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**CLIENT-PROVIDER TREATMENT AGREEMENT**

**ABOUT THE OFFICE**

Welcome to my practice. This 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 new federal law that provides new privacy protections and new patient rights with regard to the use and disclosure of your Protected Health Information (PHI). HIPAA requires that I provide you with a Notice of Privacy Practices (the Notice) for use and disclosure of PHI for treatment, payment and health care operations. The Notice, which is attached to this Agreement, explains HIPAA and its supplication in greater detail. The law requires that I obtain your signature acknowledging that I have provided you with this information and the en of this session. Please read it carefully and ask me any questions. When you sign this document it will represent tan agreement between us. You may revoke this Agreement in writing at any time. That revocation will be binding on me unless I have taken action in reliance on it; if there are obligations imposed on me by your health insurer in order to process or substantiate claims made under your policy; or if you have not satisfied any financial obligations incurred during your sessions(s).

**PSYCHOLOGICAL SERVICES**

Psychotherapy is not easily described in general statements. It varies depending on the personalities of the psychologist and patient, and the particular problems you are experiencing. Psychotherapy calls for a very active effort on your part both during our sessions and at home. Psychotherapy can have benefits and risks. Since therapy often involves discussing unpleasant aspects of your life, you may experience uncomfortable feelings. ON the other hand, psychotherapy has also been shown to have many benefits often leading to better relationships, solutions to specific problems, and significant reduction in feelings of distress. But there are no guarantees of what you will experience.

Our first few sessions will involve a thorough history and an evaluation of your current needs. If a problem requires professional services beyond the scope of my work, I will discuss this with you and recommend appropriate treatment resources. BY the end o the evaluation, I will be able to offer you some first impression on a conceptualization of the problems, what our work will include and a morally agreed upon treatment plan to follow. You should evaluation this information, along with your opinion of whether you feel comfortable working with me, in order to determine if you would like to continue therapy. If you have any questions about my procedures we should discuss them as soon as they arise.

I normally conduct an initial evaluation that will last form 3-5 sessions. Once therapy is begun, a weekly 45-minute appointment at a set day and time will be established, although some session may be longer or more frequent.

# PROFESSIONAL FEES

# The fee for the initial interview, which is usually 1.5 hours, is $350. Subsequent sessions are 45 minutes in duration and $225. This fee is also charged for other professional services you may need, though I will prorate the fee for periods of less or more than 45 minutes. These services include:

# Extended psychotherapy sessions.

# Telephone calls of 15 minutes or more, including calls to relevant school or medical personnel as well as other involved service providers such as occupational or speech therapists.

* Report or letter writing.
* Review of psychological reports and/or testing material.
* Preparation of records, forms or treatment summaries as requested by you, or with written permission by your insurance company.
* Attendance at school meetings or school observations, as authorized by you, including transportation time.
* Attendance at meeting with other professionals as authorized by you, including transportation time.

I usually do not work in court-involved cases. However, if you become involved in legal proceedings that require my participation, you will be expected to pay for all of my professional time, including preparation and transportation costs, even if I am called to testify by another party. I will make all efforts to avoid testifying, unless court ordered. The purpose of this position is to guarantee that what takes place in treatment is solely for the benefit of the patient and not to be used towards or against a parent’s, or any other party’s, agenda.

**BILLING AND PAYMENT**

Coverage for outpatient mental health services is variable. Please make sure you call your insurance company to confirm your benefits. Full payment for psychotherapy is expected at the end of each session. I, for administrative reasons, write up my statements at the end of the month. The statement I give you is designed to give the minimum information requested by most insurance companies including dates of services, diagnosis and session type. However, insurance companies are variable in the amount of information they request and they may require more information such as symptoms, treatment summary and progress before reimbursing.

Payment is due at the time of each visit. You may pay by cash or check. A MasterCard, Visa or Discover credit or debit card will be kept on file only in the case that payment is delayed by 14 or more days from the date of service. 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. This may involve hiring a collection agency or going through small claims court which will require me to disclose otherwise confidential information. In most collection situations, the only information I 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.

**HOLIDAYS**

There are a few holidays that I will be out of the office. They are Thanksgiving Day, Christmas Day, New Year’s Day, Memorial Day, Independence Day and Labor Day. I will inform you in advance of any vacation time or personal days that I will be out of the office. Please assume that unless otherwise indicated, our weekly scheduled appointment will be held. My professional calendar does not coincide with school vacations or other holidays, religious or secular.

# CANCELLATION AND ARRIVAL

# Once an appointment is scheduled, you will be expected to provide 24 hours advance notice of cancellation. You will be expected to pay the full fee should you not provide that 24 hours notice. It is occasionally necessary for cancellations due to safety concerns, such as when there is a snowstorm and I do not charge for such cancellations. I make every effort to adhere to appointment times. I take full responsibility for providing you with a full session or it will be prorated if it cannot be rescheduled. If you are late for the appointment, it is your responsibility to accept a shorter session. There is a buzzer system in the building for security. Please arrive as close to the start of your session as possible and buzz even if you walk in behind someone so I know you have arrived. Due to the sensitive nature of psychotherapy, please keep your voice to a minimum in the waiting area. Children who have a difficult time regulating themselves should be brought to the office just before the start of the session and if they are unable to maintain physical or verbal composure, wait in the hallway.

