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PSYCHOTHERAPIST – PATIENT SERVICES AGREEMENTFOR MINOR CHILD

This document (Agreement) outlines the professional services and business policies of Lisa K. Schkloven, LCSW-C. My policies are in accordance with the updated Federal Health and Insurance Portability and Accountability Act (HIPPA) of 2013.

PSYCHOTHERAPY SERVICES:

Psychotherapy refers to a variety of techniques and methods used to help children who are experiencing difficulties with their emotions and/or behavior. Contrary to the myth people often hear, children are not more adaptable and less affected by problems than adults. Because children have less life experience, fewer coping skills and less control over their environment, they are deeply affected by their feelings. Being less able to verbally describe emotional problems, children show their distress in indirect ways, such as irritability, anxiety, sleeping or eating problems, personality changes, physical complaints, disregard for personal safety, opposition and/or defiance, school problems, problems getting along with others, depression, acting younger or older than their ages, and so on.

Although there are different types of psychotherapy, each relies on communications as the basic tool for bringing about change in a person's feelings and behaviors. For children, playing, drawing, building, and pretending, as well as talking, are important ways of sharing feelings and resolving problems. Through therapeutic conversations and interactions between therapist and child, the child begins to understand and resolve problems, modify behavior, and make positive changes in his/her life. Psychotherapy is often used in combination with other treatments (medication, behavior management, parenting education/skill enhancement and/or work with the school). Psychotherapy involves the individual child, and may, at times, involve different members of the child's family.

Psychotherapy helps children in a variety of ways. They receive emotional support, learn to understand feelings and problems, try out new solutions to old problems and develop ways to resolve conflicts with people. Goals for therapy may be specific (change in behavior, improved relations with friends or family), or more general (less anxiety, better self-esteem). The length of psychotherapy depends on the complexity and severity of problems. Psychotherapy is not a quick fix or an easy answer. It is a complex and rich process that, over time, can reduce symptoms, provide insight, and improve a child or adolescent's functioning and quality of life.

CONFIDENTIALITY:

The relationship that develops between therapist and child is very important. Your child must feel comfortable, safe and understood. This type of trusting environment makes it much easier for your child to express his/her thoughts and feelings and to use the therapy in a helpful way. For that reason, each child must be afforded a "zone of privacy" in which what he/she shares with the therapist is allowed to remain confidential. Therefore, I ask you to respect this privacy and refrain from asking me about the details of your child's treatment.

While privacy in psychotherapy is very important, parental involvement is essential to successful treatment. You are encouraged to communicate with me regularly, either by phone or email, to keep me apprised of developments in your child's home, academic and social lives. In order to balance your child's right to a confidential relationship with a parents' need for information about the therapy, we will meet periodically so that I may provide you with a verbal progress report and respond to general questions about treatment. We will also use that time to discuss any ways in which you can help your child maximize his/her progress by introducing strategies at home, at school and/or in the community. This may require that I communicate with other professionals involved in your child's life. In that case, I will request that you sign a written authorization form that meets the legal requirements imposed by HIPPA and/or Maryland law.

One risk of child therapy involves disagreement among parents and/or disagreement between parents and therapist regarding the best interests of the child. If such disagreements occur, I will strive to listen carefully so that I can understand your perspectives and fully explain my perspective. We can resolve such disagreements or we can agree to disagree, so long as this enables your child's therapeutic progress. Ultimately, you will decide whether therapy will continue. If either of you decides that therapy should end, I will honor that decision, however I ask that you allow me the option of having a few closing sessions to appropriately end the treatment relationship.

Exceptions to Confidentiality:

There are exceptions to the laws of confidentiality as outlined below.

1. I may occasionally find it helpful to consult with other health professionals about a case. During a consultation, I make every effort to avoid revealing the identity of the child and his/her family. 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.
2. 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.
3. 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 that patient in order to defend myself.
4. These are a few situations in which I am legally obligated to take action. If I have concern that your child may pose a danger to him/herself and/or others, I will inform you as soon as possible. As appropriate, I will attempt to discuss my concerns and intentions with the child and I will do my best to handle any objections he/she may have.
5. I am legally obligated to act is if I have reason to believe that your child has been subjected to neglect or abuse or endangerment. The law requires that I file a report with the appropriate state agency and I am required to reveal any pertinent information about your child, his/her treatment and the family.

SEPARATED, DIVORCED OR UNMARRIED PARENTS AND PERSONS WITH LEGAL GUARDIANSHIP:

When psychotherapeutic treatment is provided to a minor child whose parents are separated, divorced or never married, there may be ethical and/or legal obligations regarding the providing of information concerning treatment of the minor child to both parents. It is my policy that, with rare exceptions, both parents of a child must consent, in writing, to treatment of the child. So too, both parents are equally responsible for payment of treatment, including any out of pocket expenses, co-pays and so on. In cases of sole legal custody situations, the custodial parent is required to provide written consent for the treatment of the child and for payment of treatment. Should this be the case, a copy of the legal custody agreement must be presented at the onset of treatment. In cases of legal guardianship situations, the legal guardian is required to provide written consent for the treatment of the child and for payment of treatment. Should this be the case, a copy of the court order authorizing legal guardianship must be presented at the onset of treatment.

Although the parents of a child in treatment may be separated, divorced or unmarried, both parents remain important in their child's treatment. Except in situations in which one parent has sole legal custody or a person has legal guardianship, both parents are entitled to the same information concerning the nature of treatment, treatment plan, time and date of appointments and any comments concerning treatment and treatment recommendation made. To effectively provide treatment, I may make therapy recommendations that would involve one or both of the child's parents. I continue to expect to meet with both parents, whether together or separately. In situations in which one or both parents are uncomfortable meeting together, arrangements for separate meetings can be made.

