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PRACTICE AGREEMENT

Welcome to our practice. This document contains important information about our 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 protection and patient rights with regard to 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 Practice (please see the separate document) for use and disclosure of PHI for treatment, payment, and health care operations. The law requires that we obtain your signature acknowledging that we have provided you with this information at the beginning of your treatment. Although this document is long, it is important that you read it carefully. We can discuss any questions you have during your appointment. When you sign this document, it will represent an agreement between us.

PSYCHOLOGICAL SERVICES

Our services vary depending on your needs. If you are interested in therapy, the first session will involve a detailed intake interview and paperwork to gather information about your history and presenting concerns. The next one to two sessions will involve ongoing evaluation of your needs. By the end of this evaluation process, your clinician will be able to offer you an initial impression of what your treatment will include and a plan to follow, if we decide to continue working together. If you have questions about procedures, please feel free to discuss them with your clinician at any time. If you are interested in psychological testing, you will complete an intake session, including paperwork related to history as well as relevant questionnaires and rating scales. If relevant, your clinician may request permission to reach out to other family members, educators, or health care providers for additional background information and for collateral reports on questionnaire measures. Your clinician will then determine the testing plan and schedule a follow-up appointment for testing procedures. This may occur all in one session or, if necessary, be spread out across several sessions to minimize fatigue. After testing is completed your clinician will prepare an integrated report which can be expected in 4-6 weeks following the completion of testing. When the report is available your clinician will schedule a feedback session to review results and discuss recommendations.

PROFESSIONAL FEE SCHEDULE**

The following schedule outlines the services available and the current fees associated with those services. Please note that these fees are reviewed periodically and subject to revision. Existing patients will receive 4 weeks notice before their fees are adjusted.

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Therapy Services

Intake Appointments	60 minutes	$225.00
	90 minutes (pre-arranged)	$335.00
Therapy Sessions		
	45-50 minutes	$165.00
	30 minutes (pre-arranged)	$120.00
	60 minutes (pre-arranged)	$225.00
	90 minutes (pre-arranged)	$335.00

Testing Services

The total cost of testing varies based on factors such as the nature of your concerns, the actual testing procedures, and the extent of documentation (i.e., report) prepared. Your clinician will provide you with an estimate of your testing and documentation fees at the conclusion of the intake appointment. Please be advised that testing typically takes two or more hours. The estimated cost may be different than the actual cost. Please note, early kindergarten testing has a different fee structure than standard psychological testing as it does not include an intake evaluation and testing is more abbreviated.

Barring typographic errors, the final report document will not be further modified. A redacted report that abbreviates psychosocial history may be requested for an additional fee. The term *test data* refers to raw and scaled scores, client/patient responses to test questions or stimuli, and psychologists' notes and recordings concerning client/patient statements and behavior during an examination. Those portions of test materials that include client/patient responses are to be considered part of the confidential test file, and will not be modified in any way following their collection. Legal and ethical standards dictate that portion of a patient's record cannot be released except to a qualified licensed psychologist, or under a judge's Protective Order.

Intake Appointment	60 minutes	$225.00
	90 minutes (pre-arranged)	$335.00
Face-to-face testing*	(per hour)	$225.00
Scoring/Interpretation/Comprehensive Report	(per hour)	$150.00

*includes both neuropsychological and psychoeducational testing

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Redacted Report Preparation (accompanying document with abbreviated psychosocial history)	(per hour, prorated)	$150.00
Classroom Observations	(per hour)	$250.00
Consultation with teacher(s)	(per hour, prorated)	$200.00
Attendance at school/IEP meeting	(per hour, prorated)	$250.00
Appointment to review results and recommendations	45 minutes 60 minutes	$165.00 $225.00
Early Kindergarten Testing	IQ only IQ & Achievement Full evaluation w/report	$200.00 $400.00 $650.00

Other Services/ Fees

Legal Proceedings	(per hour)	$500.00
Professional Consultation	15 minutes	$55.00
Communications (email, phone)	longer than 15 minutes	$55.00
Document preparation or review	15 minutes	$55.00
Late cancellations		$85.00
No show/missed appointment without notification		$165.00

***We reserve the right to alter and update the Fee Schedule at any time. All patients will be notified in writing of changes in fees at least 4 weeks prior to implementation.*

BILLING AND PAYMENTS

You will be expected to pay for each session at the time it is held, unless we agree otherwise. If you are filing with insurance your full co-pay is due at the time of service. We accept the following methods of payment: credit card, check, and cash. Checks need to be made out to Bull City

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Behavioral Health. Late charges will be added to accounts with any balance over 30 days old. Late Fees are calculated at a rate of 2% monthly. Services may be interrupted until payment is made. If your account has not been paid for more than 60 days and you have not arranged payment, we have the option of using legal means to secure payment, including collection agencies or small claims. In most collection situations, the only information released regarding a patient's treatment is his/her name, the nature of services provided, and the amount due. If such legal action is necessary, the costs will be included in the claim. Please note that if you become involved in any legal proceedings that require the participation of your clinician, you will be expected to pay for all of the professional time, including preparation and transportation costs, even if your clinician is called to testify by another party. Due to the difficulty of legal involvement, our fee is $500 per hour for preparation and attendance at any legal proceeding.

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 an insurance policy, it will usually provide some coverage for behavioral health treatment. While we will provide you with whatever assistance we can in helping you receive the benefits to which you are entitled, you (not your insurance company) are responsible for full payment of fees. It is therefore very important that you find out the extent to which my services are reimbursable through your insurance company. 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 or human resources consultant.

