a Sense of Place
Holistic Therapy & Counseling

## Psychotherapist-Patient Services Agreement

Welcome to my practice! This document (the Agreement) 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 federal law that provides privacy protections and 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 for use and disclosure of PHI for treatment, payment and health care operations. The Notice, which I 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. We can discuss any questions you have about the procedures at that time. When you sign the document, it will also represent an agreement between us. You may revoke this Agreement in writing at any time. That withdrawal will be binding on me unless:

1. I've already taken action upon it,
2. if there are obligations imposed on me by your health insurer in order to process or verify claims made under your policy, or
3. if you have not fulfilled any financial responsibilities you have incurred.

## Therapy Services

Therapy is not easily described in general statements. It varies depending on the personalities of the therapist and client, and the particular problems you are experiencing. There are many different methods I may use to deal with the problems that you present. Therapy is not like a medical doctor visit. Instead, it calls for a very active effort on your part. In order for it to be most successful, you will have to work on things we talk about both during our sessions and away from this office.

Therapy can have benefits and risks. Since it 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, it 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 will include and a treatment plan to follow if you decide to continue therapy. You should evaluate this information along with your own opinions of whether you feel willing to work 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 procedures, we should discuss them whenever they arise. If your doubts persist and we are unable to resolve the differences, I will be happy to help you set up a meeting with another mental health professional for a second opinion.

## Meetings

I normally conduct an evaluation that will last from 1-2 sessions. During this time, we both decide if I am the best person to provide the services you need in order to meet your treatment goals. If therapy has begun, I will usually schedule one 45-minute session per week at a time we agree on, although some sessions may be longer or more frequent. Once an appointment hour is scheduled, you will be expected to pay for it unless you provide 24-hours advanced notice of cancellation. It is important to note that insurance companies do not provide reimbursement for cancelled sessions.

## Professional Fees

My hourly fee varies depending on services and duration. In addition to weekly appointments, I charge this amount for other professional services you may need. However, I will break down the hourly cost if I work for periods of less than one hour. Note that these additional services are not covered by insurance. Other services include report writing, telephone conversations lasting longer than 10-minutes, Skype appointments or check-ins, consulting with other professionals with your permission, preparing of records or treatment summaries, and the time spent performing any other services you may request of me. If you become involved in legal proceedings that require my participation, you will be expected to pay for all of my professional time, including preparation and transportation costs, even if I am called to testify by another party. Because of the difficulty of legal involvement, I charge $500 per hour for preparation and attendance at any legal proceedings.

## Contacting Me

Due to my work schedule, I am often not immediately available by telephone. While I am usually in my office four days a week, I probably will not answer the phone when I am with a client. I will make every effort to return your call by the end of my business

day, with the exception of weekends and holidays. If you are difficult to reach, please inform me of some times when you will be available. If you are unable to reach me and you feel that you can't wait for me to return your call, contact your family physician, the nearest emergency room and ask for the psychologist or psychiatrist on call, or call 911. If I will be unavailable for an extended time, I will provide you with the name of a colleague contact, if necessary.

You may also utilize email at hmmj@asenseofplacechattanooga.com to communicate with me.

## Limits of Confidentiality

The law protects the privacy of all communications between a client and a therapist. 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 consultation, I make every effort to avoid revealing the identity of my client. The other professionals are also legally bound to keep information confidential. If you don't object, I will not tell you about these consultations unless I feel that it is important to our work together. I will note all consultations in your Clinical Record.

Disclosures required by health insurers or to collect overdue fees are discussed elsewhere in this Agreement.

There are some situations where I am 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 your diagnosis and treatment, such information is protected by the social worker-client 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 is requesting the information for health oversight activities, I may be required to provide it for them.

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

If a client files a worker's compensation claim, I must, upon appropriate request, pro-

vide a copy of the client's record to the Labor and Industrial Commission or the Workers' Compensation Division, or the client's employer.

There are some situations in which I am legally obligated to take actions, which I believe are necessary to attempt to protect others from harm and I may have to reveal some information about a client's treatment. These situations are unusual in my practice.

If I have reasonable cause to suspect that a child has been or may be subjected to abuse or neglect or observe a child being subjected to conditions or circumstances that would reasonably result in abuse or neglect, the law requires that I file a report with Tennessee's Department of Children's Services. Once such a report is filed, I may be required to provide additional information.

