



Outpatient Services Contract

Welcome to our practice. This document contains important information about our professional services and business policies. When you sign this document, it will represent an agreement between yourself and Hope Springs Behavioral Consultants. If you have questions about our procedures, we should discuss them whenever they arise.

PSYCHOLOGICAL ASSESSMENT / EVALUATION

Psychological assessment may help you to better understand you or your child and the problems that at home, work, relationships and/or school. This information helps plan effective treatment. The testing process varies from person to person, based on her/his needs. Some commonly tested areas include learning, memory, attention, concentration, language skills, problem solving skills, academic skills, motor skills, emotional functioning, personality functioning, and adaptive functioning. Testing will be completed by your psychologist or by our psychological assistant who has received supervision and training in the tests they will be administering. Testing sessions are scheduled on a unit basis. Testing appointments vary in length and typically are scheduled in increments of 1-2 hours at a time. However, on occasion up to four hours of testing can be scheduled. Breaks, rest periods, or multiple appointments will be offered.

Psychological assessment involves several steps:

1. Initial interview with the patient and/or parents to gather all the needed information and to plan testing.
2. Testing. You will be asked to complete paperwork.
3. Scoring and interpretation of tests.
4. Preparation of a written evaluation report.
5. Feedback phase in which assessment findings are reviewed with the patient and/or parents. For children, the feedback session is most commonly conducted with parents and child on different dates so that parents can speak candidly regarding the test findings and plan for care. However, if your child requests to be present with parents for this session, we would be willing to discuss this option with your family.

Most people enjoy their testing experience. However, some people occasionally report frustration, confusion, anger, or embarrassment. If these reactions occur, every effort will be made to make you as comfortable as possible. Charges are billed on an hourly basis and may take place on dates that you or your child are not present in the office. These charges reflect reviewing your old records, interviewing school staff or other important persons, completing the test battery, scoring test data, interpreting test data, and preparing a written report.

PSYCHOLOGICAL THERAPY SERVICES

Therapy is a partnership between you and your psychologist to find new ways of handling problems of daily living. There are many different methods we may use to deal with the problems that you hope to address. Psychotherapy is not like a typical medical doctor visit. Instead, it calls for a very active effort on your part. For the therapy to be most successful, you will likely have to work on things we talk about both during our sessions and at home. If you are bringing your child for treatment, the parent's role in therapy is essential. Your role in your child's therapy will vary, depending upon the issues presented, your family's dynamics, and the phase of therapy. You and your psychologist may share information, engage in mutual problem-solving, discuss your child's diagnosis, discuss behavior management strategies, and/or discuss parenting strategies. Or, your work may be more therapeutic in nature: you may be engaged as a "therapist" for your child, be involved in joint or family sessions with your child or be encouraged to become involved in individual or couples therapy paralleling the work being done with your child. You will be involved in developing goals for your child.

Psychotherapy can have benefits and risks. Since therapy often involves addressing difficulties in life, you may experience uncomfortable feelings like sadness, frustration, and worry. However, therapy has also been shown to have benefits for people who go through it. Therapy often leads to better relationships, solutions to specific problems, and significant reductions in feelings of distress. There are no guarantees of what you will experience. However, we will work with you as best we can to provide a positive therapy experience. If you decide to pursue psychotherapy, we will usually schedule a series of 53-minute unit sessions, usually on a weekly or bi-weekly basis. Some sessions may be longer or more frequent. It will be important for you to come on time, so you

receive the benefit of a full-length session. If you are late for your appointment, your session will still be completed at the time it was originally scheduled to end.

MISSED APPOINTMENTS

Once an appointment is scheduled, you can cancel for any reason. However, you will be expected to attend unless you provide **24 hours' notice of cancellation** (unless we both agree that you were unable to attend due to circumstances beyond your control). If you fail to attend a scheduled session or cancel a session with less than 24 hours' notice, you will receive a **charge up to the full cost of the session**. Please discuss these rates with the front desk or your provider. If this is a continuing pattern (two or more occurrences), your care may be discontinued in this clinic. Please note that some sessions (such as testing appointments and feedbacks) are typically scheduled for more than one hour (unit). If you fail to attend or cancel with less than 24 hours; notice, these appointments are charged based on the number of hours (units) scheduled.

