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Office Policies & Agreement for Psychotherapy Services

Welcome to my practice. Please take time to read this carefully and let me know if you have any questions or need more information. Please be sure to initial where indicated. When you sign this document, it will represent an agreement between us.

Psychotherapeutic Services

I am a Licensed Clinical Social Worker who has been in clinical practice for over 30 years. I work within a variety of treatment modalities. If the problems you or your family experience are outside of my expertise, I will help you with appropriate referrals to other professionals.
Psychotherapy is not easily described in general statements and varies depending on the mix of personalities and problems. Psychotherapy can have benefits and risks as it often involves discussing unpleasant aspects of your life, and you may experience uncomfortable and intense emotions. On the other hand, psychotherapy has been shown to have many benefits including solutions to specific problems, better relationships, and significant reductions in feelings of distress. However, there are no guarantees of what you will experience. Entering into this service agreement is an acknowledgement that you understand this, and that you may experience discomfort as you address difficult issues in your life.
The initial evaluation, or diagnostic interview, will last about 60 minutes and includes the evaluation of needs and a first impression of what the treatment plan will likely include. During this period you are able to evaluate information about my work and formulate your own opinions as to whether you feel comfortable with my style. Second opinions are always encouraged if desired, and referrals are available if you feel your needs would be better met elsewhere. Sessions after that continue to involve the ongoing evaluation of needs.

Contacting Me

Phone: Established clients having non urgent needs can contact me during work hours by calling my cell phone: 919-210-1720. Please limit non urgent calls to the workday. I return calls promptly so you if you have not heard from me within 24 hours it likely means that I did not receive your message and would like you to leave another message.
If you have an emergency, it is important that you call your psychiatrist if you have one, 911, or go to the nearest emergency room.

Electronic Communication: In accordance with HIPPA compliance, I am unable to

communicate with you via email and texting. The following policy is to assure security and confidentiality for clients and to assure that it is consistent with ethics and the law. It is very important to be aware that computers and unencrypted emails and texts (which are part of the clinical records) can be rather easily accessed by unauthorized people and, hence, can compromise the privacy and confidentiality of such communications.

Emails and texts in particular are vulnerable to such unauthorized access due to the fact that servers or communication companies may have unlimited and direct access to all emails and texts that go through them. In accordance with the law I will not email or text, except when clients understand these risks to their confidentiality and make an informed decision to waive this part of the HIPPA agreement. Some clients choose this as they find that emailing and texting can be an effective and efficient way to communicate about office matters like appointment scheduling and billing.

If you understand these risks to your confidentiality and wish to give me permission to communicate with you via unencrypted email and text, please initial here:__________. Even with permission from you, email and texting will still be limited to things like setting and changing appointments and other related issues, as it is difficult to address clinical matters in this way. **Clients interested in using text as a way to communicate are asked to do so during weekdays only from 8:00 a.m. to 5:00 p.m., using my cell phone number. The best way to reach me outside of these hours is email, if you are comfortable with this, or you can leave a voice message on my cell phone number.**

Confidentiality

• The law protects the privacy of communications between a client and a psychotherapist. In some cases I may ask you to sign a Release of Information, for example if it seems important to speak to another one of your health care providers.
• In some cases I will provide requested information by your insurance company unless you ask me to do otherwise.
• If I believe a client is in danger of hurting themself or someone else I am required to take necessary action to protect that person.
• Our financial agreement also brings some confidentiality limits. If I find myself in a dispute over your billing, I may also provide a collections agency with information to collect any outstanding balance.

Vacation

Aside from circumstances such as illness or family illness, clients are informed at least two weeks in advance of any time I will be away from the office. Once a year I will be out of the office for 4 - 6 weeks, and in this case clients are informed 6 - 8 weeks in advance.

While away, arrangements are made such that clients have the support they need should an urgent matter arise. In many cases a client’s psychiatrist, if they have one,

will provide this support. In other situations, another clinical therapist takes urgent calls or provides supportive services in my absence. However, as is the case when I am not on vacation, if there is an emergency clients should call 911 or go to the emergency room.

Billing and Payment

Invoices are given at regular intervals via USPS or in person. However, in attempt to streamline the billing process such that there is a minimum of paper and use of USPS, if given permission I will send billing statements via email with an updated invoice. Like all emails, these are sent via an unencrypted electronic communication which, as described above, is not in compliance with HIPPA. If you wish to give me permission to send invoices in this manner, please initial here:____.

Payment is expected at the end of each session or at the end of each month and is accepted in the form of check, cash, Venmo (renee-flam) and credit card. Ongoing balances are not acceptable unless we have made a different agreement beforehand.

As of 2024 I am no longer an in-network provider with any insurance companies. As an 'out of network' provider you will receive a monthly invoice including all of the information necessary to submit to your insurance company. There may be benefits through your insurance coverage to which you may be entitled as reimbursement for my services. **Please talk with your insurance carrier or employee benefit program administrator to better understand the terms of your mental health coverage**.

I have an 'opt-out' agreement with Medicare such that if you have this insurance you will not be able submit any of your claims to them for reimbursement and will be considered to be paying privately. *Please inform me if this is the case, as there is additional information and a separate form and explanation regarding Medicare.

