranda. Please note that due to my work schedule, I am often not available immediately by telephone. I will make every attempt to return your call the same day, except for weekends and holidays. If I am unavailable for an extended period of time, I will provide you with the name of a colleague to contact if necessary. Please always indicate if your call is urgent. Should you need immediate assistance, please call 911 or seek emergency services through the Crisis Center at 813-234-1234.

You can also email at MariaAranda@tampabay.rr.com. This is a good way to provide me with information outside of a session, such as a specific event that occurred during a week or an update on a child's behavior. **IMPORTANT** – While emails are not appropriate for crisis situations or emergencies, it can sometime be convenient to use this method for communication. However, be aware that email can be accessed by unauthorized people (e.g., hackers, server staff, and communication companies) which can compromise the confidentiality of such communications. It is also possible that emails can be sent erroneously to the wrong address. If you communicate confidential information via unencrypted emails, it will be assumed that you have evaluated the risks and are giving consent to such method of communication, despite the risks of interception by others. Finally, please note that I do not communicate via text messaging.

Agreement to pay for services

I, the client (or person acting for the client), request that Dr. Maria Aranda provide professional services to me or to _____, who is my _____.

I agree that I am responsible for the charges for services provided by this psychologist to me (or this client), although other persons or insurance companies may make payments on my (or this client's) account.

I understand that if my account has not been paid for more than 30 days and arrangements for payment have not been agreed upon, Dr. Aranda has the option of using legal means to secure payment. I understand that this may involve hiring a collection agency or going through small claims court which will require Dr. Aranda to disclose otherwise confidential information. In most collection situations, the only information Dr. Aranda will release

regarding a client's treatment is his/her name, the nature of services provided, and the amount due. My signature on this form represents my agreement and consent to Dr. Aranda's financial policies.

_____

Signature of Client

I have read and understood the office and financial policies of Maria Aranda, Ph.D., and am in agreement. **My signature below also provides consent for treatment for myself, my child, or an individual for whom I am a legal guardian**. In cases of legal guardianship or custody, I attest that I have provided Dr. Aranda with accurate information about custody or guardianship and that I am able to consent to this treatment.

Consent for Treatment

Name of person providing consent
(parent or guardian if under 18 years of age):_____

Signature of person providing consent:_____

Relationship to Patient:_____ Date:_____

Patient's name:_____

Patient's date of birth:_____

Home Address:_____

_____

Home Phone:_____Work Phone(s):_____

Cell Phones:_____

Emergency contact name and telephone number:_____

HIPAA ACKNOWLEDGEMENT OF RECEIPT

I have had the opportunity to read the "Notice of Psychologists' Policies and Practices to Protect the Privacy of Your Health Information." I understand I may ask Dr. Aranda any questions I might have about this document, which went into effect on September 1, 2013.

_____ _____
Signature Date

_____ _____
Signature Date