Important note: If you are more than 15 minutes late without notifying our practice, your appointment will be considered cancelled and you will be charged a late cancellation fee of up to the full cost of the session.

It is important for you to understand that our schedules are often quite full. Thus, you may not always be able to reschedule easily for the same week in which you cancelled or missed an appointment. You may not always be able to secure times for your child for after school appointments. However, we will do the best that we can to work with you on any scheduling concerns that you may have.

PROFESSIONAL FEES

Our professional fees vary per the service provided. You can request a list of these charges. In addition to weekly appointments, we may charge for other professional services you may need (e.g., telephone conversations, attendance at meetings with other professionals you have authorized). Any legal proceedings with your child/family will need to be discussed prior to our participation, and a separate legal service fee contract will need to be discussed and signed.

CREDIT CARD & DRIVER'S LICENSE

We require a valid credit card to be kept on file to cover unpaid charges on your account. Federal laws on identity theft require that we keep a copy of your driver's license on file.

INSURANCE, BILLING, AND PAYMENTS

You should be aware that insurance companies require your psychologist to provide them with a clinical diagnosis. Sometimes psychologists must provide additional clinical information such as treatment plans or summaries, or copies of the entire record (in rare cases). 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, we have no control over what they do with it once it is in their hands. In some cases, they may share the information with a national medical information databank. We will provide you with a copy of any report we submit, if you request it. It is important to remember that you always have the right to pay for our services out-of-pocket to avoid the problems described above. Please read our FINANCIAL AGREEMENT carefully and discuss any concerns you may have prior to signing.

PHONE CALLS

Phone calls with your provider are billed to your insurance, but they are rarely covered by current health plans. Expect to pay out-of-pocket for any phone calls. We do not offer phone therapy between sessions. It is important that your therapeutic work is done in your therapy sessions. If you feel you need to attend sessions more often, please alert us and we will discuss this option. Because we see many patients, we are often not immediately available by telephone. We will make every effort to return your call during the same week you make it, except for holidays or vacations. If you are difficult to reach, please inform us of times when you will be available. If you are unable to reach us and feel that you can't wait for us to return your call, contact your family physician or the nearest emergency room. If you are a parent, and have questions about your child or teen, it will be important for you to ask these questions during session. We are unable to communicate between sessions by phone or e-mail with parents.

PROFESSIONAL RECORDS

The laws and standards of our profession require that we keep treatment records. Legally, you are entitled to receive a copy of your records, or we can prepare a summary for you instead. Recent legal developments indicate that parents do not always have full access to their child's mental health and substance abuse treatment records. To protect your child's need for privacy, it is our policy to not provide parents copies of their child's treatment records. We will provide you only with a copy of an intake assessment report, psychological evaluation, and/or general information about your child's work in therapy, unless we feel there is a risk that your child will seriously harm himself/herself, engage in high risk activities, or harm someone else. Before giving parents information, we will discuss the matter with the child, if possible, and do our best to handle any objections s/he may have with what we are prepared to discuss.

Normally, our patients are allowed access to their Protected Health Information (PHI), and/or a copy of it, whenever they request it, but there are several instances access may be denied. By law, access to your PHI may be denied for any of the following indicated reasons. You may have access to any information that is not covered by any of the reasons below.

The following reasons are not subject to review:

- The information exists only in private notes written by your therapist.
- The information has been compiled in reasonable expectation of legal proceedings, or for use therein.
- The information was obtained from another party to whom I promised confidentiality. Allowing access would reveal that person's identity, which would be an ethical breach.
- The requested information is not in my possession.
- Because you are an inmate in a correctional institution, giving you access to this information could conceivably jeopardize the safety, health, security, rehabilitation, or custody of yourself or other inmates.
- You are an inmate of a correctional institution; therefore, access to this information might jeopardize the safety of an officer, staff member, or other person at this institution, or a person responsible for transporting you.

The following reasons are subject to review by a licensed health care provider, other than myself, if you request a review of my decision.