**HOLIDAYS**

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**HOW TO CONTACT ME**

Due to my work schedule, I am often not immediately available by telephone but will make every effort to return your call within 24 hours, with the exception of weekends and holidays. In emergency situations, please call 911 or go straight to the nearest emergency room and ask for the psychologist or psychiatrist on call. Inform my office as soon as possible. If I am not available, leave a message. I do check messages on a regular basis and will return your call as soon as possible. If I am unavailable for an extended period of time, I will provide you with the name and number of a colleague to contact if necessary. Please be advised that I do not communicate via email or text messaging. If you need to contact me, please call and leave a voicemail message. Any paper materials should be sent via land mail. I will do the same in return.

**PRIVACY AND PROTECTED HEALTH INFORMATION**

The law protects the privacy of all communications between a patient and a psychologist. 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, advance consent. Your signature on this agreement provides consent for those activities, as follows:

* Disclosures required by health insurers for claims purposes or to collect overdue fees by a third party (e.g., collections agency or small claims court).
* If a patient threatens to harm himself/herself, I may be obligated to seek hospitalization for him/her, or to contact family members, police or others who can help provide protection.
* Consultation with another health professional during which I will avoid revealing your identity. The other professionals are also legally bound to keep the information confidential.

There are some situations where I am permitted or required to disclose information without either your consent or authorization.

* If a government agency is requesting the information for health oversight activities.
* If a patient files a complaint or lawsuit against me, I may disclose relevant information regarding that patient in order to defend myself.
* If I am providing treatment for conditions directly related to worker’s compensation claim, I may have to submit such records, upon appropriate request, to Chairman of the Worker’s Compensation Board on such forms and at such times as the chairman may require.
* If you are involved in a court proceeding and a request is made for information concerning the professional services that I provided you or your child, such information is protected by the psychologist-patient privilege law. I cannot provide any information without your 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.

Also, there are some situations in which I am legally obligated to take action that, in doing so, may require me to reveal information about the individual in treatment. If any of these occur, I will limit my disclosure to only what is necessary. These situations are unusual.

* If I receive information that in my professional judgment gives me reasonable cause to suspect that the child is abused or neglected, the law requires that I report to the appropriate governmental agency. Once a report is filed, I may be required to provide additional information.
* If a patient communicates an immediate threat of serious physical harm to an identifiable victim, I have a “duty to warn” that requires me to make reasonable attempts to take protective actions including notifying the potential victim, contacting the police, or seeking hospitalization for the patient.

## PROFESSIONAL RECORDS

The laws and standards of my profession require that I keep Protected Health Information (PHI) about you in your Clinical Record. Except in unusual circumstances that involve danger to yourself and/or others or where information has been supplied to me confidentially by others, you may examine and/or receive a copy of your Clinical Record, if you request it in writing. Because these are professional records, they can be misinterpreted and/or upsetting to untrained readers. For this reason, I recommend that you initially review them in my presence, or have them forwarded to another mental health professional so you can discuss the contents. In most circumstances, I am allowed to charge a copying fee of 75 cents per page (and for certain other expenses). If I refuse your request for access to your records, you have a right to review, which I will discuss with you upon request.

**PATIENT RIGHTS**

HIPAA 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 I amend your record; requesting restrictions on what information from your Clinical Records 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 my policies and procedures recorded in your records; and the right to a paper copy of this Agreement, the attached Notice form, and my privacy policies and procedures. I am happy to discuss any of these rights with you.

**MINORS & PARENTS**

New York law gives children of any age the right to independently consent to and receive mental health treatment without parental consent if they request it and I determine that such services are necessary and requiring parental consent would have a detrimental effect on the course of the child’s treatment. In that situation, information about that treatment cannot be disclosed to anyone without the child’s agreement. Even where parental consent is given, children over age 12 have the right to control access to their treatment records. While privacy in psychotherapy is very important, particularly with teenagers, parental involvement is also essential to successful treatment, particularly with younger children. Therefore, it is my policy not to provide treatment to a child under age 12 unless he/she agrees that I can share whatever information I consider necessary with his/her parents. For children age 12 and over, I 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 that 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.

**WORKING WITH COUPLES, FAMILIES AND GROUPS**

When working with more than one person in a family it is important to identify the nature of the relationship between the therapist and each individual. If it becomes clear that individual issues not pertinent or beneficial to the specified treatment arise, a referral for appropriate treatment with another professional will be provided. Similarly, at times, you may want to inform me of things you do not want your spouse or a particular family member to know. I cannot provide confidentiality for such information, as doing so will be detrimental to my work with you as a family or couple. Furthermore, working with more than one individual during sessions limits my ability to ensure confidentiality. Out of respect for each other and the treatment, it is imperative that all individuals agree to the confidentiality of information revealed in sessions. However, such agreement is given voluntarily and is not binding by law.

YOUR SIGNATURE BELOW INDICATES THAT YOU HAVE READ THIS AGREEMENT AND AGREE TO ITS TERMS. **(All parents with legal custody must sign this form).**

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Parent #1 Signature Date

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Parent #2 Signature Date

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Adolescent Signature Date

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