If I have reasonable cause to suspect that an elderly or disabled adult presents a likelihood of suffering serious physical harm and is in need of protective services, the law requires that I file a report with Adult Protective Services. Once such a report is filed, I may be required to provide additional information.

If I believe that it is necessary to disclose information to protect against a clear and substantial risk of imminent serious harm being inflicted by the client on him/herself or another person, I may be required to take protective action. These actions may include, and/or initiating hospitalization and/or contacting the potential victim, and/or the police and/or the client's family.

If such a situation arises, I will make every effort to fully discuss it with you before taking any action and I will limit my 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.

## Professional Records

You should be aware that, pursuant to HIPAA, I keep Protected Health Information about you in two sets of professional records. One set constitutes your Clinical Record. It includes information about your reasons for seeking therapy, a description of the ways in which your problem impacts your life, your diagnosis, the goals that we set for treatment, your progress towards those goals, your medical and social history, your treatment history, any past treatment records that I receive from other providers, reports of any professional consultations, your billing records, and any reports that have been sent to anyone, including reports to your insurance carrier. Except in the unusual circumstance where disclosure is reasonably likely to endanger you and/or others or when another individual (other than another health care provider) is referenced and I believe disclosing that information puts the other person at risk of substantial harm, 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 most circumstances, I am allowed to charge a copying fee of 35 cents per page (and for certain other expenses). The exceptions to this policy are contained in the attached Notice Form. If I refuse your request for access to your Clinical Records, you have a right of review, which I will discuss with you upon request.

In addition, I also keep a set of Psychotherapy Notes. These Notes are for my own use and are designed to assist me in providing you with the best treatment. While the contents of Psychotherapy Notes vary from client to client, they can include the contents of our conversations, my analysis of those conversations, and how they impact your therapy. They also contain particularly sensitive information that you may reveal to me that is not required to be included in your Clinical Record. [They also include information from others provided to me confidentially.] These Psychotherapy Notes are kept separate from your Clinical Record. Your Psychotherapy Notes are not available to you and cannot be sent to anyone else, including insurance companies without your written, signed Authorization. Insurance companies cannot require your authorization as a condition of coverage nor penalize you in any way for your refusal to provide it.

## 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:

1. Requesting that I amend your record,
2. requesting restrictions on what information from your Clinical Records is disclosed to others,
3. requesting an accounting of most disclosures of protected health information that you have neither consented to nor authorized,
4. determining the location to which protected information disclosures are sent,
5. having any complaints you make about my policies and procedures recorded in your records, and
6. the right to a paper copy of this Agreement, the attached Notice form, and my privacy policies and procedures.

I am happy to discuss any of these rights with you.

## Minors & Parents

Clients under the age of 14 who are not emancipated and their parents should be aware that the law may allow parents to examine their child's treatment records. Because privacy in psychotherapy is often crucial to successful progress, particularly with

teenagers, it is sometimes my policy to request an agreement from parents that they consent to give up their access to their child's records. If they agree, during treatment, I will provide them only with general information about the progress of the child's treatment, and his/her attendance at scheduled sessions. I will also provide parents with a summary of their child's treatment when it is complete. Any other communication will require the child's Authorization, unless I feel that the child is in danger or is a danger to someone else, in which case, I will notify the parents of my concern. 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.

## Billing & 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.

## Billing & Payments

If your account has not been paid for more than 60 days and arrangements for payment have not been agreed upon, I 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 me to disclose otherwise confidential information. In most collection situations, the only information I release regarding a client's treatment is his/her name, 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

In order for us to set realistic treatment goals and priorities, it is important to evaluate what resources you have available to pay for your treatment. 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 full payment of my 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. Of course, I will provide you with whatever information necessary and will be happy to help you in understanding the information you receive from your insurance company.

Due to the 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. These plans are often limited to short-term treatment approaches designed to work out specific problems that interfere with a person's usual level of functioning. It may be necessary to seek approval for more therapy after a certain number of sessions. While much can be accomplished in short-term therapy, some clients feel that they need more services after insurance benefits end. Some managed-care plans will not allow me to provide services to you once your benefits end. If this is the case, I will do my best to find another provider who will help you continue your psychotherapy.

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 on 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. In some cases, they may share the information with a national medical information databank. I will provide you with a copy of any report I submit, if you request it. By signing this Agreement, you agree that I can provide requested information to your carrier.

