Simply Thrive Therapeutic Associates, PLLC

PSYCHOTHERAPIST-CLIENT SERVICE AGREEMENT

Welcome to our practice. This document contains important information about our professional services, business policies, and HIPPA, the Health Insurance Portability and Accountability Act. When you sign this document, it will also represent the agreement between you as the client and me as the therapist. ***Please initial by each area to indicate that you have read and are in agreement.***

_____ **PSYCHOLOGICAL SERVICES**

Psychotherapy is not easily described in general statements. It varies depending on the personalities of the therapist and client, and the particular problems you are experiencing. There are many different methods we may use to deal with the problems you are hoping to address. Psychotherapy is not like visiting the medical doctor. Instead, it calls for a very active effort on your part. In order for the therapy to be most successful, you will have to work on things we talk about both during our sessions and at home.

Psychotherapy had benefits and risks. Since therapy involves talking about the unpleasant aspects of your life, you may experience uncomfortable feelings like sadness, guilt, anger, frustration, loneliness, and helplessness. On the other hand, therapy has also been shown to have many benefits. Therapy often leads to better relationships, solutions to specific problems, and significant reductions in feelings of distress. But there are no guarantees of what you will experience.
Our first sessions will be an evaluation of your needs. We will be able to offer you insight and first impressions of what our work will include and a treatment plan to follow.

If you have any questions about my procedures or are dissatisfied with anything that is happening in therapy, we should discuss it as soon as possible. Also, please discuss with me when you are feeling better and feel your problems have been resolved. When you feel you are ready to terminate therapy, please tell me at least a session beforehand so we can discuss your feelings about ending and assess the progress and growth you have made.

_____ **CANCELLATION POLICY**

Most therapy clients have a standing appointment at the same time every week or every other week. This time is reserved for you. Although emergencies come up from time to time, it is expected that you will not cancel unless it is an extreme emergency. **Once an appointment hour is scheduled, you will be expected to pay for it unless you give 24 hours (1 full day) advanced notice of cancellation**. It is important to remember that insurance companies do not provide reimbursement for cancelled sessions, so under most circumstances, you will need to pay a fee of $50-100.

_____ **PROFESSIONAL FEES**

First session/assessment	45min-55minutes	$140
Out of Pocket /	55 minutes	$120
Time of Serive Discount		
Individual Psychotherapy	55 minutes	$140
Individual Psychotherapy	45 minutes	$110
Professional Time	50-55 minutes	$120
Legal Proceedings	50-55 minutes	$200
Groups	75-90 minutes	$30-60
Phone calls over 10 min	every 5 minutes	$10

In addition to weekly appointments, we charge these same amounts 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 record or treatment summaries, and the time spent performing any other services you may request of us. If you become involved in legal proceedings that require my professional time, including preparation and transportation costs, even if we are called to testify by another party. Because of the difficulty of legal involvement, we charge $200 per

hour for preparation and attendance at any legal proceeding including travel time. Fees may be raised during the course of therapy. You will be notified in advance if this occurs.

_____ **BILLING AND PAYMENTS**

You will be expected to pay for each session at the beginning of the session, unless we agree otherwise or unless you have insurance coverage that requires another arrangement. Payment schedules for other professional services will be agreed to when they are requested. Depending on your insurance company, you can begin paying only co-pay amount after we have verified your coverage with your insurance company. Please make checks payable to: Tina Winemiller Kinnan

There is a re-billing fee of 1% per month for all accounts not paid after the 1st bill, unless you have made arrangements with me. If your account has not been paid for more than 60 days and arrangements for payment have not been agreed upon, I have the option of using legal means to secure the payment (collection agency or court). In most collection situations, the information I release regarding a patient's treatment is his/her name, the nature of the service provided, any identifying and contact information, and the amount due. If such legal action is necessary, its cost will be included in the claim. Your signature at the end of this document indicates you agree.

_____ **INSURANCE REIMBURSEMENT**

In order for us to set realistic treatment goals, it is important to evaluate what resources you have available to pay for your treatment. If you have a health insurance policy, it will usually provide some coverage for mental health treatment. I will fill out forms and provide you with whatever assistance I can in helping you receive the benefits to which you are entitled; however, generally you (not your insurance company) are responsible for full payment of my fees.

If there is a problem with your insurance company paying, we will try to work it out with them first. After that, we require that you pay your outstanding balance and that you take on the responsibility of collecting from your insurance company if that is allowable.

You should also be aware that your contract with your health insurance company required that I provide it with information relevant to the services that I provide to you. I am required to provide a clinical diagnosis. 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 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, I 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 databank. I will provide you with a copy of any report I submit, if you request it. By signing this Agreement, you agree that I can provide requested information to your carrier.

I use an EHR to bill insurance called Therapy Appointment which is HIPPA approved and secure which minimizes risk of information being shared over the internet.

Once we have all 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 generally you always have the right to pay for my services yourself to avoid the problems described above.

_____ **LIMITS ON CONFIDENTIALITY**

The law protects the privacy of all communications between a patient and a Professional Clinical Counselor. In most situations, I 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, advanced consent. Your signature on this Agreement provides consent for these activities as follows:

- I may occasionally find it helpful to consult with other health and mental health professionals. During a consultation, I make every effort to avoid revealing the identity of my client. The other professionals are also

legally bound to keep the information confidential. If you don't object, I will not tell you about these consultations unless I feel that it is important to our work together.

- I also have contracts with electronic billing and collection services. As required by HIPAA, we have a formal business associate contract with these businesses, in which they promise to maintain the confidentiality of this data except as specifically allowed in the contract or otherwise by law. If you wish, we can provide you with the name of these organizations.
- Disclosures required by health insurers or to collect overdue fees are discussed elsewhere in this Agreement.

