

Shady Oak Counseling, LLC

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PLEASE READ CAREFULLY AND SIGN THE FOLLOWING

Psychotherapist-Patient Services Agreement

WELCOME TO MY PRACTICE

This document 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) used for the purpose of treatment, payment, and health care operations. 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 application to your personal health information in greater detail. **The law requires that I obtain your signature acknowledging that I have provided you with this information at the end of this session. Although these documents are long and sometimes complex, it is very important that you read them carefully before our next session. We can discuss any questions you have about the procedures at that time.** You may revoke this Agreement in writing at any time. You should be aware that this Agreement will be in effect for one year from the date of signing.

PSYCHOLOGICAL SERVICES

Psychotherapy is not easily described in general statements. It varies depending on the personalities of the psychologist and the patient, and the particular problems you are experiencing. There are many different methods I may use to deal with the problems that you hope to address. Psychotherapy is not like a medical doctor visit. Instead, it calls for a very active effort on your part. In order for the therapy to be most successful, you will have to work on things we talk about 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 like sadness, guilt, anger, frustration, loneliness, and helplessness. On the other hand, psychotherapy has also been shown to have many benefits. Therapy often leads to better relationships, solutions to specific problems, and significant reductions in feelings of distress. But there are no guarantees of what you will experience. Our first few sessions will involve an evaluation of your needs. By the end of the evaluation, I will be able to offer you some first impressions of what our work may include if you decide to continue with therapy. You should evaluate this information along with your own opinions of whether you feel comfortable working with me. Therapy involves a large commitment of time, money, and energy, so you should be very careful about the therapist you select. If you have questions about my methods, please bring them up to me whenever they arise. If your doubts persist, I will be happy to help you set up a meeting with another mental health professional for a second opinion.

PROFESSIONAL FEES

My fee for an initial intake evaluation session is \$200; an individual counseling or psychotherapy session is \$175. Sessions are normally 45-55 minutes in duration, unless prearranged for longer (or shorter) time increments. Other professional services I offer are charged at the \$175 per hour rate; and include report writing, telephone consultations lasting longer than 15 minutes, preparation of records or treatment summaries, participation in legal proceedings, etc. If you become involved in legal proceedings that require my participation, you will be expected to pay for all of my professional time, preparation, and transportation costs, even if I am called to testify by another party.

BILLING AND PAYMENTS

Cash payments and co-pays for psychotherapy sessions are due in full at the time of service unless agreements with insurance companies direct us otherwise. I accept cash, check, credit, debit, and HSA cards. **Please have payment ready at the start of each session.** This will allow us to use your session time more productively.

Payment schedules for other services will be agreed to when they are requested. There will be a charge of \$30 for checks returned for nonsufficient funds. If for some reason your account remains unpaid for more than 30 days and arrangements for payment have not been agreed upon, you will be charged a service fee of \$2.50 per month. I also reserve the option of using legal means to secure the payment if necessary.

CANCELLATION/MISSED APPOINTMENTS

Once an appointment is scheduled, you will be expected to pay a late cancellation/fail fee of \$75 unless you provide 24 hours advance notice of cancellation (unless we both agree that you were unable to attend due to circumstances beyond your control. The exception to this is EAP sessions.) **It is important to note that insurance companies do not provide reimbursement for cancelled or missed sessions.**

CONTACTING ME

The best way to reach me is by telephone. My office hours are Monday, Wednesday, and Thursday 9:30am-6:30pm and Fridays 9:30am-5pm. I do not typically answer the phone when I am with a client. When I am unavailable my telephone is answered by voicemail that I monitor frequently. I will make every effort to return your call within 24 hours, with the exception of weekends and holidays. If you are unable to reach me and feel that you can't wait for me to return your call, you may contact your family physician, the Crisis Connection (a 24-hr. free phone counseling service: 612.379.6363), or the nearest emergency room. If I will be unavailable for an extended time, I will provide you with the name of a colleague to contact, if necessary.

ELECTRONIC COMMUNICATION AND SOCIAL MEDIA

Please be informed communication by email, text message or other electronic methods of communication are not typically confidential. If you use these methods to communicate with me there is a reasonable chance that a third party may be able to intercept and eavesdrop on those messages. Such as, people in your home who can access your phone, computer or other devices that you use to read and write messages; your employer, if you use your work email to communicate with me; or third parties on the internet such as server administrators and others who monitor internet traffic. For this reason, I limit email and text messages to information related to the scheduling of meetings or other appointments only. By signing this agreement, you provide consent to me for this purpose. In regards to social media, it is my practice not to accept contact or "friend" requests from clients on social networking sites such as Facebook or LinkedIn. They can compromise privacy and also complicate our helping relationship. Please ask me if you have any questions or concerns regarding electronic communication or social media.

LICENSURE AND COMPETENCIES

I am licensed by the State of Minnesota and am competent to provide both short-term and long-term psychotherapy to adults. A copy of my licensure with the State of Minnesota is on display in my office.