Once we have all of the information about your insurance coverage, we will discuss what we can expect to accomplish with the benefits that are available and what will happen if they run out before you feel ready to end your sessions. It is important to remember that you always have the right to pay for my services yourself to avoid the problems described above.

Your signature below indicates that you have read this agreement and agree to its terms and also serves as an acknowledgement that you have received the hipaa notice form described above.

| | |
|---|---|
| Client | Date |
| Witnessed | Date |

## Patient Rights & HIPAA Authorizations

The following specifies your rights about this authorization under the Health Insurance Portability and Accountability Act of 1996, as amended from time to time ("HIPAA").

1. Tell your mental health professional if you don't understand this authorization, and they will explain it to you.
2. You have the right to revoke or cancel this authorization at any time, except: (a) to the extent information has already been shared based on this authorization; or (b) this authorization was obtained as a condition of obtaining insurance coverage. To revoke or cancel this authorization, you must submit your request in writing to your mental health professional and your insurance company, if applicable.
3. You may refuse to sign this authorization. Your refusal to sign will not affect your ability to obtain treatment, make payment, or affect your eligibility for benefits. If you refuse to sign this authorization, and you are in a research-related treatment program, or have authorized your provider to disclose information about you to a third party, your provider has the right to decide not to treat you or accept you as a client in their practice.
4. Once the information about you leaves this office according to the terms of this authorization, this office has no control over how it will be used by the recipient. You need to be aware that at that point your information may no longer be protected by HIPAA.
5. If this office initiated this authorization, you must receive a copy of the signed authorization.
6. Special Instructions for completing this authorization for the use and disclosure of Psychotherapy Notes. HIPAA provides special protections to certain medical records known as "Psychotherapy Notes." All Psychotherapy Notes recorded on any medium (i.e., paper, electronic) by a mental health professional (such as a psychologist or psychiatrist) must be kept by the author and filed separate from the rest of the client's medical records to maintain a higher standard of protection. "Psychotherapy Notes" are defined under HIPAA as notes recorded by a health care provider who is a mental health professional documenting or analyzing the contents of conversation during a private counseling session or a group, joint, or family counseling session and that are separate from the rest of the individual's medical records. Excluded from the "Psychotherapy Notes" definition are the following:
    (a) Medication prescription and monitoring,
    (b) counseling session start and stop times,
    (c) the modalities and frequencies of treatment furnished,
    (d) the results of clinical tests, and
    (e) any summary of: diagnosis, functional status, the treatment plan, symptoms, prognosis, and progress to date.

In order for a medical provider to release "Psychotherapy Notes" to a third party, the client who is the subject of the Psychotherapy Notes must sign this authorization to specifically allow for the release of Psychotherapy Notes. Such authorization must be separate from an authorization to release other medical records.

## Client Information

ARE YOU A PREVIOUS CLIENT? ☐ Yes ☐ No

CLIENT'S NAME *(As listed with insurance)*

↑ First ↑ Middle ↑ Last

MAILING ADDRESS

↑ Number & Street ↑ Apt / Suite ↑ City ↑ State ↑ ZIP Code

CONTACT INFORMATION

↑ Home Phone ↑ Cell Phone ↑ Work Phone

↑ Email Address

ADDITIONAL CLIENT INFORMATION

☐ M ☐ S ☐ M
☐ F ☐ D ☐ W

↑ Social Security Number ↑ Age ↑ Birthdate ↑ Sex ↑ Marital Status

↑ Referred by ↑ Primary Care Physician ↑ Parent / Guardian *(if client is a minor)*

EMERGENCY CONTACT INFORMATION

↑ Emergency Contact Name ↑ Relation

↑ Emergency Home Phone ↑ Emergency Cell Phone ↑ Emergency Work Phone

INSURANCE INFORMATION

*(The following information is required in order to file insurance. We do not guarantee insurance payment. All charges are the responsibility of the guarantor.)*

