Atlanta Insomnia & Behavioral Health Services, P.C.

Psychological Services Agreement

Welcome to our practice. This document contains important information about our professional services and business policies. Please read it carefully and be sure to let us know if you have any questions **at the first session**.

PSYCHOLOGICAL SERVICES:

During our first few sessions, we will discuss what brought you to therapy. These sessions will typically include informal (unstructured) assessment. By the end of the evaluation, we will be able to offer you some first impressions of what our work will include and a treatment plan to follow, if you decide to continue with therapy. You should evaluate this information along with your own opinions of whether you feel comfortable working with your doctor. If you have questions about our procedures, we should discuss them whenever they arise.

A few things to remember:

· Psychotherapy is not like a medical doctor visit. It calls for a very active effort on your part. You will likely have "homework" to complete between sessions.

· Sometimes undesirable behaviors increase in intensity before they lessen when you start addressing them. This is normal and usually temporary.

· Psychotherapy can have benefits and risks. These may vary depending on your reason for coming to therapy. While there are no guarantees of what you will experience, most people benefit from therapy. Benefits may include improved sleep, better relationships, solutions to specific problems, and significant reductions in feelings of distress. However, because therapy may involve discussing challenging aspects of your life, you could at times experience difficult emotions or discomfort.

LIMITS ON CONFIDENTIALITY

The law protects the privacy of all communications between a patient and a psychologist. In most situations, we 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:

- You should be aware that the office includes other mental health professionals and administrative staff. In most cases, we need to share protected information with these individuals for both clinical and administrative purposes, such as scheduling, billing and quality assurance. All of the mental health professionals are bound by the same rules of confidentiality.
- We have a contract with Azalea Health, which administers our electronic health records, and Gateway EDI, our insurance filing service. As required by HIPAA, we have a formal business associate contract with this business, in which they promise to maintain the confidentiality of this data except as specifically allowed in the contract or otherwise required by law. If you wish, we can provide you with a blank copy of this contract.
- Disclosures required by health insurers or to collect overdue fees are discussed elsewhere in this Agreement.
- If a patient threatens to harm himself/herself, the doctor may be obligated to seek hospitalization for him/her or to contact family members or others who can help provide protection.

There are some situations where your doctor is permitted or required to disclose information without either your consent or Authorization:

- If you are involved in a court proceeding and a request is made for information concerning our professional services, 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. *If you do request your information to be shared in a legal matter (e.g., Social Security Case, Workman's Comp Case prior to the claim decision, divorce or other proceedings), a charge of $185.00/hour will be applied for preparation of a clinical summary, as it is our policy not to share clinical notes with anyone besides other healthcare professionals. This is for your protection, as they are written in clinical, not legal language, and the information contained in them could be misinterpreted.*
- 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 either doctor or the practice, we may disclose relevant information regarding that patient in order to defend ourselves.
- If a patient files a worker's compensation claim, and we are providing treatment related to the claim, we must, upon appropriate request, furnish copies of all medical reports and bills.
- If a patient leaves one of the doctors or the practice a negative review online, we reserve the right to respond at that site. We will make every effort to not disclose protected health information other than what we did to address the problem that prompted the review.

There are some situations in which we are legally obligated to take actions, 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. <u>These situations are unusual in this practice</u>.

- If your doctor has reason to believe that a child has been abused, the law requires that she file a report with the appropriate governmental agency, usually the Department of Human Resources. Once such a report is filed, we may be required to provide additional information.
- If your doctor has reasonable cause to believe that a disabled adult or elder person has had a physical injury or injuries inflicted upon such disabled adult or elder person, other than by accidental means, or has been neglected or exploited, she must report to an agency designated by the Department of Human Resources. Once such a report is filed, she may be required to provide additional information.
- If your doctor determines that a patient presents a serious danger of violence to another, she may be required to take protective actions. These actions may include notifying the potential victim, and/or contacting the police, and/or seeking hospitalization for the patient.

If such a situation arises, your doctor will make every effort to fully discuss it with you before taking any action and she will limit her disclosure to what is necessary.

