OPTIMAL HEALTH Psychological Services
Counselor – Patient Services Agreement

CONFIDENTIALITY

It is your legal right that sessions and records are kept private. Your confidentiality is protected by states laws and rules of the profession. However, there are a few rare situations in which confidentiality is not protected. Please see Florida Notice Form for the Health Insurance Portability and Accountability Act attached.

CONFIDENTIALITY REGARDING MINORS AND PARENTS

Patients under 18 years of age who are not emancipated and their parents should be aware that the law may allow parents to examine their child's treatment records. Privacy in psychotherapy is often crucial to successful progress. Thus, before giving parents any information, the counselor will discuss this with the child, if possible, and do their best to handle any objections he/she may have. If the counselor believes that a child is in danger or is a danger to someone else, they will immediately notify the parents of their concern.

EMERGENCIES

Your therapist will make every effort to be available in case of emergency. However, since our practice is for outpatient services only, we cannot guarantee around-the-clock availability. Therefore, if you should experience a crisis and your therapist cannot be reached immediately, you are instructed go to a local hospital emergency room or call 911 immediately.

PAYMENT/BILLING POLICIES

PSYCHOTHERAPY SESSIONS ARE 50 MINUTES. Longer sessions are available, but must be specifically arranged. Longer sessions are billed at a higher rate depending on the length of the session. Your Psychologist will spend some of this 50 minutes prior to and after your session making and reviewing notes regarding your treatment plan and progress.

Our usual office charge is $150.00 -$175.00 per session for counseling. Testing and assessment fees are $175.00 per hour. All fees shall be due and paid at the time the service is rendered. We accept Medicare. We are considered "out of network" or all other insurance companies. Reimbursement is typically between 50-80% of the fee for services. Payment is due at the times of the services rendered. If you would like to submit for insurance coverage, your therapist will provide a receipt of your payment for this purpose.

CANCELLATIONS AND MISSED APPOINTMENTS

ONCE AN APPOINTMENT IS MADE YOU ARE FINANCIALLY RESPONSIBLE

Your counseling requires that your counselor reserve a significant amount of time exclusively for your benefit. In the event that your schedule requires you to reschedule or cancel an appointment, we will be happy to do so with AT LEAST 48 HOURS NOTICE. This procedure allows the opportunity for this time to be available to other clients.

You will be charged the regular fee for services for failures to cancel with adequate notice. Charges for missed appointments cannot be submitted for health insurance reimbursement.

CONSENT TO TREATMENT

I, the undersigned, consent to mental health services. I am aware that the practice of medicine, psychiatry and psychology are not exact sciences and acknowledge that no guarantee has been made to me as to the results of evaluation or treatment, the number of sessions necessary, or the total cost of all services. I authorize The OHPS to bill my medical insurance and to release any information necessary to file a claim with my insurance company or any other agency or individual providing reimbursement services. Your contract with your health insurance company requires that we provide certain information relevant to the services which you receive. We are required to provide a clinical diagnosis and sometimes additional clinical information such as treatment plans, summaries, or copies of your entire Clinical Record. We 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. We will provide you with a copy of any report we submit, if you request it. By signing this Agreement, you agree that we may provide requested information to your carrier.

You may revoke this agreement in writing at any time. That revocation will be binding unless our office staff 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.

I have read, or have had read to me, the issues and points in this brochure. I have discussed those points I did not understand, and have had my questions, if any, fully answered. I have received a copy of the "Florida Notice Form" for the Health Insurance Portability and Accountability Act (HIPAA). **I agree to act according to the points covered in this agreement. I hereby agree to enter into therapy with this therapist (or to have the client enter therapy), and to cooperate fully and to the best of my ability, as shown by my signature here.**

The undersigned certifies that he/she has read this agreement and understands the foregoing and agrees to abide by its terms.

_____ _____

Patient's signature **Date**

If the patient is a minor, signature of individual with <u>legal</u> custody of child is required.

_____ _____

Parent or Guardian signature (Please circle one.) **Date**

_____

Printed name

Your signature below serves as an acknowledgement that you have been given a copy of and have read the "Florida Notice Form" for the Health Insurance Portability and Accountability Act (HIPAA).

_____ _____

Patient's signature Date

If the patient is a minor, signature of individual with <u>legal</u> custody of child is required.

_____ _____

Parent or Guardian signature (Please circle one.) Date

If Your Therapist Needs to Contact Someone about You

If there is an emergency, or your therapist becomes concerned about your personal safety to yourself or someone else, they are required by law and by the rules of the profession to contact someone close to you—perhaps a relative, spouse, or close friend. Please provide the name and information of your chosen contact person in the blanks provided:

Name: _____

Address: _____

Phone: _____ **Relationship to you:**_____

For Medicare Patients, please present with your paperwork: Health Insurance Card & Driver's License