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PSYCHOTHERAPIST – CLIENT SERVICES AGREEMENT

This document (Agreement) outlines the professional services and business policies of Lisa K. Schkloven, LCSW-C. My policies are in accordance with the 2010 Federal Health and Insurance Portability and Accountability Act (HIPPA).

PSYCHOTHERAPY SERVICES:

Psychotherapy is not easily described in general statements. It varies depending upon the personalities of the therapist and patient, and the particular issues you present. I may use many different methods to deal with these issues. Psychotherapy is not a passive process. To be most successful, you will have to work on things we discuss both in session and at home.

Psychotherapy has benefits and risks. If often leads to better relationships, solutions to specific problems, and a reduction in feelings of distress. However, sometimes to achieve these goals, therapy may involve discussing unpleasant aspects of your life and you may experience uncomfortable feelings like sadness, guilt, anger, frustration, loneliness and helplessness. If you experience any of these feelings, it is important to discuss them in your session.

EVALUATION:

In order for us to work effectively, a period of evaluation is necessary. A typical evaluation requires two to four sessions which will involve meeting with you. During this period of evaluation, I obtain an understanding of the presenting concerns and, together, we will develop preliminary goals. I will also obtain an understanding of your background history which includes, your medical, family of origin, educational, career, social and current family information. The evaluation period may also require that I communicate with any specialists with whom you have in the past or currently work. In any of the above situations, your written permission will be obtained prior to any contact made. At the end of the evaluation period, we will review your preliminary goals and make changes, as appropriate.

APPOINTMENTS:

Appointments are scheduled for forty-five to fifty-five minute sessions (one appointment hour of forty-five to fifty-five minutes in duration) per week. **Once an appointment is scheduled, you are responsible for the entire fee, not just the co-pay, unless you cancel at least twenty-four hours prior to your appointment. Insurance companies do not provide reimbursement for late cancellations or missed scheduled appointments** In the event of a snow, other weather or traffic emergency is declared by local authorities, please call me to discuss the feasibility of keeping versus cancelling your appointment. You will be charged for the missed session if there is not a mutually agreed upon cancellation. A forecast of snow does not constitute a weather emergency. Extenuating circumstances are considered on a situation by situation basis.

PROFESSIONAL FEES:

My fee for the initial consultation session is $175. Future sessions are billed at $150 per hour for individual sessions and $165 for family or couple sessions. I charge $150 per hour for other professional services you may need such as writing reports, telephone conversations lasting longer than ten minutes, attendance at meetings with other professionals you have authorized, preparation and copying of records or treatment summaries, and time spent performing other services you may request. I apportion the hourly costs of these services into fifteen minute intervals. Should you compel me to go to court on your behalf, I charge $450.00 an hour plus and fees associated (parking, legal fees, court costs).

BILLING AND PAYMENTS:

You are expected to pay for each session at the time it is held unless we agree otherwise or you have insurance that requires other arrangements. If you have insurance coverage, you will be required to pay the co-pay at the time of service. You may pay by cash or check. I do not accept credit cards. Should your check be returned due to non-sufficient funds, you will be assessed $35.00 to cover the fees associated with this process.

Unless other arrangements have been made, payments are considered late if they are thirty days past due (i.e., thirty days past the date on which the appointment occurred). Should payment be late, interest of 1.5% per month will be incurred. If your account has not been paid for sixty days and arrangements for payment have not been agreed upon, I will consider this nonpayment of your account a breach or our working agreement. Upon breach of our working agreement, I have the option of using legal means to secure payment. This may involve hiring a collection agency or going through small claims court and will require me to disclose otherwise confidential information. At that time, I will provide only the information necessary such as your name, address, services provided and the amount due. If such legal action is necessary, those costs will be included in the claim. Your signature on this document affirms your understanding of and agreement to my course of action regarding your account should it become past due.

INSURANCE REIMBURSEMENT:

For us to set realistic treatment goals and priorities, it is important to evaluate what resources are available to pay for your treatment. If you have health insurance, you must determine exactly what mental health services are covered and what the limits are under your policy. Then we can discuss what we can expect to accomplish with the benefits that are available and what may happen if they run out before we feel it's time to for your treatment to end. You may have the right to pay for my services directly, unless prohibited by your health insurance contract.

Obtaining Preauthorization for Services:

Managed Health Care plans such as HMOs and PPOs may require you to obtain prior authorization, such as a referral from your primary care physician, for you to receive benefits under your plan. **You are responsible to obtain authorization. If you fail to obtain prior authorization for your treatment, your insurance company may reject your claim for reimbursement of benefits. You, not your insurance company, are ultimately responsible for full payment of any fees.**

Statements of Services Rendered:

At your request, I will provide you with statements that you can submit to your insurance company to seek partial reimbursement for fees incurred or to your health spending account, should you have one.

Calendar Year and Group Year Deductibles:

It is important that you understand and communicate to me the parameters of your insurance coverage in terms of your calendar year or group year coverage start date and the deductibles. If your insurance coverage reaches the start of a calendar year or group year deductible while you are in treatment, you will be responsible for payment until that deductible is met. As a provider in your insurance network, I have agreed to accept the insurance company's reimbursement rate as payment. I shall extend the same courtesy to you while you meet your deductible. As before, all fees are due at time of service.

