PSYCHOLOGIST-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 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. The law requires that I obtain your signature acknowledging that I have provided you with this information. I can discuss any questions you have about the procedures at any time. When you sign this document, it will also represent an agreement between us. You may revoke this Agreement in writing at any time. That revocation will be binding unless we have taken action in reliance on it; if there are obligations imposed on us by your health insurer in order to process or substantiate claims made under your policy; or if you have not satisfied any financial obligations you have incurred.

PSYCHOLOGICAL SERVICES

Psychotherapy can have benefits and risks. Since therapy often involves discussing difficult aspects of your life, you may experience temporary uncomfortable feelings like sadness, guilt, anger, frustration, loneliness, and helplessness. On the other hand, psychotherapy has also been shown to have many significant benefits. Therapy often leads to improved relationships, solutions to specific problems, and significant reductions in feelings of distress. However, 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 initial 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. Therapy involves a large commitment of time, money, and energy, so you should feel confident with the therapist you select.

SESSIONS

I normally conduct an initial evaluation that will last from 1 to 3 sessions. During this time, we can both decide if I am a good fit to provide the services you need in order to meet your treatment goals. If psychotherapy begins, we will usually schedule one 45- minute session week/biweekly. **If cancellations are not made 24 hours in advance, or if you do not show up for your appointment, you will be charged a $50.00 fee. It is important to note that insurance companies do not provide reimbursement for cancelled sessions. If this occurs twice in one year, you will be discharged from therapy.**

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. There are some situations in which I am **legally required to take action** to protect others from harm, even though this may require revealing some information about a patient's treatment.

- For example, if I believe a child, an elderly person, or a person with a disability is being abused, I may be required to file a report with the appropriate state agency.
- If I believe a patient is threatening serious bodily harm to another, I may be required to take protective actions, which may include notifying the potential victim, notifying the police, or seeking appropriate hospitalization.
- If a patient threatens to harm him/herself, I may be required to seek hospitalization for the patient, notify police, or to contact family members or others who can help provide protection.

These situations are unusual in my practice. However, if such a situation develops, I will make every effort to fully discuss it with you before taking action.

- 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 the 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 to our work together.
- I also have a privacy contract with our accountant. As required by HIPAA, I have a formal business associate contract with them, in which they promise to maintain the confidentiality of data except as specifically allowed in the contract or otherwise required by law.
- 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 psychologist-patient privilege law. I cannot provide any information without your (or your legal representative's) written authorization, or a court order.
- 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, provide records relating to treatment or hospitalization for which compensation is being sought.

CHILD PSYCHOTHERAPY WITH SEPARATED/DIVORCED PARENTS

Whomever brings the child in for the intake appointment will need to provide a copy of the custody agreement. If custody is anything other than sole legal/medical custody, both parents will need to provide consent to treatment before therapy begins. Please note, I do not provide custody evaluations, evaluation of parental fitness, etc.

MINORS

Patients under 19 years of age who are not emancipated should be aware that the law allows parents access to their child's treatment records. Depending on the age of the child and presenting concerns, privacy in therapy can be crucial to successful progress. In such instances, I will provide only general information about the progress of the child's treatment unless I feel the child is in danger or is a danger to someone else. If that were to occur, I would notify the parents of these concerns immediately.

RECORD KEEPING

I am required to maintain records for seven years following termination of services, or for seven years past the age of majority, which is 19 years of age in Nebraska.

PROFESSIONAL FEES

The fee for the initial diagnostic session is **$300.00**. Fees for subsequent individual psychotherapy and/or family therapy sessions are **$225.00**. An additional **$25.00** fee may be added to sessions that meet national current criterion for complex sessions. Psychological test administration/scoring is **$125.00 for the first half- hour, $75.00 each additional half-hour.** Psychological testing evaluation, interpretation of standardized test results and clinical data, clinical decision making, treatment planning, and report and interactive feedback is **$215.00 for the first hour, $130.00 for each additional hour.**

If you become involved in legal proceedings that require my participation, you will be expected to pay for 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 **$275.00 per hour** for preparation, travel and attendance at any legal proceeding.