↑ Insured's Name ↑ Relation ↑ Social Security Number

↑ Insurance Company ↑ ID / Policy Number ↑ Employer

PAYMENT AGREEMENT & AUTHORIZATION TO TREAT

I authorize treatment of the above named patient, and accept responsibility for payment of charges for services rendered to the above named patient. I understand that full payment and/or my co-payment and/or deductibles are expected at the time services are rendered unless the therapist agrees otherwise. I understand that, unless the above mentioned matient has coverage under a managed health plan (HMO, PPO, EAP, etc.) to which I subscribe and in which the therapist is a participating provider, I am personally responsible for the payment of all charges. I understand that, as a courtesy, the therapist will file insurance claims for the services provided, however, this does not release me of my responsibility for payment of the charges for services. Payment for any charges denied or not covered by my insurance company become my responsibility and I agree to pay these charges. I also understand that any court order I have is an agreement between myself and the courts, NOT the therapist, and I am responsible for payment of all charges. I understand and agree that I may be charged for and required to pay for missed appointments not cancelled at least 24 hours in advance. I agree to pay additional attorneys and collection fees resulting from non-payment. I further understand and agree that if a collection agency and/or the courts are used in the event of delinquent payment, such action could require that the therapist release to the collection agency, attorneys, and/or the courts, information which identifies the parties involved, gives the patient diagnoses, and describes the dates and nature of the charges, as well as all other information contained on any claim filed. In addition, if I have requested that the therapist file the charges to my insurance company, I understand that securing benefits under health insurance or other health plans will require that the therapist provide the plan management with confidential patient information, including diagnosis and the dates and type of service rendered. Further, I understand that for utilization review, queality assurance, and other claims review purposes, it may sometimes be necessary for the therapist to provide the plan management with additional information concerning case history, presenting problems, treatment plans, prognosis, and other case information. I fully and freely consent to the release of any and all such patient information as is necessary for the processing and review of health care claims made by or on behalf of the above named patient. I have read, or can request in writing, a copy of my client rights. This consent shall remain in effect until all claims have been fully processed and all review procedures completed.

Signature of adult patient or parent/legal guardian of patient fewer than 18 years of age

Date

## Medical and Mental Health History

PRIMARY CARE PHYSICIAN

↑ Name of Primary Care Physycian ↑ Date of Last Physical

MEDICAL HISTORY *(Check all that apply.)*

- ☐ Head Injury
- ☐ Substance Abuse
- ☐ Rheumatic Fever
- ☐ Sinus Problems
- ☐ Speech Problems
- ☐ Special Diets
- ☐ Anemia
- ☐ Heart Problems
- ☐ Gastrointestinal Problems
- ☐ Sexually Transmitted Disease
- ☐ Learning Problems
- ☐ Hepatitis
- ☐ Thyroid Problems
- ☐ Food Intolerance
- ☐ Anorexia Bulimia
- ☐ Hypertension
- ☐ Kidney Disease
- ☐ Neurological Disease
- ☐ Alcoholism
- ☐ Chicken Pox
- ☐ Cancer
- ☐ Asthma
- ☐ Tuberculosis
- ☐ Stroke
- ☐ Hypoglycemia
- ☐ Sexual Dysfunction
- ☐ NONE

DO YOU HAVE ANY ALLERGIES TO FOOD OR MEDICATIONS? ☐ Yes ☐ No

↓ If so, please list any food or medication you are allergic to.

DO YOU EXPERIENCE ANY OF THE FOLLOWING? *(Check all that apply.)*

- ☐ Abdominal Pain
- ☐ Bed Wetting
- ☐ Frequent Urination
- ☐ Menstrual Problems
- ☐ Colds
- ☐ Sore Throat
- ☐ Diarrhea
- ☐ Ear Infection
- ☐ Numbness
- ☐ Changes in Appetite
- ☐ Headaches
- ☐ Fainting Spells
- ☐ Breathing Problems
- ☐ Nosebleeds
- ☐ Coughs
- ☐ Vomiting
- ☐ Eye/Vision Problems
- ☐ Dizziness
- ☐ Fatigue
- ☐ Chest Pain
- ☐ Nausea
- ☐ Constipation
- ☐ Toothache
- ☐ Sexual Dysfunction
- ☐ Memory Problems
- ☐ NONE

HAVE YOU HAD OPERATIONS OR HOSPITALIZATIONS? ☐ Yes ☐ No

↓ If so, list any operations or hospitalizations for medical, psychiatric, drug or alcohol problems and their dates.

ARE YOU INVOLVED IN THE COURT SYSTEM? ☐ Yes ☐ No MANDATED? ☐ Yes ☐ No

↓ If so, describe the issue.

## Medical and Mental Health History *(continued)*

SUBSTANCE USE *(Check all that apply.)*

☐ Alcohol ☐ Prescription Drugs ☐ NONE

☐ Tobacco ☐ Illicit Drugs

↓ If so, please explain use, frequency/dosage, and if prescribed include the reason.

