Dr DiBenedetto
Psychology Practice

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# PATIENT SERVICES AGREEMENT

Welcome to our practice. We 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 our work. If you have any questions, thoughts, or feelings about what is printed, please always feel free to discuss them with us in your sessions. When you sign this document, it will represent an agreement between us, Dr DiBenedetto Psychology Practice Associates and you.

This document (the Agreement) contains important information about our 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 we 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. The law requires that we obtain your signature acknowledging that we have provided you with this information. Although these documents are long and sometimes complex, it is very important that you read them carefully. We can discuss any questions you have about the procedures at any time. When you sign this document, it will also represent an agreement between us. You may revoke this Agreement in writing at any time. That revocation will be binding on us unless we have taken action in reliance on it; if there are obligations imposed on us 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.

## Sessions

Our services are by appointment only. We normally conduct an evaluation that will last from 2-4 sessions. During this time, we can both decide if your therapist is the best person to provide the services you need in order to meet your treatment goads. If you decide to continue, your therapist will usually 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 our practice, we 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 we are late for a session, we 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 us 24 hours in advance**. If you do not give 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 FEE 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 us between regularly scheduled appointment times, you can reach us at (347) 815-0699. The voicemail at this number is confidential. We check these messages regularly and will return your call at our earliest possible opportunity. If you are unable to reach us and feel that you cannot wait for us to return your call, contact your family physician or go to the nearest emergency room. If we will be unavailable for an extended time, we will provide you with the name of a colleague to contact, if necessary.

**Billing, Fees, & Reports**

My fee is based upon a **45 minute** session. Our fee is $170 per session. If you are using your insurance as "out-of-network", then **payments of $170 must be paid at the end of each session.**

If you are using "in-network" insurance, **copayment must be paid at the end of each session.** Please note that returned checks are subject to a $25.00 fee.

In addition to weekly appointments, we charge this amount for other professional services you may need, though we will break down the hourly cost if we work for periods of less than one hour. Other services include report writing, telephone conversations lasting longer than 10 minutes, consulting with other professionals with your permission, preparation of records or treatment summaries, and the time spent performing any other service you may request of your psychologist. If you become involved in legal proceedings that require our participation, you will be expected to pay for all of our professional time, including preparation and transportation costs, even if your psychologist is called to testify by another party. Because of the difficulty of legal involvement, we charge $250 per hour for preparation, travel and attendance at any legal proceeding.

If your account has not been paid for more than 60 days and arrangements for payment have not been agreed upon, we have the option of using legal means to secure the payment. This may involve hiring a collection agency or going through small claims court which will require us to disclose otherwise confidential information. In most collection situations, the only information we release regarding a patient's treatment is his/her name, the nature of services provided, and the amount due. If such legal action is necessary, its costs will be included in the claim.

**Insurance Reimbursement**

If you plan to use out-of-network mental health coverage, we will fill out any necessary forms required of your insurance and provide you with whatever assistance we can in helping you receive the benefits to which you are entitled. However, you (and not your insurance provider) are responsible for full payment of our fees at the end of each session. Our session fee is $170/session. Your insurance will then

reimburse you if they cover your sessions. It is your responsibility to find out exactly what mental health services your insurance policy covers.

You should also be aware that your contract with your health insurance company requires that we provide it with information relevant to the services provided to you. We are required to provide a clinical diagnosis. Sometimes we are required to provide additional clinical information such as treatment plans or summaries, or copies of your entire Clinical Record. In such situations, we 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, we 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. We will provide you with a copy of any report we submit, if you request it. By signing this Agreement, you agree that we 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 our services yourself to avoid the problems described above.

**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. These rights include requesting that your doctor 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 our policies and procedures recorded in your records; and the right to a paper copy of this Agreement, the attached Notice form, and our privacy policies and procedures.

**Confidentiality and Privacy of Information**

We 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.

**Limits on Confidentiality and Privacy of Information**

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

- We have a privacy contract with our accountants. As required by HIPAA, we have a formal business associate contract with them, in which they promise to maintain the confidentiality of data except as specifically allowed in the contract or otherwise required by law. If you wish, we can provide you with a blank copy of this contract.

- If a patient seriously threatens to harm himself/herself, we may be obligated to seek hospitalization for him/her, or to contact family members or others who can help provide protection. NJ law provides that a professional may disclose confidential information only to medical or law enforcement personnel if the professional determines that there is a probability of imminent physical injury by the patient to the patient or others, or there is a probability of immediate mental or emotional injury to the patient.

There are some situations where we are 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 your diagnosis and treatment, such information is protected by the psychologist-patient privilege law. We cannot provide any information without your (or your legal representative's) 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 us to disclose information.
- If a government agency is requesting the information for health oversight activities, we may be required to provide it for them.
- If a patient files a complaint or lawsuit against us, we may disclose relevant information regarding that patient in order to defend ourselves.
- If a patient files a worker's compensation claim, we must, upon appropriate request, provide records relating to treatment or hospitalization for which compensation is being sought.

There are some situations in which we are legally obligated to take actions, which we believe are necessary to attempt to protect others from harm, and we may have to reveal some information about a patient's treatment. These situations are unusual in our practice.

- If we have cause to believe that a child under 18 has been or may be abused or neglected (including physical injury, substantial threat of harm, mental or emotional injury, or any kind of sexual contact or conduct), or that a child is a victim of a sexual offense, or that an elderly or disabled person is in a state of abuse, neglect or exploitation, the law requires that your doctor makes a report to the appropriate governmental agency, usually the Department of Protective and Regulatory Services. Once such report is filed, we may be required to provide additional information.
- If we determine that there is a probability that the patient will inflict imminent physical injury on another, or that the patient will inflict imminent physical, mental or emotional harm upon him/herself, or others, we may be required to take protective action by disclosing information to medical or law enforcement personnel or by securing hospitalization of the patient.

If such a situation arises, we will make every effort to fully discuss it with you before taking any action, and we will limit our 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 we are not attorneys. In situations where specific advice is required, formal legal advice may be needed.

**Professional Records**

You should be aware that, pursuant to HIPAA, we keep Protected Health Information in your Clinical Record. It includes information about your reasons for seeking therapy, a description of the ways in which your problem impacts on your life, your diagnosis, the goals that we set for treatment, your

progress towards those goals, your medical and social history, your treatment history, any past treatment records that we receive from other providers, reports of any professional consultations, your billing records, and any reports that have been sent to anyone, including reports to your insurance carrier. Except in unusual circumstances that involve danger to yourself and others, you may examine and/or receive a copy of your Clinical Record if you request it in writing. In most circumstances, we are allowed to charge a copying fee of $5 per page (and for certain other expenses). The exceptions to this policy are contained in the attached Notice Form.

**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.