CONTACT

There are a few different ways to contact me outside of our scheduled appointment time. If the concern has to do with scheduling or canceling appointments, please contact Tami at 402-488-6100. Billing/insurance questions should be directed to Susan Swenson of Swenson Management: 402-875-2433. If you have non-urgent, non-life threatening questions or updates, those messages can be communicated to me at kelly@kellybreylovephd.com. I typically respond via email within 1-2 business days. If you are experiencing suicidal thoughts and/or are unsafe after business hours, please call the office and follow the instructions on the voicemail. Text messages are not HIPAA compliant; therefore, I am not able to respond to a text message sent to my cellphone. If you are experiencing a life-threatening emergency, call 911.

BILLING AND PAYMENTS

Courtesy Claim Filing:

We file your insurance claim with your primary insurance company as a courtesy to you. Please bring your insurance card with you for every visit and promptly inform us of any changes in your insurance coverage. If you do not inform us of a change in insurance and your new insurance requires an authorization or denies for timely filing you will be responsible for the bill. If you have a secondary insurance policy, we will file a claim on your behalf, but it is your responsibility to collect the amount due. After filing your insurance claim, you will be personally responsible for the unpaid balance. If you do not have insurance, you are expected to pay in full at the time of visit.

Co-pays:

Your co-pay is due at the time of your office visit. You are responsible for checking your insurance benefits to determine your co-pay/co-insurance or deductible amounts. If we have a contract with your insurance carrier, we are responsible for collecting the co-pay and you are responsible for paying it. If your insurance does not have a co-pay, but instead has a deductible or coinsurance, your portion will be expected to be paid in full. Our office will provide options available to you for payment in full.

Responsible Party:

The parent/legal guardian bringing the minor into the office will be considered the responsible party for billing purposes. If the parents are divorced or custody has been transferred to a legal guardian, the custodial parent/legal guardian who brings the minor in will be responsible for the bill. It is then the obligation of that parent, not our office, to collect medical bills from the other parent. Emancipated minors are responsible for their own bills. We will not become involved in billing disputes in cases involving divorce or separation, and will not split bills among family members.

Billing Disputes:

We must hear from you, in writing or by telephone, no later than 60 days after your first bill is sent on which the error or problem appeared. You can telephone us, but doing so will not preserve your rights.

In writing, please provide us with the following information:

- Your Name
- Account Number
- Dollar amount of the suspected error
- An explanation of why you believe there is an error

If you need more information, describe the item you are unsure about. Please be sure the person responsible for the account signs all correspondence.

Payment Plan:

If you are unable to pay your account in full, you may contact us to discuss a possible payment plan. All balances must be paid within 6 months. In addition to your monthly payment, all future co-pays/coinsurance and deductibles must be paid at the time of service.

Your minimum payment will be calculated as follows:

Under $100.00	No payment plan. Account must be paid in full within 30 days.
$100-$600.00	$100/month minimum payments
Over $600.00	Equal payments not exceeding 6 months

If you miss a scheduled monthly payment, you will be required to make 2 payments within the next 30 days or your account will be transferred to the collection agency. If you have additional questions about your mental health coverage, or about your bill, please feel free to contact Susan Swenson at 402-875-2433.

Collection Agency:

If payment arrangements are not made with our office, or are not honored, your account may be turned over to our collection agency or taken to small claims court. At that point, all questions or payments should be sent to the collection agency. After your account is turned over to our collection agency, you must make payment in full prior to scheduling a future appointment. We reserve the right to terminate your care from our practice due to a past due balance.

My signature indicates that I have read, understand and agree to comply with the policies described above.

_____ _____

Patient Signature
(Parent/Legal Guardian signature if patient is under 19 years of age)

Date