- I believe that granting access to this information may possibly endanger the life or physical safety of you or another person.
- The information refers to another person (other than a health care provider) and it is possible that granting access to the information may cause significant harm to that person.
- You are the patient's personal representative and I believe that to grant you access would in all likelihood result in significant harm to that patient or some other individual.

COURT TESTIMONY

Unless pre-arranged with us prior to initiating services, we will not provide therapy notes, test data, or testimony to the court as a part of litigation. If we are required to provide test data, testimony, or records to the court (under court order), we reserve the right to terminate services. If you are currently involved in a court proceeding and a request is made for information concerning the professional services provided in our clinic, such information is protected by the psychologist-patient privilege law. We cannot provide any information without your 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 us to disclose information. It is our strong preference to not be involved in court proceeding, even with your permission.

Please be advised that our services for court proceedings are not covered by insurance, and that our rates for legal proceedings are higher than those for clinical services. In some proceedings involving child custody, a judge may order our testimony if s/he determines that the issues demand it. As your child's psychologist, it is our ethical duty to provide your child the best care possible. If we are asked to provide records or testimony about treatment to the court, this can contribute to a "dual-role" relationship between your psychologist and your child. A dual-role relationship means that your psychologist is providing services for conflicting roles (i.e., parent's witness and child's therapist), and can be potentially damaging to your child and her/his present or future therapy experiences due to possible violations of therapeutic trust. In addition, we have an ethical responsibility to only release records and/or test data to persons who are qualified and trained to interpret the information. Most court personnel have not received sufficient mental health training to meet these criteria and providing records and/or test data can be damaging for patients. Finally, legislation and ethical standards mandate that the psychologist protect privacy of mental health records. Because the psychologist cannot control the number of people that have access to the mental health records in the court setting, concerns for the patient's privacy may exist.

CONFIDENTIALITY

In general, the privacy of all communications between a patient and a psychologist is protected by law, and we can only release information about our work to others with your written permission. Typically, we will ask you to sign a release to share information with your physician for care coordination. Your psychologist may occasionally find it helpful to consult other health and mental health professionals about a case. During a consultation, we make every effort to avoid revealing the identity of our patient. The other professionals are also legally bound to keep the information confidential. If you don't object, your psychologist will not tell you about these consultations unless she feels that it is important to your work together. She will note all consultations in your Clinical Record (which is called "PHI" for "protected health information" in our Notice of Psychologist's Policies and Practices to Protect the Privacy of Your Health Information). All staff members have been given training about protecting your privacy and have agreed not to release any information outside of the practice without the permission of a professional staff member.

If a patient threatens to harm herself/himself, your psychologist may be obligated to seek hospitalization for her/him or to contact family members or others who can help provide protection. If a government agency is requesting the information for health oversight activities, we may be required to provide it for them. If a patient files a complaint or lawsuit against our office, we may disclose relevant information regarding that patient to defend our practice. If a patient files a worker's compensation claim, we must, upon appropriate request, provide any information concerning the employee's physical or mental condition relative to the claim.

There are some situations in which we are legally obligated to act, which we believe are necessary to attempt to protect others from harm and we may have to reveal some information about a patient's treatment. These situations are unusual in our practice.

If we have reasonable cause to believe that a child has been abused or suspect that a dependent adult has been abused, the law requires that we file a report with the appropriate government agency, usually the Department of Human Services. Once such a report is filed, we may be required to provide additional information.

If a patient communicates an imminent threat of serious physical harm to an identifiable victim, we may be required to disclose information to take protective actions. These actions may include notifying the potential victim, contacting the police, or seeking hospitalization for the patient. If such a situation arises, we will make every effort to fully discuss it with you before taking any action and we will limit our disclosure to what is necessary. 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 we are not attorneys. In situations where specific advice is required, formal legal advice may be needed. If you are the parent of a patient (minor), often other family members are involved with your child's daily life. These may include step-parents, partners, or grandparents. When other adults will be bringing your child for treatment or are involved in supporting treatment, parents will be asked to sign a release of information giving the psychologist permission to talk with those individuals about your child.

