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THERAPIST-PATIENT SERVICES AGREEMENT

Welcome to my practice: Bella Vista Behavioral Health!

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 regarding 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 5-10 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 missed appointment fee equal to 50% of your normal 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. (see Billing & Payment section) Additionally, I charge a fee to complete forms and/or to write reports and letters. This fee is dependent upon the amount of time it takes me. You will be billed for these charges at the time they occur.

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 specific situations that require you to 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.

PATIENT RIGHTS: HIPAA provides you with rights regarding 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. For additional information, please see my Summary Notice of HIPAA Privacy Practices.

MINORS & PARENTS: Patients under 18 years of age 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: I am an out-of-network provider for insurance. I can provide you with a statement that you can submit to your insurance carrier for reimbursement, if they provide out-of-network coverage. I accept cash, checks or credit cards. My fee schedule for 2021 is as follows:

Individual Therapy Session:	50 Minutes	$125
Parenting Therapy Session:	50 Minutes	$125
Group Therapy Session:	60 Minutes	$45
After Hours Telephone Sessions:	$35 per each 15 minute increment	

You are expected to pay for each session at the time it is held unless we agree otherwise. If your account is not paid in a timely manner and arrangements for payment have not been agreed upon, I will be unable to schedule you for future appointments.

INSURANCE: I do not believe that insurance companies should be the deciding factor on who you see, how often you see them, or how that time should be utilized. You also have the right to keep all your personal health information private. My clients and I choose not to involve their insurance provider in their treatment. Your care is a collaborative effort involving my professional expertise and your personal preferences and goals.

We believe that everyone's mental health is important and taking care of it is an investment. That investment may require time, money, or action on your part. In return, you get an expert specialist who will focus on providing you the best care possible for you to accomplish the goals and changes you strive for. These benefits stay with you going forward.
You are worth the investment!

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 / Guardian's Signature, for minors)