PATIENT SERVICE AGREEMENT

Emotional Wellness Center of Valdosta

Your Name : _____ **Today's Date :** _____

Name of Patient (If not yourself) : _____

Welcome to the Emotional Wellness Center of Valdosta! We appreciate the opportunity to support your emotional and mental well-being. This document serves as a formal agreement to inform you of our practice policies and procedures. It also outlines your rights under the Health Insurance Portability and Accountability Act (HIPAA), a federal law designed to protect your privacy and govern the use and disclosure of your Protected Health Information (PHI) for purposes of treatment, payment, and health care operations (refer to the Georgia Notice form for more details). Please review this information carefully. If you have any questions or concerns, we encourage you to discuss them with your provider.

INITIAL EVALUATION

The initial evaluation typically lasts one or two sessions, allowing us to better understand you and your specific needs. At the end of this process, you and your provider will decide together if the therapeutic relationship feels like a good fit. Recommendations for appropriate treatment options and a course of care will be provided. Therapy involves both benefits and risks. While discussing difficult aspects of life can bring up emotions such as anger, sadness, guilt, or hopelessness, it can also lead to meaningful change, resolving challenges, improving relationships, reducing stress, and increasing overall well-being.

I agree ☐ **disagree** ☐ **with the information regarding counseling/therapeutic service.**

PROVIDER CONTACT

Our current operating hours are Monday–Thursday, 8:00 AM to 5:00 PM, and Friday, 8:00 AM to 12:00 PM. We may not be immediately available to answer phone calls; please leave a detailed voicemail, and we will make every effort to return your call within 24 hours. If your provider is unavailable for an extended period, you will be given the contact information of a covering provider if needed.
Please note that we do not provide crisis intervention or after-hours services. In the event of an immediate crisis, you are encouraged to:

- Contact your primary care physician
- Visit your nearest emergency room and ask for the on-call mental health specialist
- Contact a psychiatric facility, such as:
  - Greenleaf Hospital: (229) 506-7977
  - Legacy Behavioral Health Crisis Center: (229) 671-3500
- Call the Georgia Crisis & Access Line: 1-800-715-4225 | www.mygcal.com
- Call the Florida Crisis & Access Line: 1-800-950-6264 | www.namiflorida.org
- Call or text the National Suicide & Crisis Lifeline: 988

Appointments and Cancellations

Therapy sessions are typically 45–60 minutes long. If you need to cancel or reschedule, please provide at least 24 hours' notice. Cancellations made with less than 24 hours' notice, or failure to attend a scheduled session, will result in a $50 No-Show Fee, which is not covered by insurance and is the patient's responsibility.
Exceptions to this policy may be made in advance for anticipated issues with health or scheduling. If you are running more than 5 minutes late, you must notify the office by phone or email to avoid being charged for a missed session.
Please be aware that three (3) consecutive no-shows may result in immediate dismissal from our services.

I agree ☐ **disagree** ☐ **with the with the information regarding provider contact.**

INSURANCE, BILLING, AND PAYMENTS

You are expected to pay for each session at the time it is held, unless other arrangements are made in advance or your insurance requires a different billing process.

The current self-pay rate is:

- Initial clinical evaluation: $125
- 60-minute psychotherapy session: $125

(*Fees for self pay are subject to periodic increases, and written notice will be provided in advance.)*

- **Additional Services**
  - Non-therapy services such as letters, reports, or extended phone calls (over 15 minutes) will be billed based on actual time and expenses. These services are not covered by insurance, and payment terms will be agreed upon as needed.
- **Legal Involvement**
  - We do not engage in forensic work and will not participate in legal proceedings unless legally required. If your provider is involved in legal matters, including being subpoenaed or testifying, you will be billed at $350 per hour for all professional time (including preparation and travel), regardless of which party initiates the request. This fee applies even if the court appearance is canceled within 24 hours of the scheduled time, as providers must clear their clinical schedule in advance.
- **Payment Terms**
  - Fees are due at the beginning of each session or in advance. Payments may be made by cash or check (payable to your provider). Returned checks will incur additional fees. No outstanding balances will be carried longer than one week without prior arrangement. If an unpaid balance is not resolved within 60 days of your final session, we reserve the right to use legal means, including collection services or attorneys, to recover the balance. In such cases, your confidentiality is limited to the disclosure of your name and contact information for collection purposes.
- **Insurance and Confidentiality**
  - If using insurance, please be aware that your insurer will require clinical information, including a mental health diagnosis, which becomes part of your permanent medical record and may affect future insurance eligibility. We will release only the minimum necessary information and strive to protect your privacy. However, once shared with your insurer or a third party, we cannot guarantee how your personal health information will be handled or stored. Some insurance companies may report this information to national databases used in determining future insurability.