Clinicians at Bull City Behavioral Health are currently an in-network providers for the Duke Student Medical Insurance Plan (SMIP) and with most Blue Cross Blue Shield plans, and will assist you with filing these claims. At this time, we are "out-of-network providers" for all other insurance companies. We will provide you with a claim form at the time of service to submit to your insurance company for direct reimbursement. We strongly encourage you to contact your insurance company prior to initiating services to determine your out-of-network benefits. We cannot follow up on any disputed claims.

You also should be aware that if you request reimbursement from your insurance carrier, your contract requires that your clinician provide them with information relevant to the services that were provided to you. We are required to provide a clinical diagnosis and a service code. Sometimes we are required to provide information such as treatment plans or summaries or copies of your entire Clinical Record. In such situations, we will make every effort to release only the minimum information that is necessary for the purpose requested. Although all insurance

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companies claim to keep information confidential, we cannot control what they do with the information once they have it. In some cases they may share the information with a national medical information databank. We will provide you with a copy of any report we submit, if you request it. By signing this Agreement, you agree that we can provide requested information to your insurance carrier if you decide to submit claim forms to them for reimbursement.

It is important to remember that you always have the right to pay for my services yourself to avoid the problems described above (unless expressly prohibited by your insurance policy.) Paying for services yourself provides maximal privacy protection and control over the services you receive.

CANCELLATION POLICY

Your appointment time is reserved exclusively for you. Once this 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. In the event of inclement weather, contact your clinician directly for the day's schedule.

CONTACTING YOUR CLINICIAN

PHONE

Due to the nature of our work, your clinician may not be immediately available; we do not answer the phone when we are with patients. When your clinician is unavailable, their telephone is answered by voice mail, which is monitored frequently. Please leave a message for your clinician if you get their voicemail and they will make every effort to respond within 24 hours (with the exception of Sundays and holidays). If you cannot reach your clinician and feel that you have an emergency, call 911 or go to the nearest emergency room and ask for the psychiatrist on call. If your clinician will be unavailable for an extended period of time, you will be notified and provided with contact information for another clinician, if necessary.

EMAIL/ MESSAGING

Once your first appointment is scheduled you will receive online access to a HIPPA compliant, secure messaging system. This messaging system, provided through Simple Practice, is our preferred medium for all electronic communication. Should you decide to contact your clinician via email, which is not a secure means of communication, you are accepting the risk associated with transmitting personal information over the Internet. Emails should be limited to scheduling, as they are not a means by which we can provide appropriate clinical care.

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Please recognize that despite precautions and the use of a HIPPA compliant messaging system, a privacy breach is still possible. If there is a breach of your PHI, we will immediately inform you of the nature and extent of the information involved, the person who obtained the unauthorized access, and whether that person has an independent obligation to protect the confidentiality of the information, and the extent to which the risk has been mitigated, such as by obtaining a signed confidentiality agreement from the recipient.

LIMITS ON CONFIDENTIALITY

In general, the law protects the privacy of all communication 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. However, we must release information without consent in the following situations:

- If your clinician believes that a patient presents an imminent danger to him/herself, they may be required to seek hospitalization for the patient, or contact family members or others who can help provide protection.
- If there is cause to suspect that a child under 18 is abused or neglected or reasonable cause to believe that a disabled adult needs protective services, the law requires that a report be filed with the appropriate agency. Once such a report is filed, additional information may be required.
- If there is reason to believe that a patient presents an imminent danger to the health and safety of another, your clinician may be required to disclose information in order to take protective actions, including initiating hospitalization, warning the potential victim, and/or calling the police.
- If a patient files a complaint or lawsuit against your clinician, they may disclose relevant information regarding that patient in order to defend myself.

If such a situation arises in which confidential information needs to be released, your clinician will make every effort to fully discuss it with you before taking any action, and will limit the disclosure to only information that is necessary.

It is important for you to know that if you are involved in a court proceeding and a request is made for information concerning the professional services that were provided to you, such information is protected by the psychologist-patient privilege law. Your clinician cannot provide any information without your 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 your clinician to disclose information.

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Bull City Behavioral Health is a collaborative practice, which means that to provide you with the best possible care, clinicians may consult with one another when clinically indicated. If your clinician is out of town or for some other reason is unavailable, it is important that the other clinicians in the practice have access to relevant information and records in order to provide the best possible care for you.

MINORS AND PARENTS

Parental involvement is essential to successful treatment and therefore some private information should be shared with parents. It is our policy only to share information that is considered necessary with a minor patient's parents, such as general information about the progress of the child's treatment and his/her attendance at scheduled sessions. Before giving parents any information the clinician will make every effort to discuss this information with the child, if possible, and an attempt will be made to handle any objections he/she may have. Should legal/custody problems arise, we furnish treatment summaries only.

Children over the age of eighteen also have the right to independently consent to and receive mental health treatment without parental consent and, in that situation, information about that treatment cannot be disclosed to anyone without the patient's agreement.

PATIENT RIGHTS

HIPAA provides you with several new or expanded rights concerning your Clinical Records and disclosures of protected health information. These rights include requesting that we amend your record; requesting restrictions on what information from your Clinical Records is disclosed to others; requesting an accounting of most disclosures of protected health information that you have neither consented to nor authorized; determining the location to which protected information disclosures are sent; having any complaints you make about my policies and procedures recorded in your records; and the right to view and copy your records. We will be happy to discuss any of these rights with you. These rights are explained further in the HIPAA Privacy Notice.

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SIGNATURES

By signing below I _____, acknowledge that I understand and accept all the terms in the above agreement for services provided by my clinician.
(print your full name here)

I also acknowledge that I have received the HIPAA Notice described above.

_____

Patient's signature (required for patients 18 years or older) Date

_____

Parent or Legal Guardian's signature (required for minor patients 17 or younger) Date