Communicating with Your Insurance Company:

Your contract with your health insurance provider may require me to provide it with information regarding the services that I provide to you. Maryland permits me to send some information without your consent in order to file appropriate claims. I am required to provide insurance companies with a clinical diagnosis, dates of services, and the type of services rendered. Sometimes I am required to provide additional clinical information, such as treatment plans or summaries, or copies of your entire Clinical Record. In such situations, I make every effort to release only the minimum information that is necessary for the purpose requested. I will notify you if I believe that your health insurance company is requesting unreasonable amounts of information. You may instruct me not to send requested information, but this could result in claims not being paid. Once the insurance company has this information, it will become part of the insurance company's files and will probably be stored on its computers. I have no control over what they do with this information, though all insurance companies claim to keep such information confidential. I will provide you with a copy of any report I submit, if you request it. By signing this Agreement, you consent to allow me to provide your health insurance provider with the information that it requests.

CONTACTING ME:

Due to my work schedule and the fact that I do not interrupt sessions to take phone calls, I am often not immediately available by telephone. When I am unavailable, my telephone is answered by voice mail that I monitor frequently. I will make every effort to return your call as quickly as possible, with the exception of weekends and holidays. If there are limitations in your availability, please inform me of times that you are available when you leave your message and I will make every effort to return your call at one of those times.

If you have an urgent concern and need to contact me after business hours, on weekends or holidays, you may call the after-hours phone number that I will provide to you. When leaving a message, please make sure you leave a call back number along with your concern.

In the event of a clinical emergency, which I define as a situation where immediate therapeutic or medical intervention is necessary to prevent dire consequences to you or others, please contact your nearest hospital emergency room and ask for psychiatric assistance. Then, please notify me.

PROFESSIONAL RECORDS:

The laws and standards of my profession require that I keep Protected Health Information (PHI) about you in your Clinical Record. The Clinical Record includes the following information: 1) the reason for seeking therapy, 2) a description of the ways in which your problem/s impacts on your life, 3) your diagnosis, 4) the goals set for treatment, 5) your progress towards those goals, 6) your medical and social history, 7) your treatment history, 8) any past treatment records that I receive from other providers, 9) reports of any professional consultations, 10) the billing records, and 11) any reports that have been sent to anyone, including reports to your insurance carrier.

You may examine or receive a copy of your Clinical Record, upon written request. I will provide you with a copy of your Clinical Record unless I have reasonable concern that seeing it would cause you emotional harm. Professional records may be misinterpreted by an untrained reader. For that reason, I recommend that you initially review it in my presence, or have me forward the record to another mental health professional to discuss the contents. I charge a copying fee of $1.00 per page. You will be obligated to pay for any copying, time spent preparing, mailing/delivery charges or other charges incurred in the preparation and sending of your Clinical Record.

PATIENT RIGHTS:

HIPPA provides you with several new and expanded rights regarding your Clinical Record and the disclosure of Protected Health Information (PHI). These rights include requesting that I amend my records; requesting restrictions on what information from your Clinical Records is disclosed to others; requesting an accounting of disclosures of Protected Health Information (PHI) to which you have neither consented nor authorized; having any complaints you make about my policies and procedures recorded in your records. The registering of a complaint with me will not adversely impinge on your treatment.

CONFIDENTIALITY:

In general, the privacy of all communications between patient and psychotherapist is protected by law. I only release information about your treatment to others if you sign a written authorization form that meets certain legal requirements imposed by HIPPA and/or Maryland law. However, there are a few exceptions.

I may occasionally find it helpful to consult without any identifying information about you. The consultant is also legally bound to keep the information confidential. If you do not object in writing, I will not tell you about these consultations unless I believe that is it important to treatment.

As required by HIPPA, in the event of insurance claims are submitted electronically, the clearing house that submits these claims is also contractually bound to maintain the confidentiality of protected information.

If you are involved in a court proceeding, I cannot provide any protected information without your written authorization, or a court order. If you file a complaint or lawsuit against me, I may disclose relevant information regarding you in order to defend myself.

These are a few situations in which I am legally obligated to act even if I have to reveal some information about your treatment. For example, if I have reason to believe that a child or vulnerable adult has been subjected to neglect, abuse or endangerment, the law requires that I file a report with the appropriate state agency.

If I know that you have a propensity for violence and/or you indicate that you have the intention to inflict imminent physical injury upon a specific person(s), I am required to take protective action. These actions may include notifying the potential victim, seeking hospitalization for you, or contacting the police. If I believe that there is an imminent risk that you will inflict serious physical harm to yourself, or that immediate disclosure of protected information is required to provide for your emergency health needs, I may be required to seek hospitalization for you or contact family members or others who can provide for your protection. These situations are very unusual in my practice. In the event of such a situation, I will make every effort to fully discuss it with you before taking any action and will limit our disclosure to what is absolutely necessary.

While this written summary of exceptions to confidentiality should prove helpful in informing you about the law and our policies, it is important that we discuss any questions or concerns you may have. However, the laws governing confidentiality are quite complex. If you need specific, formal legal advice, please contact an attorney.

You may revoke this Agreement at any time, in writing only. Such revocation is binding unless I have taken actions in reliance on this Agreement; there are obligations imposed upon me by your health insurer in order to process claims made under your policy, or if you have not satisfied any financial obligations you have incurred.

Your signature below indicates that you have read this Agreement, agreed to abide by its terms during our professional relationship.

Patient's Signature	Patient's Signature
Date	Date

Therapist's Signature

Date