Disputes with your insurance carrier regarding claims are your responsibility unless clinical clarification or documentation is specifically required from us.

I agree ☐ disagree ☐ with the with the information regarding billing and payments.

NOTICE OF POLICIES AND PRACTICES IN PROTECTING YOUR HEALTH INFORMATION

REVIEW CAREFULLY

CONFIDENTIALITY

Information about you, including professional records that are required by the laws and standards of our profession, is kept strictly confidential in accordance with the Ethical Principles of the American Psychological Association and Georgia/Florida State Law. These guidelines require confidentiality to be breached, where discloser of PHI without your consent or authorization in the following circumstances:

1. **Child Abuse:** If we know, or have reasonable cause to suspect, that a child is abused, abandoned, or neglected by a parent, legal custodian, caregiver, or other person responsible for the child's welfare, the law requires such knowledge or suspicion to be reported to the Georgia/Florida Department of Children and Families.
2. **Adult and Domestic Abuse:** If we know, or have reasonable cause to suspect, that a vulnerable adult (disabled or elderly) has been or is being abused, neglected, or exploited, the law requires us to immediately report such knowledge or suspicion to the Georgia/Florida Department of Children and Families.
3. **Serious Threat to Health or Safety:** If you present a clear and immediate probability of physical harm to yourself, to other individuals, or to society, relevant information may be communicated concerning this to the potential victim, appropriate family member, or law enforcement or other appropriate authorities.
4. **Health Oversight:** If a complaint is filed against us with the Georgia/Florida Department of Health on behalf of the Board of Psychology or any other Board, the Department has the authority to subpoena confidential mental health information from us relevant to that complaint.
5. **Judicial or Administrative Proceedings:** If you are involved in a court proceeding and a request is made for information about your diagnosis or treatment and the records thereof, such information is privileged under state law and will not be released without the written authorization of you or your legal representative, or a subpoena of which you have been properly notified and you have failed to inform us that you are opposing the subpoena or a court order. The privilege does not apply when you are being evaluated by a third party or where the evaluation is court ordered. You will be informed in advance if this is the case.
6. **Worker's Compensation:** If you file a worker's compensation claim, we must, upon request of your employer, the insurance carrier, an authorized qualified rehabilitation provider, or the attorney for the employer or insurance carrier, furnish your relevant records to those persons. In addition to these legally mandated reports, we may occasionally find it helpful to consult with other health and mental health professionals. During a consultation, we will not disclose your identity unless you have signed a release permitting me to do so. The other professionals are also legally bound to keep the information confidential, not all consultations will be discussed. Records also can be released to a third party with your written consent (e.g., to another treatment provider or to an insurance carrier per your request). Please note, however, that we cannot be responsible for the confidentiality or disposition of records released to a third party once released to that third party. You may revoke all such authorizations at any time, provided each revocation is in writing. You may not revoke an authorization to the extent that *(1) we have relied on that authorization; or (2) if the authorization was obtained as a condition of obtaining insurance coverage, and the law provides the insurer the right to contest the claim under the policy.*

PROFESSIONAL RECORDS PURSUANT TO HIPAA

We maintain Protected Health Information (PHI) in two types of professional records: your Clinical Record and Psychotherapy Notes.

Your Clinical Record includes information such as:

- Reasons for seeking therapy
- Diagnosis and treatment goals
- Medical and social history
- Treatment history and records from other providers
- Consultation reports
- Billing information
- Any reports sent to third parties (e.g., insurance companies)

You may request in writing to examine or obtain a copy of your Clinical Record. Access may be denied in certain situations, including:

- When disclosure may pose a serious risk of harm to yourself or others
- When the record contains references to another person (other than a health care provider) and releasing that information could cause harm
- When information has been provided confidentially by others

Because clinical records can sometimes be misinterpreted, we recommend reviewing them with your provider or another qualified mental health professional. Reproduction of records may incur time and expense fees, which can be discussed based on your request.
Psychotherapy Notes are for the provider's personal use to support the therapeutic process and are kept separate from your Clinical Record. These notes are not available for review and cannot be shared with anyone, including insurance companies.

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)

We are required by federal law to provide you with information about the Health Insurance Portability and Accountability Act (HIPAA). HIPAA requires that we provide you with a Notice of Psychologist's Policies and Practices to Protect the Privacy of Your Health Information (the Notice) for use and disclosure of PHI for treatment, payment, and health care operations. The Notice explains HIPAA and its application to your personal health information in greater detail. The law requires that we obtain your signature acknowledging that we have provided you with this information. HIPAA provides you with several rights about your Clinical Record and disclosures of protected health information. These rights include requesting that your record be amended by the provider; requesting restrictions on what information from your Clinical Record is disclosed to others; requesting an accounting of most disclosures of protected health information; 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 Informed Consent agreement, the attached Notice form, and our privacy policies and procedures.