LIMITS ON CONFIDENTIALITY

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:**

I may occasionally find it helpful to consult other health and mental health professionals about a case. During a consultation, I make every effort to avoid revealing the identity of my patient. The other professionals are also legally bound to keep the information confidential. If you don't object, I will not tell you about these consultations unless I feel that it is important in our work together. I will note all consultations in your Clinical Record (which is called "PHI" in my Notice of Psychologists Policies and Practices to Protect the Privacy of Your Health Information.) You should be aware that I employ administrative personnel. In most cases, I need to share protected information with these individuals for administrative purposes, such as data processing, billing and marketing. All personnel have been given training about protecting your privacy and have agreed not to release any information outside of the practice without permission.

I also have contracts with Paragon Billing, Inc. and legal services when needed. As required by HIPAA, I have formal business associate contracts with these businesses, in which they promise to maintain the confidentiality of personal data except as specifically allowed in the contract or otherwise required by law.

These are some situations where I am permitted or required to disclose information without either your consent or Authorization:

In the case that I or my Clinical Records are subpoenaed or ordered by a court of law. In many cases, if you are involved in a court proceeding and a request is made for information concerning the professional services I provided to you, such information is protected by the psychologist-patient privilege law. I cannot provide any information without your (or your legal representative's) 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.

If a government agency, pursuant to their lawful authority, is requesting the information for health oversight activities, I may be required to provide it for them.

If a patient files a complaint or lawsuit against me, I may disclose relevant information regarding that patient in order to defend myself.

If a patient files a worker's compensation claim, I must, upon appropriate request, disclose information related to the claim to appropriate individuals, which may include the patient's employer, the insurer or the Department of Labor and Industry.

There are some situations in which I am legally obligated to take actions necessary to protect others from harm. These actions may involve revealing information about a patient.

If I know or have reason to believe a child is being neglected or physically or sexually abused or has been neglected or physically or sexually abused within the preceding three years, the law requires that I file a report immediately with the appropriate government agency, usually the local welfare agency. Once such a report is filed, I may be required to provide additional information.

If I have reason to believe that a vulnerable adult is being or has been maltreated or if I have knowledge that a vulnerable adult has sustained a physical injury which is not reasonably explained, the law requires that I file a report immediately with the appropriate government agency, usually an agency designated by the county. Once such a report is filed, I may be required to provide additional information.

If I believe that you present a serious and specific threat of physical harm to yourself or another, I may be required to disclose information necessary to take protective actions. These actions may include notifying a potential victim, contacting your family or others who can help provide protection, contacting the police, or seeking your hospitalization.

While this written summary of exceptions to confidentiality should prove helpful in informing you about potential problems, it is important that we discuss any questions or concerns that you may have now or in the future. The laws governing confidentiality can be quite complex, and I am not an attorney. In situations where specific advice is required, formal legal advice may be needed.

PROFESSIONAL RECORDS

The laws and standards of my profession require that I keep Protected Health Information about you in your Clinical Record. These Clinical Records are the property of this private practice. Except in unusual circumstances that involve danger to yourself and / or 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 certain situations, I may charge a minimum fee of \$25 for copying and time involved. If I refuse your request for access to your records, you have a right of 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 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 will be happy to discuss these rights with you.

ISSUES AND COMPLAINTS

You may register a complaint about me or my services to my licensing board. Before doing so, I encourage you to bring to me directly any concerns you may have about me or our work together. Following is the address and

phone number of my licensing board: **Minnesota Board of Psychology, 2829 University Ave SE, #320, Minneapolis, MN 55414, phone number (612)617-2230.**

COLLECTIONS

I reserve the option of using legal means to secure payment for services remaining unpaid after 30 days. 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, address, phone number, the nature of services provided, and the amount due. If such legal action is necessary, its costs will be included in the claim.

INSURANCE REIMBURSEMENT

If you have a health insurance policy, it will usually provide some coverage for mental health treatment. I will fill out forms and provide you with whatever assistance I can in helping you receive the benefits to which you are entitled; however, you (not your insurance company) are responsible for the full payment of my fees at the time of service (unless agreements with insurance companies direct us otherwise). **It is very important that you find out exactly what mental health services your insurance policy covers. You may do so by calling the phone number on the back of your health insurance card.**

Due to rising costs of health care, insurance benefits have increasingly become more complex. It is sometimes difficult to determine exactly how much mental health coverage is available. "Managed Health Care" plans such as HMOs and PPOs often require authorization before they provide reimbursement for mental health services. You should also be aware that your contract with your health insurance company requires that I provide it with 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 only the minimum information about you that is necessary for the purpose requested. This information will become part of the insurance company files and will probably be stored in a computer. Though all insurance companies claim to keep such information confidential, I have no control over what they do with it once it is in their hands. **By signing this Agreement, you agree that I can provide requested information to your insurance carrier.** It is important to remember that you always have the right to pay for services yourself to avoid the problems described above.

YOUR SIGNATURE BELOW INDICATES THAT YOU HAVE READ THIS AGREEMENT AND AGREE TO ITS TERMS. YOUR SIGNATURE ALSO SERVES AS AN ACKNOWLEDGEMENT THAT YOU HAVE RECEIVED THE HIPAA NOTICE FORM DESCRIBED ABOVE.

(Your name printed)

(Signature) (Date)

(Suzanne May, MA, LP) (Date)