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THERAPIST-PATIENT SERVICES AGREEMENT

Welcome to my practice. The Therapist-Patient Services 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 Federal law that provides privacy protections 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. You may revoke this Agreement in writing at any time.

PSYCHOTHERAPY SERVICES: I usually conduct 50-minute sessions, leaving the last 5 minutes of the session for follow-up appointments. Once an appointment is scheduled, you will be expected to pay for it. There will be a $50 missed appointment fee unless you provide at least one business day's (24 hours) advance notice of cancellation.

TELEPHONE CONSULTATION & FORMS COMPLETION FEES: I charge a fee for telephone calls relating to your care. Additionally, I charge a fee to complete forms and to write reports and letters. You will be invoiced for these charges and you are responsible for paying these charges.

CONTACTING ME: My office is usually open Monday through Friday, by appointment. I may close office for holidays and vacations. To schedule or cancel an appointment, you may call or text me at 210-326-4294, or email me at DeborahLaneLCSW@gmail.com. In case of emergency, please call or text me at 210-326-4294.

LIMITS ON CONFIDENTIALITY: In most situations, I can only release information about your treatment to others if you sign a written authorization form. There are other situations that require only that you provide written, advance consent. Disclosures required by health insurers or to collect overdue fees are discussed elsewhere in this Agreement. If a patient seriously threatens to harm himself/herself, I may be obligated to seek hospitalization for him/her, or to contact family members or others who can help provide protection.

PROFESSIONAL RECORDS: I maintain personal health information about you in your clinical record. Except in unusual circumstances that involve danger to 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 confusing if read without the guidance of a mental health professional. 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 charge a copying fee of $5.00. If I refuse your request for access to your records, you have a right of review, which I will discuss with you upon your request. Insurance companies can request and receive a copy of your clinical record.

PATIENT RIGHTS: HIPAA provides you with rights with regard to your clinical record and disclosures of PHI. 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; 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 request a paper copy of this Agreement.

MINORS & PARENTS: Patients under 18 years of age who are not emancipated. Their parents should be aware that the law may allow parents to examine their child's treatment records. 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.

BILLING AND PAYMENTS: At this time, I am on very limited insurance panels. My therapy sessions are usually self-pay at the rate of $100.00 per 50-minute session. You are expected to pay for each session at the time it is held, unless we agree otherwise or unless you have insurance coverage that requires other arrangements. If I am an in-network provider for your insurance, I will collect the portion of the fee that the insurance does not cover. If your account is not paid in a timely manner 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 hiring an attorney, which will require me to disclose otherwise confidential information. In most collection situations, the information released includes the patient's name, contact information, the nature of services provided and the amount due. If there are any extra costs involved in the collection process, these costs will be included in the claim.

INSURANCE REIMBURSEMENT: If you have health insurance for which I am a contracted provider, I can file insurance claims to help you receive your benefits. **Please note that *you*, not your insurance company, are responsible for full payment of my fees. If your insurance changes, you are responsible for notifying my office of this change *in writing*.** It is important that you find out exactly what mental health services your insurance policy covers. Your contract with your health insurance company requires that I provide the health insurance company 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 the minimum information about you that is necessary for the purpose requested. This information will become part of the insurance company files. In some cases, the insurance companies may share clinical information with a national medical information databank. I can provide you with a copy of any report I submit, at your request. By signing this Agreement, you agree that I can provide requested information to your insurance carrier.

Your signature below indicates that you have read the information in this document and agree to abide by its terms during our professional relationship. You may request a copy of this document.

Patient's Name (Please Print): _____

Date: _____

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Patient's Signature (or Parent's or Guardian's Signature, for minors)