Good Faith Estimate of Charges

As required by the 'No Surprises Act' of 2020, all mental health providers are required to ask about client's insurance coverage (including whether clients intend to submit claims to their insurance company) and to provide a 'Good Faith Estimate for Heath Care Items and Services' to all self-pay or uninsured clients when care is scheduled, and/or when requested by the client. I will provide this estimate to all self-pay and uninsured clients at the beginning of treatment and annually thereafter. A Good Faith Estimate is not necessary at this time for clients who are planning to use their insurance benefits to cover their services, but all clients have a right to request a Good Faith Estimate at any time.

TELEHEALTH INFORMED CONSENT

Telehealth is healthcare provided by any means other than a face-to-face visit. In telehealth services, medical and mental health information is used for diagnosis,

consultation, treatment, therapy, follow-up, and education. Health information is exchanged interactively from one site to another through electronic communications. Telephone consultation, videoconferencing, transmission of still images, e-health technologies, patient portals, and remote patient monitoring are all considered telehealth services.

Please initial by each of these points to indicate that you have read this, have had any concerns addressed and are in agreement:

_____I understand that telehealth involves the communication of my medical/mental health information, information in an electronic or technology-assisted format.

_____ I understand that I may opt out of the telehealth visit at any time, and if so future care will be determined at that time.

_____I understand that telehealth services can only be provided to clients who are residing in the state of North Carolina at the time of this service.

_____I understand that all electronic medical communications carry some level of risk. While the likelihood of risks associated with the use of telehealth in a secure environment is reduced, the risks are nonetheless real and important to understand. These risks include but are not limited to:

~ It is easier for electronic communication to be forwarded, intercepted, or even changed without my knowledge and despite taking reasonable measures.

~ Electronic systems that are accessed by employers, friends, or others are not secure and should be avoided. It is important for me to use a secure network.

~ Despite reasonable efforts on the part of my healthcare provider, the transmission of medical information could be disrupted or distorted by technical failures.

_____I understand that medical information, including medical records, are governed by federal and state laws that apply to telehealth. This includes my right to access my own medical records (and copies of medical records).

_____I understand that I will be seen via a HIPPA compliant platform and that if FaceTime, or similar services, are requested by you they will not secure HIPPA compliance.

_____I understand that I must take reasonable steps to protect myself from unauthorized use of my electronic communications by others.

____The healthcare provider is not responsible for breaches of confidentiality caused by an independent third party or by me.

Schedule of Fees

Initial Interview (Diagnostic Evaluation)	55 minutes $225
Individual Psychotherapy Session	55 minutes $185
Individual Psychotherapy Session	55 minutes $160
Individual Psychotherapy Session	30 minutes $120
Phone Consultation	each 15 minute period $ 75
Out of Office Consultation; including transportation	per hour $350
Court Testimony; to be paid in advance	per hour $500

Once an appointment hour is scheduled, you will charged for the session unless you provide 24 hours advance notice of cancellation. However, I recognize that occasionally there are some circumstances, to which I need to agree, that you are unable to attend due to circumstances beyond your control (such as unpredictable crisis or illness). It is important to note that insurance companies do not provide reimbursement for cancelled sessions.

NORTH CAROLINA NOTICE FORM

Notice of Psychotherapist Policies and Practices to Protect the Privacy of Your Health Information

THIS NOTICE DESCRIBES HOW PSYCHOLOGICAL 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 health care 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 you give me information that leads me to suspect child abuse, neglect, or death due to maltreatment, I must report such information to the county Department of Social Services. If asked by the Director of Social Services to turn over information from your records relevant to a child protective services investigation, I must do so.
Adult and Domestic Abuse: If information you give me gives me reasonable cause to believe that a disabled adult is in need of protective services, I must report this to the Director of Social Services.
Health Oversight: The North Carolina Psychology Board has the power, when necessary, to subpoena relevant records should I be the focus of an inquiry.
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 your written authorization, 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. You will be informed in advance if this is the case.
Serious Threat to Health or Safety: I may disclose your confidential information to protect you or others from a serious threat of harm by you.

Worker's Compensation: If you file a workers' compensation claim, I am required by law to provide your mental health information relevant to the claim to your employer and the North Carolina Indus- trial Commission.

IV. Client's Rights and Psychologist's Duties

Client'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 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.

Psychotherapist'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. Complaints

If you are concerned that I have violated your privacy rights, or you disagree with a decision I made about access to your records, please bring this to my attention as soon as possible. You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services.

VI. Effective Date, Restrictions and Changes to Privacy Policy

This notice is in effect as of April 14, 2003. I reserve the right to change the terms of this notice and to make the new notice provisions effective for all PHI that I maintain. I will provide you with a revised notice by mail.

Your signature indicates that you have read, understand and agree to abide to the terms of this document. It also indicates that you are acknowledging the receipt of the Notice of Privacy as outlined above.

____ ___________________
Signature Date

Name:____

Birthdate:_______________________

Gender Identity:___________

Address:____

Email address:____

Cell phone number:__________________Work number/other:______________________

_______Yes, it's okay to send messages to this email

I require an Emergency Contact Person (ECP) who I may contact on your behalf in a life-threatening emergency only. Please enter this person's name and contact information below.

Either you or I will verify that your ECP is willing and able to go to your location in the event of an emergency. Additionally, if either you, your ECP, or I determine necessary, the ECP agrees take you to a hospital. Your signature at the end of this document indicates that you understand I will only contact this individual in the extreme circumstances stated above.

Please list your ECP here:

Name:____

Phone:____