Deborah Levi Lane, LCSW, PLLC
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Tel. 210-326-4294

PATIENT-THERAPIST SERVICES AGREEMENT

Welcome to my practice: Bella Vista Behavioral Health! I believe that a true understanding and respect of the individual's needs is necessary to insure a successful treatment outcome. My work as a psychotherapist is to find what works for each person. I build on the strengths of the individual. There is no cookie-cutter approach to therapy.

The Therapist-Patient Services Agreement contains important information about my professional services and business policies. It also contains information about your rights as a patient. You will receive a copy of this agreement and you may revoke it 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.

CONTACTING ME: My office is usually open Monday through Friday, by appointment. I may close my office for holidays and vacations. To schedule or cancel an appointment, you may call or text my office at 210-707-6888, or email me at DeborahLaneLCSW@gmail.com. In case of an urgent situation, please call or text me at 210-326-4294. Please understand that as a solo practitioner I am unable to personally provide continuous 24-hour crises services. In the event of an emergency involving a threat to your safety or others, please call 911 to request emergency assistance or go to the nearest emergency room for evaluation.

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.

PATIENT RIGHTS: HIPAA provides you with rights regarding your clinical record and disclosures of PHI. For additional information, please see my Summary Notice of HIPAA Privacy Practices.

LIMITS ON CONFIDENTIALITY: In most situations, I can only release information about your treatment to others if you sign a written authorization form, except where required and permitted by law. There are other specific situations that are exceptions to patient confidentiality. 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. The same applies to when a patient threatens to harm others. I am also required to report abuse.

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.

SOCIAL MEDIA: social media such as Facebook or LinkedIn are not private or confidential. Therefore, I will not become "Friends" on Facebook or connections on LinkedIn with any of my clients/patients.

COURT APPEARANCES: I do not voluntarily participate in any litigation or custody dispute in which you and another individual, or entity, are parties. I will also generally not provide records or testimony unless compelled to do so. Should I be subpoenaed, or ordered by a court of law, to appear as a witness in an action involving you, you agree to reimburse me for any time spent in preparation, travel, or time in which I have made myself available for such appearance at a rate of $300 per hour, including time I have cancelled other clients to be "on call" for a subpoena.

ANIMALS: Due to medical reasons, I do not allow any pets/animals in the office.

RECORDING DEVICES: Due to confidentiality reasons, recording of any part of a patient session by either the patient, family member or friend, or myself, is not permitted.

THREATS & HARRASMENTS: Threats or harassment toward me by a patient, patient friend, or family member is grounds for immediate termination of the patient-therapist relationship and may result in the release of patient information.

BILLING AND PAYMENTS: I am an out-of-network provider for almost all insurance plans. Therefore, I don't bill, or fill out billing forms, for insurance plans. The one exception is ComPsych, both EAP and managed care. I can provide you with a statement that you can submit to your insurance carrier for reimbursement if they provide out-of-network coverage. It is your responsibility to contact your insurance to verify their out-of-network benefits.

I accept cash, checks or credit cards. My fee schedule for 2022 is as follows:

Individual Therapy Session:	50-60 Minutes	$150
Parenting Therapy Session:	50-60 Minutes	$150
Group Therapy Session:	75 Minutes	$50
After Hours Telephone Sessions:	$40 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.

YOUR INVESTMENT: 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 understand the terms and agreements as stated above. You also agree to abide by its terms and agreements during our professional relationship. You may terminate this Patient-Therapist Agreement at any time with written notice.

Patient's Name (Please Print): _____

Date: _____

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