I agree ☐ disagree ☐ with the policies and practices involving your PHI (Personal Health Information).

USE OF ELECTRONIC MEDIA

The best and preferred mode of communication is by phone or email. While email, and other forms of electronic communication may seem convenient, the security and confidentiality of these media cannot be guaranteed. Further, these communications may be intercepted, corrupted, lost, destroyed, arrive late or incomplete, or contain viruses. Please be aware of this when communicating with your provider in this manner. We will use and respond to email messages only for scheduling. We cannot communicate with you via electronic media concerning anything that would be considered Protected Health Information (PHI), as your confidentiality cannot be assured. If you choose to communicate PHI to me via any form of electronic media, your signature below indicates your understanding that you waive your confidentiality rights in those types of electronic communications.

SOCIAL MEDIA

Please be aware that we cannot interact with you on any form of social media or any online forum. This policy is intended to preserve your confidentiality as well as your privacy, and it aims to protect the clear and safe boundaries of our therapeutic relationship. It is our desire to know you directly based on our therapeutic interactions rather than to obtain information about you from other sources. If you use location-based services on your mobile phone, please be aware of the privacy issues related to using these services. It is possible that others may be able to determine your identity or otherwise track your status as a patient to our location. Your privacy will be more secure if location tracking is turned off when you are in the office.

I agree ☐ **disagree** ☐ **with the policies and practices involving electronic media.**

TELEHEALTH

A portion of our practice is conducted virtually via HIPAA-compliant audiovisual platforms, and some patients request phone sessions. Please be aware that although we use a secure, encrypted, HIPAA complaint platform, we cannot guarantee the security of any audiovisual platform or phone connection. As such, we cannot ensure protection of your confidentiality or privacy in out-of-office virtual sessions. Further, these sessions are sometimes not covered by health insurance. You will be responsible for determining if your insurance will cover out-of-network psychotherapy via these modalities. If telehealth is elected as the primary way of engaging in therapy, you will be required to sign a separate supplemental consent form specific to telepsychology.

I agree ☐ **disagree** ☐ **with the policies and practices involving telehealth services.**

MINORS AND PARENTS

Privacy in counseling/therapy is crucial to successful progress, particularly with adolescents. Parental involvement is also essential. Our policy is to request an agreement with minors and their parents about access to information. This agreement provides that during treatment, parents will be provided with only general information about the progress of treatment, and the patient's attendance at scheduled sessions and any necessary follow up as deemed appropriate.

I agree ☐ **disagree** ☐ **with the information regarding minors and parents.**

SEPARATION, DIVORCE, AND/OR CHILD CUSTODY

We recognize the complexities involved in families separated by divorce. If you are divorced and you are considering seeking services for your child(ren) with our office, we will inquire as to the nature of the legal and physical custody of your child. When parents have joint or shared custody, both parents have the right to consent to and to refuse treatment. It is imperative that we know **BEFORE THE FIRST SESSION** that both parents agree to the child receiving treatment in our office. In addition to assisting with the logistics of scheduling your child, therapeutic benefits are optimized when both parents agree with the treatment plan. We will often request to meet with both parents, even if one parent has sole legal responsibility. It is our goal to understand as much as possible about the child's situation and to make sure our care is as comprehensive as possible. If issues related to separation, divorce, or child custody arise during the course of your child's therapy, it is vital that you understand that we **CANNOT** provide expert testimony for any purpose other than that related to therapy. If you need expert advice about separation, divorce, or custody, you must hire a different mental health professional for any evaluations that may be requested. This position is based upon the following:

1. Our statements may be seen as biased in your favor because we have a therapeutic relationship.
2. Most, if not all, of the information we have has been provided by you or your child and we do not have independent knowledge about either your parenting skills or the appropriateness of various custody considerations.
3. Our testimony would likely affect our therapeutic relationship.
4. Our professional ethics do not allow us to maintain dual relationships (therapeutic and forensic).

I agree ☐ disagree ☐ with the information regarding separation, divorce, & child custody.

PATIENT – THERAPIST CONTRACT

YOUR SIGNATURE BELOW INDICATES THAT YOU HAVE READ AND UNDERSTOOD THE PATIENT SERVICES AGREEMENT AS OUTLINED ABOVE.

Patient Signature (Guardian Signature if Patient is a Minor) _____ **Date** _____

Printed Name of Signee _____ **Relationship to Patient** _____

Name of Patient _____ **Date of Birth** _____

Name of Person Responsible for any Payments _____