<u>PATIENT RIGHTS</u>

HIPAA provides you with several new or expanded rights with regard to your Clinical Record and disclosures of protected health information. These rights include requesting that your doctor 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 policies and procedures recorded in your records; and the right to a paper copy of this Agreement, the attached Notice form, and our privacy policies and procedures. We are happy to discuss any of these rights with you.

BILLING AND PAYMENTS

You will be expected to pay for each session at the time it is held, unless we agree otherwise or unless you have insurance coverage that requires another arrangement. Payment schedules for other professional services will be agreed to when they are requested.

If your account has not been paid for more than 60 days and arrangements for payment have not been agreed upon, we have the option of using legal means to secure the payment. This may involve hiring a collection agency or going through small claims court which will require us to disclose otherwise confidential information. In most collection situations, the only information we release regarding a patient's treatment is his/her name, the nature of services provided, and the amount due.

INTERNET CONTACT

Social Media: We do not accept friend or contact requests from current or former clients on any social networking site (Facebook, LinkedIn, etc). Adding clients as friends or contacts on these sites can compromise your confidentiality and our respective privacy. It may also blur the boundaries of our therapeutic relationship.

Email: We may occasionally email sound files for at-home practice and will always ask your consent before doing so. As email is not completely secure or confidential, we ask that you limit email contact and call the office for appointment changes or clinical questions. Please do not email content related to your therapy sessions. Any emails we receive from you and any responses that we send to you become a part of your legal record.

ACKNOWLEDGMENTS:

Please discuss any questions or concerns with your therapist. Your signature below indicates that you consent for us to treat you, that you understand and agree with the terms of the Psychological Services Agreement, and that you acknowledge receipt of the HIPAA Notice:

_____ _____ _____

Client Name (please print) *Client Signature* *Date*

If Applicable:

_____

Parent/Legal Guardian Name (please print)

_____ _____

Parent/Legal Guardian Signature *Date*

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Financial Policy

The following information pertains to the practice's financial policy. We hope this will answer any questions you may have, but if you have any questions or special concerns please do not hesitate to discuss them with us **at the first session.** Please acknowledge your understanding of this policy by signing at the end of this form. If you would like a copy of this form for your records, we will be happy to provide one for you.

1. Our fee is $150.00 per therapy hour for individual sessions, $165.00 per therapy hour for group or family sessions, **payable at the end of each session**. The usual therapy hour consists of 45-50 minutes. Group therapy hours may last as long as 60-75 minutes. The fee for the initial diagnostic session is $185.00. Additional fees may be incurred for psychological testing, but we will discuss these ahead of time with you. Charges for consultations outside the usual therapy hour (i.e., hospital visits, depositions, etc.) will be determined on an individual basis.

2. Payment is expected at each session. **Please discuss exceptional circumstances with your doctor at the first session**. Credit, debit, and flexible spending account cards are accepted for your convenience. Please note that Dr. Bartolucci is in-network for the following managed care plans: Aetna, Blue Cross/Blue Shield PPO, Medicare (until 12/31/2016), and some United Healthcare plans. *Please note that sometimes insurance companies contract out their mental health benefits to other carriers, and we may not be in network for some private Medicare plans.* If your insurance company is not listed, feel free to explore out of network benefits for your insurance company. If payment in full for our services is a hardship for you, we can discuss a payment plan. Please note, the practice will make ***two attempts*** to collect payment from your insurance company. If we are unable to do so, you will be responsible for the session fee.

3. Since your appointment time is reserved for you, please notify the practice by telephone as soon as possible if you find that you must cancel an appointment. **Appointments not canceled with at least 24 hours notice will be billed according to the fee schedule on the attached credit card policy. Monday appointments must be canceled by 1:00 p.m. the Friday before to avoid charges.** It is important to note that insurance companies do not reimburse for missed or late canceled sessions, so the late cancellation fee will be your responsibility.