There are some situations where I am 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 evaluation, diagnosis or treatment, such information is generally protected by the therapist-patient privileged law. I cannot provide any information without your (or your personal or 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 me to disclose information
- If a government agency is requesting the information for health oversight activities (ex, the North Carolina Board of Licensed Professional Counselors), I may be required to provide it for them.
- If a patient files a complaint or lawsuit against me, I may disclose relevant information regarding that patient in order to defend myself.
- If a patient files a worker's compensation claim, the patient must execute a release so that I may release the information, records or reports relevant to the claim.

There are some situations in which I am legally obligated or permitted to take actions, which I believe are necessary to attempt to protect others from harm and I may have to reveal some information about a patient's treatment.

- Generally, if I know or have some reason to suspect that a child under 18 years of age or a mentally retarded, developmentally disabled, or physically impaired child under 21 years of age has suffered or faces a threat of suffering any physical or mental wound, disability, or condition of a nature that reasonably indicates abuse or neglect of the child, the law requires that I file a report with the appropriate government agencies, usually Children's Services Agency. Once such a report has been filed, I may be required to provide additional information.
- If I have reasonable cause to believe that an elderly or vulnerable adult is being abused, neglected, or exploited, or is in a condition which is the result of abuse, neglect, or exploitation, the law requires that I report such belief to the county Department of Job and Family Services or other appropriate agency.
- If I know or have reasonable cause to believe that a client has been the victim of domestic violence, I must note that knowledge or belief and the basis for it in the client's records.
- If I believe that a client presents a clear and substantial risk of imminent serious harm to him/herself or someone else and I believe that disclosure of certain information may serve to protect that individual, then I may disclose that information to appropriate public authorities, and/or the potential victim, and/or professional works, and or the family of the client.

If such a situation arises, I will, depending on the circumstances, make every effort to fully disclose it with you before taking actions and I will limit my disclosure to what is necessary.

_____ **PROFESSIONAL RECORDS**

You should be aware that pursuant to HIPAA, I keep Protected Health Information about you in your Clinical Record which has your personal data, diagnosis, and treatment plan. I keep my therapy notes brief in case someone (i.e. insurance companies, a court order) has to look at them.

_____ **PATIENT RIGHTS**

HIPPA provides you with several new or expanding rights with regarding to your Clinical Record and disclosures of protected health information. These rights include requesting that I 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 or that are not for treatment, payment or health care operations; determining the location to which protected information disclosures are sent; having any complaints you make about my Policies and Practices to protect the privacy of your health information is provided for you . I am happy to discuss any of these rights with you.

_____ **MINORS AND PARENTS**

Patients under 18 years of age who are not emancipated and their parents should be aware that the law allows parents to examine their child's treatment records unless a court order blocks access. Children between 14-18 may independently consent to and receive 6 sessions of psychotherapy (provided within a 30-day period) and no information about those sessions can be disclosed to anyone without the child's agreement with some limited exceptions. While privacy in psychotherapy is often crucial to successful progress, particularly with teens, parent involvement is also essential to success of treatment. For children 12 and over, it is my policy, to request an agreement between my patient and his/her parents allowing me to share general information about the progress of the child's treatment and his/her attendance at scheduled sessions. Any other communication will require the child's Authorization, unless I feel the child is in danger or is a danger to someone else, in which case, I will notify the parents of my concern. Before giving parents any information, I will discuss the matter with the child, if possible, and do my best to handle any objections he/she may have. Although I will attempt to prevent a parent's access on this basis, there is no guarantee that the information can be protected form disclosure to parents.

_____ **CONTACTING ME**

You may contact the office by telephone at **(919) 636-0762** – your call will be answered in 24 business hours. After your initial assessment, this is not a place to cancel your appointments. You must cancel or reschedule all appointments with me via therapy appointment scheduler or my direct line. This information will be given to your at your first session. Due to work schedules, I am often not immediately available by phone, since I do not answer my phone when I'm with a client. You may leave a voicemail message. I will make every effort to return your call within 24 hours. Please leave times when you are available and if this is an emergency. If I have not called you back and you are having an emergency, please call urgent care or go to the hospital emergency room. Emailing is for scheduling only.

My Therapist's name and number is_____

I may also email her here_____

Therapy Appointment scheduling User name_____

Password:_____

You may revoke this Agreement in writing at any time. That revocation will be binding on me unless I have action in reliance on it; if there are obligations imposed on my 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.

I have read this agreement and I agree to its terms. I understand that I have the right to an explanation of the risks and benefits of each proposed treatment, of alternative treatments, and of no treatment. I understand that I can refuse treatment at any time and that I have the right to have alternative treatment approaches planned with me.

Simply Thrive Therapeutic Associates, PLLC

SIGNATURE PAGE

I understand the first 4 pages of this document is mine to keep to review if questions arise

I have read this agreement and I agree to its terms. I understand that I have the right to an explanation of the risks and benefits of each proposed treatment, of alternative treatments, and of no treatment. I understand that I can refuse treatment at any time and that I have the right to have alternative treatment approaches planned with me.

Simply Thrive Therapeutic Associates will submit claims to my insurance and I understand that the payment for services is ultimately my responsibility

I understand copays will be processed at my session

I agree to abide by the cancelation policy of first NO SHOW is $50 and $100 thereafter

I understand the limits of confidentiality with using insurance and online EHR providers

I understand the therapeutic process is individualized to service each client's needs and the amount of time in session varies by the individual

_____ _____

Client's Signature Date

_____ _____

If minor, signature of parent/guardian Date

_____ _____

Therapist's Signature Date