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PSYCHOTHERAPIST-CLIENT SERVICES AGREEMENT

Welcome to my practice. Please read this information carefully. 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 new federal law that provides new privacy protections and new patient rights with regard to the use and disclosure of your Protected Health Information (PHI) used for the purpose of treatment, payment, and health care operations. HIPAA requires that I provide you with a Notice of Privacy Practices (the NC Notice Form) for use and disclosure of PHI for treatment, payment and health care operations. The Notice, which is attached to this Agreement, explains HIPAA and its application to your personal health information in greater detail. The law requires that I obtain your signature acknowledging that I have provided you with this information at the end of this session. Although these documents are long and sometimes complex, it is very important that you read them carefully before our next session. We can discuss any questions you have about the procedures at that time. 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 on me unless I have taken action in reliance on it; if there are obligations imposed on me 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. I reserve the right to change the privacy policies and practices described in this agreement at any time and will provide you with a revised notice by mail.

PSYCHOLOGICAL SERVICES

I am a Licensed Psychologist-Health Services Provider (HSP-P) specializing in providing clinical psychology services to adolescents and adults. I have previously been in private practice, taught at the community college level, and consulted to various individuals and groups. I work with teenagers and adults, individually and in families. If the problems you or your family experiences are outside my expertise, I will help you with appropriate referrals to other professionals.

Psychotherapy is most effective when a trusting relationship is established between a therapist and his/her client. There are many different methods I may use to deal with the problems that you hope to address. Psychotherapy can have benefits and risks. Since therapy often involves discussing unpleasant aspects of your life, you may experience uncomfortable and possibly intense emotions. On the other hand, psychotherapy has also been shown to have many benefits. Therapy often leads to better relationships, solutions to specific problems, and significant reductions in feelings of distress. Because each individual is unique, there are no guarantees as to what you will experience.

SESSIONS

During the assessment phase, we can both decide if I am the best person to provide the services you need in order to meet your treatment goals. I will be happy to help you arrange a consultation with another mental health professional for a referral or a second opinion, if you would like. If psychotherapy is begun, I usually schedule one 45-minute session per week at a time

we agree on, although some sessions may be longer or more frequent. Please understand that regular clients are usually scheduled the same time and day each week when possible. Once an appointment is scheduled, you will be expected to pay for it unless you provide **24 hours** advance notice of cancellation. It is important to note that insurance companies do not provide reimbursement for cancelled sessions. If it is possible, I will try to find another time to reschedule your cancelled appointment within the week.

PROFESSIONAL FEES

Initial diagnostic interview (child or adult) 60 minutes	\$175.00
Psychotherapy session (regular, 45 minutes)	\$140.00
Psychotherapy session (brief, 25 minutes)	\$90.00
Psychotherapy session (extended, 75 minutes)	\$200.00

In addition to weekly appointments, I charge differing amounts for other professional services you may need, though I will break down the hourly cost if I work for periods of less than one hour. Other services include report writing, telephone conversations lasting longer than 10 minutes, consulting with other professionals with your permission, preparation of records or treatment summaries, and the time spent performing any other service upon which we agree. Please note that fees are set annually and are subject to review.

CONTACTING ME

While I can sometimes be reached during business hours, I do not answer the phone when I am with a client. My telephone is answered by an automated, confidential voice mail that I monitor throughout the day. I will make every effort to return your call on the same day you make it, with the exception of calls received after 7 pm, weekends or holidays. If you are difficult to reach, please inform me of some times when you will be available and at what number. If you are unable to reach me and/or feel that you can't wait for me to return your call, contact your family physician or go to the nearest emergency room and ask for the psychiatrist on call. You may also call the Holly Hill Hospital Respond Line at 919.250.7000, 24 hours a day.

LIMITS ON CONFIDENTIALITY

The law protects the privacy of all communications between a patient or client and a psychologist. In most situations, I can only release information about your treatment to others if you sign a written Authorization form that meets certain legal requirements imposed by HIPAA. There are other situations that require only that you provide written, advance consent. Your signature on this Agreement provides consent for those activities, as follows:

- I may occasionally find it helpful to consult other health and mental health professionals about a client. During a consultation, I make every effort to avoid revealing the identity of my client. 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 will note all consultations in your Clinical Record (which is called "PHI" in my Notice of Psychologist's Policies and Practices to Protect the Privacy of Your Health Information).
- Disclosures required by health insurers or to collect overdue fees are discussed elsewhere in this Agreement.
- If I believe that a client presents an imminent danger to his/her health or safety, I 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 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 the professional services that I provided you, such information is protected by the psychologist-client privilege law. I 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 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, and my services are being compensated through workers compensation benefits, I must, upon appropriate request, provide a copy of the client's record to the patient's employer or the North Carolina Industrial Commission.