GROUND FOR TERMINATION

Services are provided at our discretion. We reserve the right to terminate therapy services if either parent behaves inappropriately toward us or our staff, if we are court-ordered to testify (thus causing a dual-role relationship with your child), if there is consistent failure to attend scheduled appointments, if there is failure to complete payment for services, or if either parent does not consent for services.

WEATHER POLICY

You are not responsible for a late fee or no-show charge if our office is closed or if you are unable to attend your session due to inclement weather. If we close our office, we will make every effort to contact you, so please make sure that we have up to date phone numbers for you.

E-MAIL CONTACT

At times, we will use e-mail to communicate with you regarding appointment information, session information, or answer your questions. With your written consent, we may also use e-mail to correspond with your physician. You have the right to decline this option at any time. We will use reasonable means to protect the security and confidentiality of any information sent and received by e-mail. Patients should understand that there are known and unknown risks that may affect the privacy of personal health care information when using e-mail to communicate. Those risks include, but are not limited, to:

- E-mail may be forwarded, printed, and stored in numerous paper and electronic forms and be received by many intended and unintended recipients without a patient's knowledge or agreement.
- E-mail may be sent to the wrong address by any sender or receiver.
- E-mail may be easier to forge than handwritten or signed papers.
- Copies of e-mail may exist even after the sender or the receiver has deleted his or her copy.
- E-mail service providers have a right to archive and inspect e-mails.
- E-mail may be intercepted, altered, or used without detection or authorization.
- E-mail may spread computer viruses.
- E-mail delivery is not guaranteed.

You should not use e-mail for medical emergencies or to send time-sensitive information. You should understand and agree that it is your responsibility to follow up with us if you have not received a response to an e-mail within a reasonable time-frame.

SECOND OPINION

If you are requesting a second opinion of a previous evaluation, we want you to receive the most accurate assessment and care. Thus, your child will be required to repeat similar measures of assessment.

INFORMATION FOR SEPARATED, DIVORCED, OR NEVER MARRIED PARENTS

Entering a helping relationship for your child is a big step for your child and your family. We want to make this process as easy as possible, regardless of your family circumstances. From our experience, there are often special issues that arise when parents do not reside together. We hope this information will clarify our policies and procedures.

CONSENT FOR TREATMENT

Parents with joint legal custody have equal rights in consenting to medical treatment, unless otherwise noted in a custody or divorce decree. For many reasons, it is critical that both parents agree that treatment is appropriate and that both parents agree on a mental health provider. If consent is not received from both parents, it is likely that the psychologist will not move forward with treating your child. If this situation arises, the psychologist will work with both parents to recommend a different mental health provider.

CUSTODY AND VISITATION ISSUES

The psychologist, as your child's therapist, cannot make any recommendations about custody or visitation issues. If custody and visitation issues are a concern, the psychologist may speak with you about a referral to another psychologist for a formal custody evaluation, a mediator, or guardian ad litem. It is assumed that both parents want to work toward the best interest of their child, which includes maintaining a safe, therapeutic environment with the psychologist. The psychologist will not provide records to attorneys or testify in court in a custody or visitation dispute.

COURT MANDATED THERAPY

Mandated therapy participation or therapy recommendations should not be included in the divorce decree without our previous consent.

BEHAVIOR / CONDUCT

Children under the age of 13 cannot be left alone in the waiting room. A parent or therapist must be with them always. Poor waiting room behavior can result in termination of care from our office.

At times, parents who are involved in divorce or custody disputes have difficulty maintaining an appropriate decorum in the waiting room, clinic office, or therapist office. Out of concern for your child, other patients in our clinic, and clinic staff, parents are asked to behave respectfully to one another in our office and in this clinic. If they do not behave in a civil manner, they may be required to attend sessions separately or we may terminate services with their child.

HIPAA PRIVACY INFORMATION

The Hope Springs Behavioral HIPAA privacy information form is located on our website, and a hard copy is on display on the bulletin board in our office. You also can request to have a printed copy at any time.

Financial Agreement / Authorizations

Thank you for choosing our office as your mental health care provider. We are committed to serving you with skill and high-quality care. The services provided by our office are services you have elected to receive which may imply a financial responsibility on your part.

