Dr D'Benedetto
Psychology Practice

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PATIENT SERVICES AGREEMENT

Welcome to my practice. I appreciate your trust and the opportunity to assist you. I am providing you with the following information to answer many of the questions people typically have when beginning counseling/psychotherapy, and to outline policies and procedures that are specific to my work. If you have any questions, thoughts, or feelings about what is printed, please always feel free to discuss them with me in our sessions. When you sign this document, it will represent an agreement between us.

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 protection and patient 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. HIPAA requires that I provide you with a Notice of Privacy Practices (the Notice) for use and disclosure 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.

Meetings

My services are by appointment only. I normally conduct an evaluation that will last from 1 to 3 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 goals. Usually I will schedule one 45-minute session per week at a time we agree on, although some sessions may be more frequent. Due to the nature and structure of my practice, I must adhere firmly to time guidelines. As such, if you are late for a scheduled session, it will end at its regularly scheduled time. If I am late for a session, I will make up the lost time.

Cancellation Policy

It is important for you to understand that your appointment time is reserved exclusively for you. As such, you are financially responsible for your appointment. **Should you not be able to attend a session for any reason, you need to notify me 24 hours in advance**. If you do not give me 24 hours notice, and we can not find another time in the week to reschedule then YOU WILL BE RESPONSIBLE FOR PAYING FOR THE SESSION IN TOTAL. If you are seen as an in-network client, then the fee is what the insurance company considers the "allowed amount", NOT your weekly copay amount. If you are seen as an out-of-network client, then the fee is the regular session amount. Any missed sessions cannot be billed to insurance, so payment is solely your responsibility.

Telephone and Emergency Policy

If you need to reach me between regularly scheduled appointment times, you can call me at (347) 815-0699. The voicemail at this number is confidential. I check these messages regularly and will return your call at my earliest possible opportunity. If you are unable to reach me and feel that you cannot wait for me to return your call, contact your family physician or go to the nearest emergency room. If I will be unavailable for an extended time, I will provide you with the name of a colleague to contact, if necessary.

Billing and Fees

My fee is based upon a 45-minute session. **Copayment must be paid at the end of each session.** Please note that returned checks are subject to a $25.00 fee.

Insurance Reimbursement

If you plan to use out-of-network mental health coverage, I will fill out any necessary forms required of me and provide you with whatever assistance I can in helping you receive the benefits to which you are entitled. However, you (and not your insurance provider) are ultimately responsible for full payment of my fees. It is very important that you find out exactly what mental health services your insurance policy covers.

Patient Rights

HIPAA (Health Insurance Portability and Accountability Act) provides you with several new or expanded rights with regard to your clinical records and disclosures of protected health information. The attached form entitled "Notice of Policies and Practices to Protect the Privacy of Your Health Information" lists these rights.

Confidentiality and Privacy of Information

I will make every effort to safeguard the privacy of information concerning our work together. All clinical records are protected from public viewing and access. Patient information will not be shared without written consent of the client, except, as required by law, or in a situation determined to be potentially life threatening.

Acknowledgement

Your signature below indicates that you have read this agreement and agree to its terms, and also serves as an acknowledgement that you have received the HIPAA notice form "Notice of Policies and Practices to Protect the Privacy of Your Health Information."

Name of Patient: _____

Signature of Patient: _____ Date: _____

If minor, Guardian's Signature: _____ Date: _____

Signature of Therapist_____ Date: _____

Alyse DiBenedetto, Psy.D. / Associate

Please return this signed consent form to me. I will provide you with a copy for your records. Thank you.