SALEM PSYCHOLOGICAL ASSOCIATES, P.A.

87 Stiles Rd, Suite 106, Salem, NH 03079

OUTPATIENT SERVICES AGREEMENT

This is important information about our services and business policies, and the Health Insurance Portability and Accountability Act (HIPAA), a federal law which provides privacy and patient rights for your Protected Health Information (PHI).

PSYCHOLOGICAL SERVICES Psychotherapy requires active effort on your part, and to be most successful you will need to work on things we talk about. We may discuss unpleasant aspects of your life, sometimes involving uncomfortable feelings such as sadness, guilt, anxiety, anger, frustration, and helplessness. But therapy often leads to significant reduction in feelings of distress, better relationships, and resolution of specific problems. As psychotherapy is a complex process, there can be no guarantee regarding the outcome or degree of progress achieved. In our first sessions we will evaluate your needs and I will offer you some initial impressions.

MEETINGS We will usually schedule one session per week, though sometimes more frequent sessions can be helpful. Once an appointment is scheduled, you will be expected to pay for it unless you provide **24 hours advance notice of cancellation.** Insurance will not reimburse missed appointments**,** so you will be responsible for the entire session fee, **not just the copay.**

BILLING AND PAYMENTS You will be expected to pay for each session when it is held, unless we agree otherwise, or you have insurance coverage. Insurance co-pays are due at each session.

Individual, couple, or family session (45-50 minutes)	$150.00
Telephone sessions (per 15 minute increments)	30.00
Correspondence (per 15 minute increments)	30.00
Psychological evaluations and testing (per hour)	175.00
Forensic work and court appearances (per hour)	300.00
Substance Abuse Evaluation (per hour)	150.00
Returned Check Fee	25.00

When treating children, the clinician may spend working time outside of the session. Insurance typically covers only face-to-face therapy. Outside-of-session time will be billed directly to parents. Additional fees include: communicating with guidance counselors or teachers, reviewing previous reports, revising 504 plans or IEPs, attending school meetings, and scoring assessments. The fee is $30 for 15-minute increments. I will notify you if any of these charges apply.

OVERDUE ACCOUNTS If your account is past 60 days overdue, I have the option of using legal means to secure payment, including collection agencies or small claims court. The cost of proceedings will be included in the claim. In most cases, the only information I would release would be the client's name, the nature of the services provided, and the amount due.

INSURANCE REIMBURSEMENT AND DEDUCTIBLES To set realistic treatment goals, it is important to review what payment resources are available to pay for your treatment. It is important you **find out exactly what your insurance policy covers, and any deductible the insurance company requires you to pay.** Speak to the insurance company or your employer with any questions. I will provide what assistance I can, including filling out forms or calling the

insurance company on your behalf, if necessary. **However, you are responsible for full payment of the fee should your insurance company not cover your treatment.** Some plans, such as HMOs and PPOs, require advance authorization for sessions. They are often oriented toward brief treatment of very specific problems that interfere with daily functioning. A lot can be accomplished in short-term therapy, though many clients feel more services are necessary after insurance benefits expire. It is important to discuss what we can accomplish with the benefits available, and what will happen if benefits run out before you feel ready to end our sessions. You may always pay for my services yourself and avoid any insurance complexities.

CONTACTING ME I'm often not immediately available by phone, and your call will reach my voicemail. I will try to return your call as soon as possible, with the exception of weekends and holidays. If you are difficult to reach, please leave some times when you will be available. If it is urgent, call my answering service at 603.886.6941, let them know you are in crisis, and have them get in touch with me or one of the other clinicians. If you can't wait for a call back, go to the nearest Emergency Room and have them get in touch with me. If I plan to be away from the office for an extended period of time, I will provide you the name of a trusted colleague you can contact if necessary.

MINORS If you are under 18, your parents may have the right to examine your records. My policy is to request that parents give up that right. If they agree, I will provide them only with general information about our work together, unless I feel there is a high risk you will seriously harm yourself or another. In that case I will notify them of my concern. Before giving them any information, I will discuss it with you, if possible. Under Federal Confidentiality Laws, a child twelve years or older seeking treatment for substance use has the same rights to confidentiality as an adult. Under this law, I may not let anyone know you attend counseling here or identify you as a substance user.

OUR PRIVACY PRACTICES, OUR LEGAL DUTIES, AND YOUR RIGHTS CONCERNING PROTECTED HEALTH INFORMATION (PHI)

Salem Psychological Associates (SPA) is required by the federal Health Insurance Portability and Accountability Act (HIPAA) to provide you with this notice. It describes how psychological and medical information about you may be used and disclosed, and how you can get access to this information. PLEASE REVIEW IT CAREFULLY.

SPA USES OR DISCLOSES YOUR HEALTH INFORMATION FOR THE FOLLOWING PURPOSES:

TREATMENT We may use or disclose PHI to provide, coordinate, or manage your treatment. This may include coordination with a third party, consultation between health care providers, or referral from one provider to another.

PAYMENT We may disclose your PHI to receive payment for your treatment. This may concern insurance eligibility, billing, claims management, and collection activities. This includes a diagnosis and sometimes additional information such as a treatment summary (or in rare cases, a copy of the entire record.) Insurance companies are required to keep information confidential, but I have no control over what they do once it has left our office.

HEALTH CARE OPERATIONS This includes quality assessment, professional review of healthcare professionals, and business-related matters such as auditing, claims adjudication, and general administration.

OTHER POSSIBLE USES AND DISCLOSURES NOT REQUIRING YOUR AUTHORIZATION:

In general, communication between a client and mental health clinician is confidential by law, and I can only release information about our work with your written permission. However, there are some exceptions. Although this summary should prove helpful, it is important we discuss any questions or concerns you might have. The laws governing these issues are complex, and I am not an attorney. I am happy to discuss these issues, but should you need specific advice, legal consultation may be desirable. If you request, I will provide you with relevant portions or summaries of applicable state and federal laws.

