Associated Psychological Services, LLC.

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Client Services Agreement

Please Print and Complete Form BEFORE Appointment

Welcome to Associated Psychological Services. Please read our policies and let us know if you have any questions. Please sign and date the last page and return back to us prior to or at your initial appointment.

This document (the Agreement) contains important information about our services and business policies. It also contains summary information about the Health Insurance Portability and Accountability Act (HIPAA), a federal law that provides privacy protection and client 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 we provide you with a Notice of Privacy Practices (the Notice) 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.

CONFIDENTIALITY

Confidentiality is essential in conducting psychotherapy. Therefore, no information whatsoever will be released to anyone, including family members, without your expressed written consent, except for where the law dictates. There are certain exceptions to confidentiality of which we are mandated to report, by law. These exceptions are:

1. If your therapist suspects that your child or any other child is being abused or neglected.
2. If you threaten to or if we have reason to believe that you will harm yourself or someone else, we are obligated to protect you or the potential victim.
3. Issuance of a subpoena from a court of law.

If you are a minor, or you are the parent of a minor being treated, your parents/guardian may be informed of your progress if they ask. However, I will not reveal specific details of our sessions without your consent unless those details fall under the above exceptions.

CANCELLATION POLICY

Your appointment time is reserved exclusively for you, and therefore you are financially responsible for your appointment. We have a 24 hour cancellation policy, Since we will be unable to fill this time with anyone else, you will be directly billed your therapist's full fee for all missed appointments, or those canceled with less than 24 hours notice, except under exceptional circumstances.

PHONE CALLS AND EMERGENCY POLICY

We have a voicemail system. Should you need to reach your therapist you can dial their extension and leave a message. Telephone conversations normally should be used for changing appointment times, getting simple questions answered, or other such routine matters. We also have an on-call therapist if you need to speak with a therapist for an urgent matter and yours is not available. You can call our main number and touch 1 after the initial message begins, then follow the directions. However, in case of a true psychiatric emergency, please go to your nearest emergency room for immediate treatment.

INSURANCE REIMBURSEMENT and FEES

Outpatient psychotherapy is covered by most major medical insurances. If you have not done so already, please contact your insurance carrier to find out specific details of what your mental health plan includes. You should ask if your specific therapist is in-network, deductibles on plan, how much of the deductible has been filled, coinsurance, copays and if your plan requires preauthorization. If you plan to use out-of-network mental health coverage, please be aware that you (and not your insurance provider) are ultimately responsible for full payment of fees. This means that you must pay fees up front and collect reimbursement from your insurance provider. Payment is required at the time of service. Please note that a returned check is subject to a $35 fee. If you request a letter regarding your treatment, this is not covered by insurance and will be charged your therapist's hourly rate.

CREDIT CARD AGREEMENT

A credit/debit card is required on file to secure any payments due for services rendered. Please complete the credit/debit card authorization form. As with clinical records, all information will be kept secure. Please note that we accept Visa, Mastercard, and Discover, but not American Express. Your card will not be charged without your permission, unless a balance is due. We will make every effort to assist you in collecting your claims. However, all charges incurred are the responsibility of the patient/guardian, regardless of the coverage or reimbursement. Our goal is to focus on you and your therapy. We do appreciate you being current with your balance.

LITIGATION and LAWSUITS

We do not voluntarily get involved in court litigation or lawsuits for any purpose. If you are involved in litigation and inform the court of these services, please know that you are waiving your right to confidentiality as the court can subpoena your records of which, at that time, are no longer deemed confidential. We will strongly resist appearing in court and will testify only under the judge's direct order. If we are subpoenaed to court, you will be required to sign a separate form. You will be responsible for your therapist's hourly rate specifically for court appearances, typically charged by half day or full day fees, of which are not covered by insurance and are lost wages for your therapist. Payment is due 7 days prior to the hearing. These fees will be charged on your credit card on file, unless other arrangements have been made. If the court or you require summaries, affidavits, court documents etc., you will also be charged your therapist's hourly court rate.

GUARANTEE OF ACCOUNT

For and in consideration of services rendered by your therapist at Associated Psychological Services, the undersigned (jointly and separately, if more than one name) guarantees payment of all charges incurred for said patients in accordance with the policy of payment of such bills. There will be an added 30% collection and/or reasonable attorney fee if your account goes to collection, in addition to 1.5% interest charged monthly.

CLIENT RIGHTS

HIPAA (Health Insurance Portability and Accountability Act) provides you with several new or expanded rights with regard to your clinical records and disclosures of protected health information. The attached form entitled "Notice of Policies and Practices to Protect the Privacy of Your Health Information" lists these rights.

ACKNOWLEDGEMENT

Your signature below indicates that you have read this agreement and agree to its terms, agree to treatment from Associated Psychological Services, LLC., and also serves as an acknowledgement that you have received the HIPAA notice form "Notice of Policies and Practices to Protect the Privacy of Your Health Information."

I have reviewed a copy of Associated Psychological Services Notice of Privacy Practices (HIPAA) and understand how it sets forth how Associated Psychological Services may use and disclose my individually identifiable health information. I hereby acknowledge the uses and disclosures of my individually identifiable health information consistent with such Notice of Privacy Practices.

I have read and agreed with each of the points listed above. I had an opportunity to clarify questions/discuss points of concern before signing.