Psychotherapy for your child is made solely for treatment purposes, and is not for legal or custodial purposes unless I agree to provide treatment in accordance with a court ordered appointment to provide therapy. Unless therapy has been court ordered and I am required to testify in court concerning treatment of your child, I will decline to provide reports or discuss therapy with the attorneys of either party. I may file a motion with the court to quash any subpoenas that you, your child's co-parent or either attorney may file for testimony or records. These steps would be taken to preserve my role as therapist with your child. If you initiate action to compel me to provide reports, discuss therapy with your attorney or in any other way involve me in legal actions, I will bill you for my time at the rate of $500.00 per hour, and expect payment in full within 10 days of billing. You will be responsible for any court costs or legal fees incurred by me. If you initiate action to compel me by court order to be involved in legal proceedings, I may also move to terminate my role as therapist. In short – my role is that of your child's therapist, not as forensic provider in custody litigation. Your signature on this document affirms your understanding of and agreement to the fees and obligations stated herein.

PSYCHOTHERAPY WITH ADOLESCENTS:

If your child is an adolescent, it is possible that he/she will reveal sensitive information regarding activities and behavior of which you may not approve or of which you may be upset - but that do not put him/her at risk of serious and/or immediate harm. Sometimes these behaviors are within the range of normal adolescent experimentation, but at other times they may require your intervention. If I ever believe that your child is at serious risk of harming him/herself or others, I will inform you. When possible and to the extent that it is clinically appropriate, I will first inform your adolescent of my decision, discuss any/all concerns he/she may have and encourage him/her to be part of our discussion.

EVALUATION:

To work effectively with your child a period of evaluation is necessary. A typical evaluation requires two to four sessions which will involve meeting with both parents, with parents and child and with your child alone. During this period of evaluation, I obtain an understanding of the presenting concerns as well as a history of your child and the family. The evaluation period may also require that I communicate with any specialists with whom your child works and/or communicate with or observe at the school where your child attends. In any of the above situations, your written permission will be obtained prior to any contact made. At the end of the evaluation period, I will meet with your to review my clinical impressions, make treatment recommendations and referrals to other specialists, 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 child's 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. An early closing of your child's school does not automatically cancel your child's appointment. Extenuating circumstances are considered in 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. As stated previously, should you compel me to go to court, I will bill you for my time at the rate of $500.00 per hour, and expect payment in full within 10 days of billing. Your signature on this document affirms your understanding of and agreement to the fees and obligations stated herein.

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.

Late 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 past due account.

INSURANCE REIMBURSEMENT:

In order 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 child's 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 that you obtain prior authorization, such as a referral from your child's pediatrician, for your child to receive benefits under your plan. **You are responsible to obtain authorization. If you fail to obtain prior authorization for your child's treatment, your insurance company may reject the 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 in order 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 total payment until that deductible is met. As a provider in your insurance network, I have agreed to accept the insurance company's reimbursement schedule 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 about your child and need to contact me after business hours, 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 your child or others, please contact your nearest hospital emergency room and ask for psychiatric assistance. Then, please notify me.

INTERRUPTIONS IN THERAPY:

Sometimes it is appropriate for a child to stop coming to therapy for a proscribed amount of time. These "breaks" in the therapeutic process need to be introduced in enough time prior to any potential absence to allow us the opportunity to discuss the pros and cons of your child's

time away from therapy and to allow your child and me to process the upcoming absence. If I determine that this interruption in therapy is appropriate, I will "hold" your child's time slot, pending an agreed upon time period, after which your child returns to therapy. As my time is limited and the demands for therapy are great, I will be unable to hold your child's time slot longer than our mutually agreed upon time period unless I hear from you and we have a chance to discuss any extensions in your child absence from therapy.

Prior to your child's absence, you are expected to satisfy any outstanding balance that exists. If, for some reason, you have not satisfied any outstanding balance in your child's account, you will be expected to pay this outstanding balance in full prior to your child's return to therapy or make arrangements with me to meet your financial obligations in a timely manner, including any late payment fees, collection agency feels or legal fees that the account has accrued.

PROFESSIONAL RECORDS:

The laws and standards of my profession require that I keep Protected Health Information (PHI) about your child in his/her Clinical Record. The Clinical Record includes the following information: 1) the reason for seeking therapy for your child, 2) a description of the ways in which your child's problem impacts on his/her life, 3) his/her diagnosis, 4) the goals set for treatment, 5) your child's progress towards those goals, 6) your child's medical and social history, 7) your child's 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.

In respecting your child's "zone of privacy", I request that, to the extent possible, you refrain from examining the Clinical Record. If you feel that it is necessary, you may examine or receive a copy of your child's Clinical Record, upon written request. 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. 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 child's Clinical Record. Your signature on this document affirms your understanding of and agreement to any charges incurred in the preparation of your child's Clinical Record.

PATIENT RIGHTS:

HIPPA provides you with several new and expanded rights with regard to your child's 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 child's 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 child's records. The registering of a complaint with me will in no way adversely impinge on your child's treatment.

While this written summary of exceptions to confidentiality should prove helpful in informing you about the law and my 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 and agree to abide by its terms during the professional relationship I establish with your child and you.

_____	_____
Printed Name	Printed Name
_____	_____
Signature	Signature
_____	_____
Relationship to Child	Relationship to Child
_____	_____
Date	Date

_____

Therapist's Signature

_____

Date