



CLIENT SERVICE AGREEMENT and CONSENT FOR TREATMENT

Welcome to my practice. This document 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 federal law that provides privacy protections and patient rights about the use and disclosure of your Protected Health Information (PHI) for the purposes of treatment, payment, and health care operations. Although these documents are long and sometimes complex, it is very important that you understand them. When you sign this document, it will also represent an agreement between us. We can discuss any questions you have when you sign them or at any time in the future.

APPOINTMENTS

Appointments will ordinarily be 50- 60 minutes in duration. The frequency of the appointments will be determined based on clinical need and your availability. If I am not able to meet the desired frequency of care, I offer to refer you to another therapist. The time scheduled for your appointment is assigned to you and you alone. You are welcome to invite others to your session should we agree it is clinically appropriate. If you need to cancel or reschedule a session, I ask that you provide me with 48 hours notice. If you miss a session without canceling, or cancel with less than 48 hour notice, my policy is to collect the amount of \$75 [unless we both agree that you were unable to attend due to circumstances beyond your control]. It is important to note that insurance companies do not provide reimbursement for cancelled sessions; thus, you will be responsible for the portion of the fee as described above. If it is possible, I will try to find another time to reschedule the appointment. In addition, you are responsible for coming to your session on time; if you are late, your appointment will still need to end on time. I use a web-based system for scheduling and for reminders to be sent out via text.

TELETHERAPY

I will offer teletherapy when appropriate. I use a HIPAA protected platform. Please refer to the Tele-therapy consent that is located on my website, www.amywatsonpc.com.

PROFESSIONAL FEES

Fees are listed on the Disclosure Statement. You are responsible for paying at the time of your session unless prior arrangements have been made. Please note, rates are also driven by insurance plans and companies and I will abide by my fee schedule, which is many times different than my fees. I will accept cash, check, debit, flex cards and/or credit card as payment. Any checks returned to my office are subject to an additional fee of up to \$25.00 to cover the bank fee that I incur. I reserve the right to terminate services if payment is not received for provided services or inconsistency with attendance of appointments. My philosophy and goal are to provide affordable mental health services and remove financial barriers.

In addition to appointments, it is my practice to charge for the following for services non- therapeutic in nature that are not covered by insurance:

Copies	\$25.00
Court	\$150.00 / hour
Letters	\$50.00
Disability Paperwork	\$150.00
Phone Calls	First 5 min. free, beyond 5 min is standard rate

You may keep a credit card on file, in a secure site, to allow for easy payment.



INSURANCE

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. With your permission, I will assist you to the extent possible in filing claims and ascertaining information about your coverage, but you are responsible for knowing your coverage and for letting me know if/when your coverage changes.

You should also be aware that most insurance companies require a documented clinical diagnosis. (Diagnoses are technical terms that describe the nature of your problems and whether they are short-term or long-term problems). All diagnoses come from a book entitled the DSM-5. There is a copy in my office and I will be glad to let you see it to learn more about your diagnosis, if applicable.). Sometimes I have to provide additional clinical information such as treatment plans or summaries, or copies of the entire record (in rare cases). This information will become part of the insurance company file. Though all insurance companies claim to keep such information confidential, I have no control over what they do with it once it is in their hands.

If I am not a participating provider for your insurance plan, I will supply you with a receipt of payment for services, which you can submit to your insurance company for reimbursement. Please note that not all insurance companies reimburse for out-of-network providers. If you prefer to use a participating provider, I will refer you to a colleague.

PROFESSIONAL RECORDS

I am required to keep appropriate records of the therapy services that I provide. Your records are maintained in a secure location in the office, as well as in a HIPAA compliant Electronic Health Record. I keep brief records noting that you were here, your reasons for seeking therapy, the goals and progress we set for treatment, your diagnosis, topics we discussed, your medical, social, and treatment history, records I receive from other providers, copies of records I send to others, and your billing records. You have the right to your professional record. I require that I will review the record with you and answer any questions you may have re: the record. In some exceptional and unusual circumstances there are cases where it would be harmful for you or others to have access to the record. For this reason, I may suggest that I provide you with a written summary of treatment.

If an outside entity, i.e. medical professional, or other professional request your records, I require a consent to release the records and in some cases a court order. Please note, once the record leaves my office, I am not able to control the protection and safe guards of the record.

CONFIDENTIALITY

My policies about confidentiality, as well as other information about your privacy rights, are fully described in a separate document entitled Notice of Privacy Practices. You have been provided with a copy of that document and it is located on my web site (www.amywatsonpc.com). Please remember that you may reopen the conversation at any time during our work together. I am obligated by law and per licensure standards, that confidentiality may be broken in the event of abuse, neglect and exploitation. It may also be broken if I suspect harm to yourself or to others. I will make every effort to discuss and work through these issues with you.

You will receive a text/email reminder system for your appointments generated from a HIPAA compliant system. If you prefer not to receive text/email reminders, you are welcome to opt out of this benefit.

I require a court order should



CONTACTING ME

I am often not immediately available by telephone. I do not answer my phone when I am with clients or otherwise unavailable. At these times, you may leave a message on my confidential voice mail and your call will be returned as soon as possible, but it may take a day or two for non-urgent matters. If, for any number of unseen reasons, you do not hear from me or I am unable to reach you, and you feel you cannot wait for a return call or if you feel unable to keep yourself safe, call 911 and ask to speak to the mental health worker on call. I will make every attempt to inform you in advance of planned absences, and provide you with the name and phone number of the mental health professional covering my practice. You are welcome to text me or e-mail me at contact@amywatsonpc.com.

OTHER RIGHTS

If you are unhappy with what is happening in therapy, I hope you will talk with me so that I can respond to your concerns. Such comments will be taken seriously and handled with care and respect. You may also request that I refer you to another therapist and are free to end therapy at any time. You have the right to considerate, safe and respectful care, without discrimination as to race, ethnicity, color, gender, sexual orientation, age, religion, national origin, or source of payment. You have the right to ask questions about any aspects of therapy and about my specific training and experience. You have the right to expect that I will not have social or sexual relationships with clients or with former clients. You have the right to invite people to therapy that you feel safe with and have a desire to have them in session with you if their presence will help you achieve your therapy goals. If you are legally separated or divorced with joint custody of the minors involved in therapy, you have equal right to your child's progress in therapy per the 'Parents & Minors' section above. Custody papers will be requested to ensure compliance with the court order.

CONSENT TO OUTPATIENT THERAPY

Your signature below indicates that you have read and understand this Agreement and the Notice of Privacy Practices and agree to their terms and that you consent to outpatient services.

Signature of Patient or Personal Representative

Printed Name of Patient or Personal Representative

Date _____

Relationship of Personal Representative's Authority: _____