____
Name of Client (Printed)

____
Client Signature (if 18 or older)

____
Parent/Guardian Signature

____
Date

Notice of Psychologists' Social Workers' and Professional Counselors' Policies and Practices to Protect the Privacy of Your Health Information

This notice describes how mental health and medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

I. Uses and Disclosures for Treatment, Payment, and Health Care Operations

I may *use* or *disclose* your *protected health information* (*PHI*), for *treatment, payment, and health care operations* purposes with your *consent*. To help clarify these terms, here are some definitions:

- "*PHI"* refers to information in your health record that could identify you.
- *"Treatment, Payment and Health Care Operations"*
  - – *Treatment* is when I provide, coordinate or manage your health care and other services related to your health care. An example of treatment would be when I consult with another health care provider, such as your family physician or another psychologist.
  - - *Payment* is when I obtain reimbursement for your healthcare. Examples of payment are when I disclose your PHI to your health insurer to obtain reimbursement for your health care or to determine eligibility or coverage.
  - - *Health Care Operations* are activities that relate to the performance and operation of my practice. Examples of healthcare operations are quality assessment and improvement activities, business-related matters such as audits and administrative services, and case management and care coordination.
- "*Use*" applies only to activities within my office, such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.
- "*Disclosure*" applies to activities outside of my office, such as releasing, transferring, or providing access to information about you to other parties.

II. Uses and Disclosures Requiring Authorization

I may use or disclose PHI for purposes outside of treatment, payment, and health care operations when your appropriate authorization is obtained. An "*authorization"* is written permission above and beyond the general consent that permits only specific disclosures. In those instances when I am asked for information for purposes outside of treatment, payment and health care operations, I will obtain an authorization from you before releasing this information. I will also need to obtain an authorization before releasing your psychotherapy notes. *"Psychotherapy notes"* are notes I have made about our conversation during a private, group, joint, or family counseling session, which I have kept separate from the rest of your medical record. These notes are given a greater degree of protection than PHI.

You may revoke all such authorizations (of PHI or psychotherapy notes) at any time, provided each revocation is in writing. You may not revoke an authorization to the extent that (1) I have relied on that authorization; or (2) if the authorization was obtained as a condition of obtaining insurance coverage, and the law provides the insurer the right to contest the claim under the policy.

III. Uses and Disclosures with Neither Consent nor Authorization

I may use or disclose PHI without your consent or authorization in the following circumstances:

- **Child Abuse:** If I have reasonable cause to believe that a child has been subject to abuse, I must report this immediately to the New Jersey Child Protection and Permanency office.
- **Adult and Domestic Abuse:** If I reasonably believe that a vulnerable adult is the subject of abuse, neglect, or exploitation, I may report the information to the county adult protective services provider.

- **Health Oversight:** If the New Jersey State Board of Psychological Examiners issues a subpoena, I may be compelled to testify before the Board and produce your relevant records and papers.
- **Judicial or Administrative Proceedings:** If you are involved in a court proceeding and a request is made for information about the professional services that I have provided you and/or the records thereof, such information is privileged under state law, and I must not release this information without written authorization from you or your legally appointed representative, or a court order. This privilege does not apply when you are being evaluated for a third party or where the evaluation is court ordered. I must inform you in advance if this is the case.
- **Serious Threat to Health or Safety:** If you communicate to me a threat of imminent serious physical violence against a readily identifiable victim or yourself or the public and I believe you intend to carry out that threat, I must take steps to warn and protect. I also must take such steps if I believe you intend to carry out such violence, even if you have not made a specific verbal threat. The steps I take to warn and protect may include arranging for you to be admitted to a psychiatric unit of a hospital or other health care facility, advising the police of your threat and the identity of the intended victim, warning the intended victim or his or her parents if the intended victim is under 18, and warning your parents if you are under 18.
- **Worker's Compensation**: If you file a worker's compensation claim, I may be required to release relevant information from your mental health records to a participant in the worker's compensation case, a reinsurer, the health care provider, medical and non-medical experts in connection with the case, the Division of Worker's Compensation, or the Compensation Rating and Inspection Bureau.

IV. Patient's Rights and Provider"s Duties

Patient's Rights:

- **Right to Request Restrictions:** You have the right to request restrictions on certain uses and disclosures of protected health information about you. However, I am not required to agree to a restriction you request.
- **Right to Receive Confidential Communications by Alternative Means and at Alternative Locations:** You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations. (For example, you may not want a family member to know that you are seeing me. Upon your request, I will send your bills to another address.)
- **Right to Inspect and Copy:** You have the right to inspect or obtain a copy (or both) of PHI and psychotherapy notes in my mental health and billing records used to make decisions about you for as long as the PHI is maintained in the record. I may deny your access to PHI under certain circumstances, but in some cases, you may have this decision reviewed. On your request, I will discuss with you the details of the request and denial process.
- **Right to Amend:** You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. I may deny your request. On your request, I will discuss with you the details of the amendment process.
- **Right to an Accounting:** You generally have the right to receive an accounting of disclosures of PHI for which you have neither provided consent nor authorization (as described in Section III of this Notice). On your request, I will discuss with you the details of the accounting process.
- **Right to a Paper Copy:** You have the right to obtain a paper copy of the notice from me upon request, even if you have agreed to receive the notice electronically.

Provider's Duties:

- I am required by law to maintain the privacy of PHI and to provide you with a notice of my legal duties and privacy practices with respect to PHI.
- I reserve the right to change the privacy policies and practices described in this notice. Unless I notify you of such changes, however, I am required to abide by the terms currently in effect.
- If I revise my policies and procedures, I will provide you with a revised notice by mail.

V. Questions and Complaints

If you have questions about this notice, disagree with a decision I make about access to your records, or have other concerns about your privacy rights, you may contact me directly.

If you believe that your privacy rights have been violated and wish to file a complaint with me, you may send your written complaint to Associated Psychological Services, LLC..

You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services at 200 Independence Avenue, S.W., Washington, D.C. 20201,Toll Free Call Center: 1-877-696-6775.

You have specific rights under the Privacy Rule. I will not retaliate against you for exercising your right to file a complaint.