↓ Please list any supplement or homeopathic medication you are taking.

WHAT HAS BROUGHT YOU TO THIS OFFICE? *(Check all that apply.)*

☐ Depression ☐ Anger ☐ Grief/Loss ☐ Sexual Problems

☐ Relationship Issues ☐ Moodiness ☐ Illness ☐ Anxiety

☐ Children ☐ Family Problems ☐ Traumatic Experience ☐ Other: _____

↓ Briefly describe.

ARE YOU CURRENTLY HAVING SUICIDAL IDEATIONS? ☐ Yes ☐ No

HAVE YOU HAD CONTACT WITH A PSYCHIATRIST FOR MEDICATION OR EVALUATION? ☐ Yes ☐ No

↓ If you have, please state where and with whom.

DO YOU HAVE A FAMILY HISTORY OF MENTAL ILLNESS? ☐ Yes ☐ No

↓ If so explain relation, illness, and medications.

## Symptoms Checklist *(Check all that apply.)*

- ☐ Depressed Mood
- ☐ Lost interest in most activities
- ☐ Increased appetite
- ☐ Decreased appetite
- ☐ Weight Gain
- ☐ Weight Loss
- ☐ Difficulty going to sleep
- ☐ Difficulty staying asleep
- ☐ Fatigue, loss of energy
- ☐ Feelings of worthlessness
- ☐ Inappropriate guilt
- ☐ Difficulty concentrating
- ☐ Preoccupation with death
- ☐ Suicidal thoughts
- ☐ Excessive or uncontrollable worry
- ☐ Restlessness
- ☐ Irritable
- ☐ Decreased need for sleep
- ☐ Increased talking
- ☐ Racing thoughts
- ☐ Distractible
- ☐ Elevated mood
- ☐ Engaging in risky, pleasurable activities
- ☐ Mood swings
- ☐ Feelings of panic
- ☐ Pounding heart, chest pains, shaking
- ☐ Shortness of breath, dizziness, sweating
- ☐ Recurrent undesirable thoughts
- ☐ Repetitive behaviors (hand washing, checking) or mental acts (counting etc.)
- ☐ Nausea or abdominal stress
- ☐ Fear of losing control
- ☐ Fear of dying
- ☐ Recurrent intrusive memories
- ☐ Flashbacks
- ☐ Efforts to avoid memories
- ☐ Fear of social situations
- ☐ Alcohol problems
- ☐ Drug use problems
- ☐ Compulsive dieting
- ☐ Vomiting, use of laxatives
- ☐ Marital problems
- ☐ Sexual problems
- ☐ Impulsive
- ☐ Overwhelmed
- ☐ Angry
- ☐ Easily upset, on edge
- ☐ Careless, forgetful, easily, distracted, difficulty organizing, losing things
- ☐ NONE

## Protected Health Information *(Check all that apply.)*

SCHEDULING VIA FULLSLATE

↓ Cell Phone

- ☐ It is okay to contact me via text message.
- ☐ It is okay to leave appointment reminders via text message.
- ☐ It is okay to leave a message from this office on my cell phone.
- ☐ It is okay to leave a message from this office with whoever answers the cell phone.

↓ Email Reminder

- ☐ It is okay to leave appointment reminders via email.

↓ Home Phone

- ☐ It is okay to leave a message from this office on my answering machine.
- ☐ It is okay to leave a message from this office with whoever answers the telephone.

↓ Work Phone

- ☐ It is okay to leave a message from this office on my direct voicemail.
- ☐ It is okay to leave a message from this office with whoever answers the telephone.

WRITTEN COMMUNICATION

- ☐ It is okay to send mail to my home address.
- ☐ It is okay to fax this number _____ from this office.
- ☐ It is okay to contact me via email.

PERMISSION TO SHARE INFORMATION

Heather Monson-James, LCSW has my permission to share information gathered in therapy sessions with the following person(s):

| ↑ Name | ↑ Relationship to Client |
|---|---|
| ↑ Name | ↑ Relationship to Client |
| ↑ Name | ↑ Relationship to Client |
| ↑ Name | ↑ Relationship to Client |

HIPAA PRIVACY PRACTICES

- ☐ I acknowledge that I have received a copy of HIPAA privacy practices.

Signature of adult patient or parent/legal guardian of patient fewer than 18 years of age

Date