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Client Agreement for Therapy Services

Welcome to the therapeutic practice of Avis Augustine-Miller dba Distinctively Yours, LLC Counseling and Consulting. This document (the Agreement) 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 client 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. One of the requirements of HIPAA is that I provide you with a Notice of Privacy Practices (the Notice) for use and disclosure of PHI for treatment, payment and health care operations. The Notice, which is attached to this Agreement, explains HIPAA and its application to your personal health information in greater detail. The law requires that I obtain your signature acknowledging that I have provided you with this information at the end of this session. Although these documents are long and sometimes complex, it is very important that you read them carefully before our next session. We can discuss any questions you have about the procedures at that time. When you sign this document, it will also represent a binding 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 there are obligations imposed on me by your health insurer in order to process or substantiate claims made under your policy; or if you have not satisfied any financial obligations you have incurred.

THERAPY SERVICES

Therapy is not easily described in general statements. It varies depending on the personalities of the therapist and client, and the particular problems you are experiencing. There are many

different methods I may use to treat the difficulties that you hope to address. Therapy is not the same as visit to a medical doctor where he does an examination *of* you. Instead, it calls for a very active effort *by* you. In order for the therapy to be most successful, I recommend that you work on things we talk about both during our sessions and at home.

Therapy can have both benefits and risks. Since therapy often involves discussing unpleasant aspects of your life, you may experience uncomfortable feelings like sadness, guilt, anger, frustration, loneliness, and helplessness. On the other hand, therapy has also been shown to have many benefits. Therapy often leads to better relationships, solutions to specific problems, and significant reductions in feelings of distress. However, there are no guarantees of what you, as an individual, will experience.

Our first few sessions will involve an evaluation of your needs, goals and objectives for treatment. By the end of the evaluation, I will be able to offer you some initial impressions of what our work might involve 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 methods, procedures or anything else that happens in our sessions, please discuss them with me as they arise. If you should ever have doubts about our work, I'd be happy to talk to you about setting up a consultation with another therapist, or, if you prefer, give you some names of therapists you can consult on your own for a second opinion.

MEETINGS

I normally conduct an evaluation that will last from 1 to 4 sessions. During this time, we can both decide if I am the best person to provide the services you need in order to meet your treatment goals. If psychotherapy is begun, I will usually schedule one 50- to 55-minute session (one appointment hour of 50 minutes' duration) per week at a time we agree on, although some sessions may be longer or more frequent. I require at least 24 hours' notice if you need to cancel a scheduled appointment. It is important to note that insurance companies do not provide reimbursement for cancelled sessions, so you would be expected to pay the entire fee, not just the co-insurance/copay amount you might normally pay. In a few circumstances, I may work out

different financial policies with you. If so, I will discuss this with you before instituting the new policy.

PROFESSIONAL FEES

My hourly fee is \$125.00 for the initial intake and \$105.00 for each therapy session of 45 – 60 minutes. In addition to weekly appointments, I charge this amount for other professional services you may need, though I will break down the hourly cost if I work for periods of less than one hour. Examples of other services might include report writing, telephone conversations lasting longer than 10 minutes, preparation of records or treatment summaries, and the time spent performing any other service you may request of me. If you become involved in legal proceedings that require my participation, you will be expected to pay for all of 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 \$350.00 per hour for preparation and attendance at any legal proceeding. Court Appearances and Depositions are billed this way to include the counselor's travel ^{[[SEP]]}time and the amount of time the counselor is obligated to be away from the office. Payment for legal appearances is to be paid in advance, to be used as a retainer. Any unused funds will be refunded to the client. ^{[[SEP]]}

CONTACTING ME

Due to my schedule, I am often not immediately available by telephone. My telephone, (434) 421-5161, is answered by a confidential voice mail that I monitor frequently throughout the business day and once daily during weekends and holidays. If you are difficult to reach, please specify particular times when you will be available. Please be aware that I do not return calls during weekends except in the case of a clinical emergency. In this case, make it clear in your message that it is an emergency. I will return your call within 20 minutes of receiving it. If you are unable to reach me and feel that you cannot wait for me to return your call, please call 911 to request a CIT Trained police officer, contact your family physician, the nearest emergency room or mental health crisis center. If I will be unavailable for an extended time, I will provide you with the name of a colleague to contact, if necessary.

LIMITS ON CONFIDENTIALITY

The law protects the privacy of all communications between a client and a psychologist. In most situations, I can only release information about your treatment to others if you sign a written

Client Name: _____

DOB: _____

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 client. 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. I will note all consultations in your Clinical Record to Protect the Privacy of Your Health Information.

Disclosures required by health insurers or to collect overdue fees are discussed elsewhere in this Agreement.

If a client threatens to harm himself/herself, I may be obligated to seek hospitalization for him/her or to 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 my professional services, such information is protected by the therapist-patient privilege law. I cannot provide any information without your written authorization, or a court order. If you are involved in or are 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 client files a complaint or lawsuit against me, I may disclose relevant information regarding that client in order to defend myself.