AUTHORIZATION FOR INSURANCE

If you want insurance to cover your care, you will need to authorize Hope Springs Behavioral Consultants, PLC to release mental health information, to the full extent specified under Iowa Code Chapter 228, or as subsequently amended, to your insurance company and to any organization contracting with this insurance company to 1) Administer claims submitted or to be submitted for payment, 2) Conduct a utilization and quality control review of mental health care services provided or proposed to be provided, or 3) Conduct an audit of claims paid.

You may inspect the information disclosed at any time, and may revoke this authorization at any time if you furnish written revocation to Hope Springs Behavioral Consultants, PLC. In the event you revoke authorization, you will need to accept financial liability for mental health care services provided if your insurance company or its affiliates or subsidiaries deny claims for benefits because of the inability to examine our mental health records.

INSURANCE

Patients must present their insurance card. **Copayments are due on the day of service.** Your insurance policy is a contract between you and your insurance company. Please be aware that all charges are your responsibility whether or not your insurance company pays your claims.

By signing this policy, you agree to permit us to electronically submit insurance claims and accept payment directly for services rendered to you. We will keep track of necessary documentation, referrals, and pre-certifications you will need to be treated in this office. However, as our patient, you are ultimately responsible for all authorizations/referrals needed to seek treatment in this office. You must inform the office of all insurance changes and authorization requirements, referrals, and pre-certifications.

If the insurance company does not pay within 60 days from the date of service, the patient or guardian seeking care for a minor will be responsible for payment of services. The patient or guardian seeking care for a minor must verify our doctors are "in-network" or will be subject to out-of-network rates. Not all services are a "covered" benefit in all insurance policies. In the event your health plan determines a service to be "not covered", or you do not have an authorization, you will be responsible for all charges. We will attempt to verify benefits for some services; however, you remain responsible for charges for services rendered. Patients are encouraged to contact their plans for clarification of benefits prior to services being rendered.

PAYMENT FOR SERVICES

We accept cash, checks, and all major credit cards. We will send you a billing statement for co-insurance, deductible, and non-covered amounts after insurance has processed your claims. We expect payment in full within 30 days of your statement. There is a \$70.00 fee for all chargebacks. Chargebacks on a credit card will result in an automatic discharge from care.

Where minors are concerned, the parent or guardian that signs this policy is the only party that will be held financially responsible. If the patient is not a minor, then the patient is the only person held financially responsible.

We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, we encourage you to contact us promptly for assistance in managing your account. Any payment exceptions will be agreed upon in writing.

DELINQUENT ACCOUNTS

If your account balance has not been paid for more than 90 days and arrangements for payment have not been agreed upon, our office has the right to use legal means to secure the payment. This may involve hiring a collection agency or going through small claims court. If such action is necessary, the court costs and collection costs will be included in the claim. This will involve at least a 40% increase in the amount that was originally billed. Returned checks will incur an additional \$35 fee. Accounts no longer maintaining a financial "good faith" status will result in you and your immediate family members being discharged from this office. If this occurs, you will receive a letter and will need to find alternate mental health care.

AUTHORIZATIONS AND ASSIGNMENT

I hereby assign all insurance benefits directly to Hope Springs Behavioral Consultants for payment of any services rendered. I agree to pay the amount charged by Hope Springs Behavioral Consultants. I have read and understand this Financial Agreement. I authorize the use of this signature for all insurance submissions. I authorize release of medical records necessary to process my health insurance claims. I understand that in the event my insurance company does not pay for services I received, I will be

financially responsible for payment. I acknowledge that I was provided a copy of the Hope Springs Behavioral Consultants Notice of Privacy Practices. I permit a copy of this authorization to be used in place of the original. I hereby give authorization for treatment.

YOUR SIGNATURE BELOW INDICATES

- You have read the information in this document and agree to abide by its terms during our professional relationship.
- You have reviewed been offered a copy of the Hope Springs Behavioral Consultants HIPAA privacy information form.
- You authorize Hope Springs to bill your insurance for your services.

Patient's Name, if minor: _____

Signed: _____ Date: _____

(Patient signature or Financially responsible party/parent/guardian, if minor)

Printed Name: _____ Relationship to Patient: _____