There are some situations in which I am legally obligated to take action, which I believe are necessary to attempt to protect others from harm and where I may have to reveal some information about a client's treatment:

- If I have cause to suspect that a child under 18 is abused or neglected, or if I have reasonable cause to believe that a disabled adult is in need of protective services, the law requires that I file a report with the County Director of Social Services. Once such a report is filed, I may be required to provide additional information.
- If I believe that a client presents an imminent danger to the health and safety of another, I may be required to disclose information in order to take protective actions, including initiating hospitalization, warning the potential victim, if identifiable, and/or calling the police.

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. The laws governing confidentiality can be quite complex, and I am not an attorney. In situations where specific advice is required, formal legal advice may be needed.

PROFESSIONAL RECORDS

You should be aware that, pursuant to HIPAA, I keep Protected Health Information (PHI) 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 on 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 unusual circumstances that involve danger to yourself and/or others or the record makes reference to another person (unless such other person is a health care provider) and I believe that access is reasonably likely to cause substantial harm to such other person, 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 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 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 on 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 and information revealed to me confidentially by others. 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 them.

PATIENT RIGHTS

HIPAA provides you with several new or expanded rights with regard to your Clinical Records and disclosures of PHI. These rights include requesting that I amend your record; requesting restrictions on what information from your Clinical Records is disclosed to others; requesting an accounting of most disclosures of PHI that you have neither consented to nor authorized; determining the location to which PHI disclosures are sent; having any complaints you make about my policies and procedures recorded in your records; and the right to a paper copy of this Agreement, the attached Notice form, and my privacy policies and procedures. I am happy to discuss any of these rights with you.

MINORS & PARENTS

In the state of North Carolina, individuals under the age of 18 may not consent to receive psychological services without parental consent. While privacy in psychotherapy is very important, particularly with teenagers, parental involvement is also essential to successful treatment and this requires that some private information disclosed by a child or teen be shared with parents. It is my policy not to provide treatment to a child or teen under 16 unless he/she agrees that I can share whatever information I consider necessary with his/her parents. For teens 16 and over, I request an agreement with my client allowing me to share general information about the progress of the teen's treatment and his/her attendance at scheduled sessions. I expect parents or guardians to respect that communication between myself as therapist and their child/teen/ward is confidential. The exception would be if I believe that the child is in danger or is a danger to someone else. In such a case, I will notify the parents of my concern. Before giving parents any information, I will discuss the matter with the child or teen, if possible, and do my best to handle any objections he/she may have.

BILLING AND PAYMENTS

You will be expected to pay for each session at the time it is held. Adolescent clients who drive themselves to my office should be provided with payment from parents for each session. In situations involving separated or divorced families, the person who initiates services for a child is the person responsible for payment, **regardless** of any other arrangement made with the ex-spouse. Payment schedules for other professional services will be agreed to when they are requested. In circumstances of unusual financial hardship, I may be willing to negotiate a fee adjustment or payment installment plan. A late fee of \$50 per month will be assessed against any balance outstanding over 45 days. Any returned checks will be charged a fee of \$40.

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 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. After each session, I will give you a statement to provide you with pertinent psychological information to help you receive the benefits to which you are entitled if you choose to make a claim; however, you are responsible for full payment of my fees at the time of service. **I do not file for, or accept assignment of, insurance payments nor do I participate as a provider with any insurance panels. Therefore, your insurance company will consider me an "out-of-network provider."**

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. You should also be aware that if you submit my bill to your health insurance company, they often require me 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; I have no control over what the company does with it once it is in their hands.** I will provide you with a copy of any report I submit for your initial review, and have you send it to the insurer directly. By signing this Agreement, you agree that I can provide requested information to your carrier.

Your signature below indicates that you have read the information in this document and agree to abide by its terms during our professional relationship. I look forward to working with you.

Print name

Signature

Clinician's signature