DISCLOSURES REQUIRED BY LAW This may be to comply with a court order, administrative order, subpoena, or other lawful process. In most legal proceedings you have the right to prevent me from providing information about your treatment. However, in some circumstances, such as child custody cases or cases in which your emotional condition is an important element, a judge may require my testimony. The law requires reporting of information related to victims of abuse or neglect, or to law enforcement for law enforcement purposes. We may disclose PHI for civil, administrative, or criminal investigations, licensing board actions, or other necessary activities, including assisting public health authorities or other legal authorities to prevent or control disease, injury, or disability.

HEALTH AND SAFETY PHI may be disclosed to avert a serious threat to the health or safety of you or any other person. I am legally required to take action to protect others from harm, even if that requires revealing some information about a client's treatment. For example, if I believe that a child, or an elderly or disabled person is being abused or neglected, I am required to report this to the appropriate state agency. If I believe a client is threatening serious harm to self, or to another, I am required to take protective actions. These may include notifying a potential victim, notifying the police, seeking appropriate hospitalization for the client, or contacting family members or others who can help provide protection. These situations rarely arise in my practice. Should one occur, I would make every effort to discuss it with you before taking any action.

GOVERNMENT FUNCTIONS PHI may be disclosed for specialized government functions, such as protection of public officials, and national security. PHI may also be disclosed to comply with laws and regulations related to Worker's Compensation.

PROFESSIONAL PEER CONSULTATION I may occasionally find it helpful to consult about a case with other professionals. Consultants are also legally bound to keep information confidential. Unless you object, I will not tell you about these consultations unless I feel it is important to our work together.

OTHER USE AND DISCLOSURE Most other disclosure of PHI requires your written authorization. You have the right to revoke such authorization by submitting your request in writing to Dr. Philip Robbins at this address. You may not revoke an authorization to the extent that I have already relied on it, or if the authorization was obtained as a condition of obtaining insurance coverage, and the insurer has the legal right to contest the claim under your policy.

YOUR HEALTH INFORMATION RIGHTS

RIGHT TO INSPECT AND COPY YOUR RECORDS Submit requests in writing to Dr. Philip Robbins at this address. We may charge a fee for copying, mailing or other supplies. We may deny your request in certain limited circumstances. Because these are professional records, they can be misinterpreted or upsetting to untrained readers. 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.

RIGHT TO AMEND PHI If you feel records are incorrect or incomplete, you may ask us to amend the information for as long as the information is kept by SPA. Your request must be submitted in writing to Dr. Philip Robbins at this address. We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request to amend information that: Was not created by us, is not part of the medical information kept by or for SPA, is not part of the information which you would be permitted to inspect and copy, or is accurate and complete.

RIGHT TO AN ACCOUNTING OF DISCLOSURES other than those for the purpose of treatment, payment, healthcare operations, or certain other authorized disclosures. Submit a written request to Dr, Philip Robbins at this address. Your request must state a time period, which may be no longer than six years.

RIGHT TO REQUEST RESTRICTIONS OR LIMITATIONS to PHI we use or disclose for treatment, payment or health care operations. You may also request a limit on disclosure to someone involved in your care or the payment for your care, such as a family member or friend. We are not required to agree to your request for restrictions. In your request, you must tell us: (1) what information you want to limit; (2) whether you want to limit our use, disclosure or both; and (3) to whom you want the limits to apply, for example, disclosures to a spouse. You have the right to request we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at home, at work, or by mail or email. Where possible, we will accommodate all reasonable requests. Submit requests in writing to Dr. Philip Robbins at this address.

You have a right to be notified following a breach of unsecured PHI.
You have the right to a copy of this notice.

HOW TO FILE A COMPLAINT If you believe your privacy rights have been violated by SPA, you may file a complaint addressed to Dr. Philip Robbins at this address. Your complaint must be in writing. You may also file a complaint with the U.S. Department of Health and Human Services, with instructions available at hhs.gov/hipaa/filing-a-complaint. You will not be penalized or retaliated against for filing a complaint.

Salem Psychological Associates reserves the right to change the terms of this notice. If this should occur, you will receive a copy of the revised document in session, if you are still a client here. The revised notice will also be displayed in the waiting rooms.

Revised June 2018

SALEM PSYCHOLOGICAL ASSOCIATES, P.A.

87 Stiles Road, Suite 106, Salem, NH 03079

OUTPATIENT SERVICES AGREEMENT

-and-

PRIVACY, OUR LEGAL DUTIES, AND YOUR RIGHTS CONCERNING PROTECTED HEALTH INFORMATION

I have read the information in the Outpatient Services Agreement, including the notice of Privacy Practices, Our Legal Duties, And Your Rights Concerning Your Protected Health Information. I agree to abide by its terms during our professional relationship.

_____ *please initial* **I understand that missed appointments are not covered by insurance, and that I will be responsible for the entire session fee.**

_____ *please initial* **I understand that should my insurance company not cover my treatment, I will be responsible for full payment of the fee.**

_____ *please initial* **I understand there may a deductible amount applied by my insurance company to services at SPA, and I agree to pay deductible charges, should there be any. I acknowledge that, though my clinician may offer assistance, I am ultimately responsible for obtaining deductible information from my insurance company.**

_____ _____

Signature(s) **Date**

_____ _____

Witness **Date**

.....

PERMISSION TO TREAT A MINOR UNDER 18 YEARS OF AGE

I/we, _____,

parent(s)/legal guardian(s) of _____, give my/our permission for my/our son/daughter to receive counseling/ treatment from:

_____

_____

Signature(s)

_____ _____

Witness Date