Client Name: _____

DOB: _____

- ✓ If a client files a worker's compensation claim, and I am providing treatment related to the claim, I must, upon appropriate request, furnish copies of all medical reports and bills.
- ✓ 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 client's treatment. These situations are very unusual in my practice.
- ✓ If I have reason to believe that a child has been abused, the law mandates that I file a report with the appropriate governmental agency, usually the Department of Human Services. Once such a report is filed, I may be required to provide additional information.
- ✓ If I have reasonable cause to believe that a disabled adult or elder person has had a physical injury or injuries inflicted upon such disabled adult or elder person, other than by accidental means, or has been neglected or exploited, I am mandated to report to an agency designated by the Department of Human Services. Once such a report is filed, I may be required to provide additional information.
- ✓ If I determine that a client presents a serious danger of violence to another, I am required to take protective actions. These actions may include notifying the potential victim, and/or contacting the police, and/or seeking hospitalization for the client.

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 danger to yourself and others or makes reference to another person (unless such other person is a health care provider)

Client Name: _____

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and I believe that access is reasonably likely to cause substantial harm to such other person or where information has been supplied to me confidentially by others, you may examine and/or receive a copy of your Clinical Record, if you request it in writing. 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. My fee for copying a Clinical Record is \$1.00 per page. If I need to refuse your request for access to your records, you have a right of review (except for information provided to me confidentially by others), which I will discuss with you upon request.

In addition, I may also keep a set of therapy notes on your case. These notes are for my own use and are designed to assist me in providing you with the best treatment. While the contents of therapy notes vary from client to client, they generally consist of notes to myself about our work that would not be very meaningful to others. They may also contain particularly sensitive information that you or others reveal to me that is not required to be included in your Clinical Record. therapy notes are kept separate from your Clinical Record. Your therapy notes are not available to you and cannot be sent to anyone else, including insurance companies without your written, signed authorization. I've never been asked to release copies of my therapy notes, and in most cases, would refuse to do so unless mandated by law, so this information remains highly protected and confidential. Insurance companies cannot require you to authorize me to release my therapy notes as a condition of coverage nor penalize you in any way for your refusal to provide it.

CLIENT RIGHTS

HIPAA provides you with several new or expanded 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, the attached Notice form, and my privacy policies and procedures. I am happy to discuss any of these rights with you.

Client Name: _____


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BILLING AND PAYMENTS

You will be expected to pay for each session at the time it is held, unless we agree otherwise or unless you have insurance coverage that requires another arrangement. Payment schedules for other professional services will be agreed to when they are requested. In circumstances of unusual financial hardship, I may be willing to negotiate a fee adjustment or payment installment plan. For telehealth clients, copays, coinsurances and self-pays are expected at the start of the session.

Although this has never become necessary in my practice, 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 could involve hiring a collection agency or going through small claims court which would require me to disclose otherwise confidential information. In most collection situations, the only information I release regarding a client’s treatment is his/her name, the nature of services provided, and the amount due. If such legal action becomes necessary, its costs may be included in the claim.

For your convenience, and to secure future appointments, please enter credit card information below. I authorize Distinctively Yours, LLC to place my credit card information on file to charge for copays, co-insurances, outstanding balances and any applicable fees. 

Cardholder’s Name: _____ Billing Zip Code _____ <i>(Please Print)</i>
CC# _____ Exp: _____ CVC: _____
Credit Card Holder’s Signature: _____ Date: _____

INSURANCE REIMBURSEMENT

In order for us to set realistic treatment goals and priorities, it is important to evaluate what resources you have available to pay for your treatment. 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.

You should carefully read the section in your insurance coverage booklet that describes mental health services. If you have questions about the coverage, call your plan administrator. Of course, I will provide you with whatever information I can based on my experience and will be happy to help you in understanding the information you receive from your insurance company.

Due to the rising costs of health care, insurance benefits have increasingly become more complex. It is sometimes difficult to determine exactly how much mental health coverage is available. “Managed Health Care” plans such as HMOs and PPOs often require authorization before they provide reimbursement for mental health services. These plans are often limited to short-term treatment approaches designed to work out specific problems that interfere with a person’s usual level of functioning. It may be necessary to seek approval for more therapy after a certain number of sessions. While much can be accomplished in short-term therapy, some clients feel that they need more services after insurance benefits end.

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. Sometimes I am required to provide additional clinical information such as treatment plans or summaries, or, in rare cases, copies of your entire Clinical Record. In such situations, I will make every effort to release only the minimum information about you that is necessary for the purpose requested. 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. In some cases, they may share the information with a national medical information databank. 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.

Once we have all of the information about your insurance coverage, we will discuss what we can expect to accomplish with the benefits that are available and what will happen if they run out before you feel ready to end your sessions. It is important to remember that you always have the right to pay for my services yourself to avoid the problems described above.

Client Name: _____

DOB: _____

Please note that there are two places below for you to sign. The first indicates that you have received the HIPAA Notice form described above. The second indicates that you have read this agreement and agree to its terms.

I have received the HIPAA Notice form:

_____	_____
Printed name	Signature

Date	

I have read this agreement and agree to its terms:

_____	_____
Signature	Date

Rev. 02-2020

Client Name: _____

DOB: _____