I acknowledge responsibility for all fees incurred, and if it is necessary, I consent to have my account collected through an attorney or collection agency. I also agree that I will be responsible for all costs of litigation including attorney's fees. I have read and understand the above policies.

_____ _____

Patient's Signature Date

_____

Parent or Guardian's Signature of minor

Credit Card Policy

We ask that patients give us a credit card number to be kept securely on file in our office. This card will be charged for co-payments, missed appointment fees, and all fees not paid by your insurance company. Billing will occur as follows:

Copays/Self-Pay: Co-payments and self-pay patient fees are due at the time of service and can be charged to your card on file or another card you specify when you arrive for your appointment.

Missed Appointment Fees: A missed appointment fee will be charged to your card on file at the end of the business day when your missed appointment occurred. Appointments are considered missed if you do not show up for your appointment or reschedule less than 24 hours prior to your appointment according to the following schedule:

First Missed Appointment: $50.00
Second Missed Appointment: Your contracted insurance rate or $100.00 for self-pay clients
Third Missed Appointment: $150.00

Your time is valuable to us, so we strive to run on time and will never double-book your appointment. Therefore, arriving more than 15 minutes late for your appointment will result in an abbreviated visit or the need to reschedule so that we can stay on time for patients with appointments after yours. The missed appointment fee will be charged if we need to reschedule your appointment due to your late arrival.

Deductibles/Co-Insurance/Non-Covered Charges: After your insurance company processes our claim they will send you and us an Explanation of Benefits (EOB). This EOB will indicate any fees for which you are responsible (i.e. deductibles and co-insurance). We will automatically charge your card for these fees.

If you have questions we are happy to discuss them with you.

I have read and agree to the above terms.

Patient Name: _____

Signature: _____ Date: _____

NOTE: Once entered into our triple-encrypted, password-protected accounting system, this portion of the form is shred for security purposes.

Name on card: _____ Card Number: _____

Expiration Date: _____ CVV: _____ Zip Code: _____

Patient Information:

NAME: _____
First Middle Last

ADDRESS: _____
Street City State Zip

PHONE: _____ _____ _____
Home Work Cell

Can a message be left at Home? ____Yes ____No Work? ____Yes ___No Cell? ____ Yes ____ No

SEX/IDENTIFIED GENDER: _____ Male _____ Female MARITAL STATUS: S M D W

DATE OF BIRTH: _____ AGE:_____

EMPLOYER: _____ POSITION:_____

REFERRED BY: _____ May I contact this person? ____Yes ____No

May I send reports and/or office notes to your referring physician? ____Yes ____No

Have you been in therapy before? ___Yes ___No For your current problem? ____Yes ____No

If so, Where? _____When? _____

Emergency Contact:

Name: _____Relationship: _____

Phone: _____ _____ _____
Work Home Cell

Responsible Party/Spouse/Parent Information:

Name: _____ Date of Birth: _____ Phone:_____

Primary Insurance (if applicable):

Name of carrier: _____ Name of insured: _____

ID #: _____ Group #: _____ Phone #:_____

Appointment Reminders:

As a courtesy to our patients, we attempt to contact you two days before your scheduled appointment to remind you of the appointment date and time. **However, it is your responsibility to keep up with your scheduled appointments**. If, due to technical difficulties or unforeseen circumstances, we are unable to give you a reminder, you are still responsible for keeping your appointment and will be charged for a late cancellation or no-show according to the schedule listed on the Credit Card Agreement.

Please let us know how you would like to receive your appointment reminders (choose one):

__ By telephone. Please give us the best number to contact you. By giving us this number, you also give us consent to leave a voicemail or message if you do not answer.

Best telephone number: ( ) _____

__ By email. Please give us the best email to contact you. By giving us this email, you acknowledge that email is not a secure form of communication and absolve us from any liability should it be intercepted, hacked, or otherwise compromised and your confidentiality broken.

Best email: _____

__ I do not wish to receive appointment reminders.

Primary Care Physician Information:

Name _____

Address _____

Phone _____

How long have you been a patient of this physician? _____

For purposes of continuity of care, may we contact your physician to let him/her know of your visit?
Yes ___No___

If yes, I _____ give permission to _____
to send a general statement notifying my primary care physician of my visit today. The information sent will be used for coordination of care, and will be limited to a brief description of the problem area and/or diagnosis, and a general outline of treatment.

_____ _____

Patient Signature Date

Important Information for Insurance Patients

Insurance Patients: Please read the following information and sign the Agreement at the bottom of this page if you would like us to file insurance for you.

Health Insurance Coverage
If you have a health insurance policy, it will usually, although not always, provide some coverage for mental health treatment. Our office will fill out forms and provide you with whatever assistance we can in helping you receive the benefits to which you are entitled; however, you (not your insurance company) are responsible for full payment of our fees. It is very important that you find out exactly what mental health services your insurance policy covers. You should carefully read the section in your insurance coverage booklet that describes mental health services. If you have questions about the coverage, call your plan administrator and inquire about mental health benefits. Of course, we will provide you with whatever information we can based on our experience and will be happy to help you in understanding the information you receive from your insurance company. If it is necessary to clear confusion, we will be willing to call the company on your behalf. The practice will make ***two attempts*** to collect payment from your insurance company. If we are unable to do so, you will be responsible for the session fee.

Despite our best efforts in determining your coverage, it is very common for insurance companies to pay differently than what they quoted you at the time of the first visit, deny coverage at a later date, or request a refund for funds previously dispersed. For that reason, you may receive a bill for services rendered if your insurance company does not reimburse as anticipated or requests a refund for previously paid services.

Authorization for Treatment
Many insurance plans require authorization before they provide reimbursement for mental health services. This authorization is typically required prior to or on the day of the first session. Our office will do everything we can to acquire authorization on the first day of treatment, but, ultimately, **it is the patient's responsibility to contact the insurance company for authorization.** If the correct information is not provided at the first appointment, then this will likely delay the authorization process. Insurance companies rarely back-date authorizations, so the initial appointment and subsequent appointments may not be covered until authorization is obtained. *If you have an appointment late in the day (e.g., 4:00 or 5:00), we may not be able to obtain authorization for that initial session if you wait until the appointment time for us to verify your benefits. You will then be responsible for the entire cost of that session.* Insurance carriers often limit the number of sessions authorized at a time. We are willing to complete any paperwork necessary to request authorization for more sessions, but *it is your responsibility to notify us of when your sessions are about to expire so we may request more without any gap in coverage. Failing to do so may result in your being billed for any sessions not covered.*

Insurance Reimbursement
You should also be aware that your contract with your health insurance company requires that we provide them with information relevant to the services we provide to you. **Your doctor is required to provide a clinical diagnosis for reimbursement.** Sometimes we are required to provide additional clinical information such as treatment plans or summaries, or copies of your entire Clinical Record. In such situations, we 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 end up in a database. We have no control over what they do with this information once it is in their hands. In some cases, they may share the information with a national medical information databank, which may affect your health insurance premiums, ability to acquire an individual insurance policy, or life insurance eligibility and premiums. We will provide you with a copy of any report we submit, if you request it. If

you have any questions about this information, please let your doctor know at the beginning of the first session. By signing this Agreement, you agree that we can provide requested information to your carrier.

Assignment of Benefits

I authorize Dr. Anne Bartolucci to release any medical, diagnostic, or other information necessary for the processing of insurance claims. I authorize payment of medical benefits to Atlanta Insomnia &Behavioral Health Services for services rendered. I accept personal responsibility for any balance remaining for services rendered including those that may be determined "not medically necessary" by my insurance carrier or denied coverage for any reason. I may receive a bill for services rendered if my insurance company does not reimburse as anticipated or requests a refund for previously paid services. I acknowledge responsibility for all fees incurred and accept responsibility for payment in full. If it is necessary, I consent to have my account collected through the credit card on file or an attorney or collection agency. I also agree that I will be responsible for all costs of litigation including court and legal fees.

_____ _____

Patient/Parent or Guardian Signature Date