Case No. _____
Referred By _____

New Tampa Psychological Services, Inc.
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PSYCHOTHERAPIST-CLIENT SERVICES AGREEMENT: GENERAL INFORMATION. OFFICE POLICY. INFORMED CONSENT

Welcome and thank you for choosing me as your psychologist. I recognize the trust you place in me as your therapist and I will do everything I can to merit that confidence. One aspect of building trust lies in informing you of your rights as a therapy client, your obligations, confidentiality, other information relevant to treatment, and general office policies. This document is intended to provide you with a written record of your psychotherapy contractual arrangement. It also contains summary information about the Health Insurance Portability and Accountability Act (HIPAA), a new federal law that provides new privacy protections and new patient 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 I provide you with a Notice of Privacy Practices for use and disclosure of PHI for treatment, payment and health care operations. The Notice of Privacy Practices Form, which is attached to this agreement document, explains HIPAA and its application to your personal health information in greater detail. The law requires that I obtain your signature acknowledging that I have provided you with this information before the end of your first therapy session. Although these documents are long and sometimes complex, it is very important that you read them. Carefully review the information which follows and discuss with me any remaining questions you may have. When you sign this document, it will represent an agreement between us. You may revoke this agreement in writing at any time.

Goals and Therapeutical Approach:

Psychotherapy is not easily described in general statements. It varies depending on the personalities of the psychologist and the client and the particular problems. The major goal is to help you and/or your child to identify and cope more effectively with problems in daily living and to deal with inner conflicts which may disrupt ability to function effectively. All therapists operate from a particular theory and set of practices. There are many different methods I may use to deal with the problems you hope to address. You have the right to ask me about any of the procedures used in therapy and my reasons for using or suggesting certain techniques. Your therapy may also involve other modes of treatment such as couple, family, or group therapy. In order to facilitate effective treatment, you are responsible for providing necessary information and are expected to play an active role in your or your child's treatment, including working with me to outline treatment goals, assess progress, and completing homework assignments.

Psychotherapy can have benefits and risks. Since therapy often involves discussing unpleasant aspects of one's life, you or your child may experience uncomfortable feelings like sadness, guilt, anger, frustration, loneliness, and helplessness. On the other hand, psychotherapy has also been shown to have many benefits. Therapy often leads to better relationships, solutions to specific problems, and significant reductions in feelings of distress. However, there are no guarantees of what the client will experience. No therapist can guarantee success, however I certainly promise that I will bring all of my education and experience to bear in serving you.

Our first few sessions will involve an evaluation of your current concerns and needs as well as recording relevant details of your history and present life situation. By the end of the evaluation, I will be able to offer you some first impressions of what our work will include and a treatment plan to follow, if you decide to continue with therapy. You should evaluate this information along with your own opinions of whether you feel comfortable working with me. Therapy involves a large commitment of time, money, and energy, so you should be very careful about the therapist you select. You may expect assessment of treatment and progress to be a continuous and jointly defined process. While the success of your therapy depends on a host of factors, your prompt attendance and active participation will contribute to therapy effectiveness. Therapeutic work outside the therapy hour will usually maximize these effects and assist you in achieving treatment goals. If you have questions or concerns about my procedures or your treatment, we should discuss them whenever they arise. If your doubts persist, I will be happy to provide you with appropriate community referrals.

Appointments:

Appointments are usually 45 minutes. I normally conduct a treatment evaluation that will last from 2 to 4 sessions. During this time, we can decide if I am the best person to provide the services that you need in order to meet your treatment goals. If psychotherapy is begun, I will usually schedule one 45-minute session (one appointment hour of 45 minutes duration) per week at a time we agree on, although some sessions may be longer or more frequent. If you came to seek psychoeducational and/or psychological assessment, I will discuss with you in advance approximately how many hours of testing to expect.

An appointment is a commitment to our work. We agree to meet here and to be on time. If I am ever unable to start on time, I ask your understanding. I also assure you that you will receive the full time agreed to. If you are late, we will probably be unable to meet for the full time, because it is likely that I will have another appointment after yours.

You have the right to discontinue treatment at any time, but it is wise to discuss any decision with me as soon as possible so we can plan our final meeting(s).

Cancellation and Missed Appointments:

You will be billed the full session fee (not just a co-payment) for a session that you cancel with less than 48 hours notice. You will also be billed if you decide to leave the office prior to being seen. To cancel appointments, you may leave messages 24 hours per day on my voice mail. It is important to note that Insurance companies do not reimburse for no-show or late cancelled appointments. If advanced notice is provided, I will try to find another time to reschedule the appointment that week.

I maintain this policy in order to provide the best services possible and to make efficient use of available office hours. I keep a waiting list of clients who would like to be seen if an appointment becomes available. Appointments that are cancelled with very short notice or for which clients do not show make it impossible for me to offer that time to someone else. Additionally, a cancelled appointment delays our work. I will consider our meetings very important and ask you to do the same. Please try not to miss sessions if you can possibly help it. When you must cancel, please give me advance notice.

Office Contact and After Hours Phone Calls:

Due to my work schedule, I am often not immediately available by telephone. I will make every effort to return your call on the same day you make it, with the exception of weekends and holidays. If you are difficult to reach, please inform me of some times when you will be available. I do not communicate via e-mail on clinical matters with my clients because it is not secure. However, please feel free to contact me via email regarding scheduling. If you are unable to reach me and feel that you can't wait for me to return your call or in the event of a true psychiatric /medical emergency, contact your family physician or the nearest emergency room and ask for the psychologist/psychiatrist on call. If I will be unavailable for an extended time, I will provide you with the name of a colleague to contact, if necessary.

I do ask that non-emergency calls (except for the cancellation of next day appointments), be placed ONLY during normal business hours.

Fees and Payments:

Professional fees are discussed and agreed upon prior to the scheduling of the first session. You will be given advance notice if my fees should change. Fees are subject to change every six months. You will be expected to pay for each session at the time it is held, unless we agree otherwise or unless you have insurance coverage that requires another arrangement. Other fees and payment schedules for other professional services will be agreed to when they are requested (e.g., phone contacts over 5 minutes, school and home visits, travel beyond 5 miles, preparation of special forms, consults with other professionals etc.). If you become involved in legal proceedings that require my participation, you will be expected to pay for my professional time even if I am called to testify by another party. Because of the difficulty of legal involvement, my hourly fees for preparation and attendance at any legal proceeding are higher than my regular hourly fee. Some services may require payment in advance. Some of specific services that are sometimes requested or needed are:

Telephone consultations: I believe that telephone consultations may be suitable or even needed at times in our therapy. If so, I will charge you our regular fee, prorated over the time needed. If I need to have long telephone conferences with other professionals as part of your treatment, you will be billed for these at the same rate as for regular therapy services. If you are concerned about this, please be sure to discuss it with me in advance so we can set a policy that is comfortable for both of us. Of course, there is no charge for calls about appointments or similar business.

Extended sessions: Occasionally it may be better to go on with a session, rather than stop or postpone work on a particular issue. When this extension is more than 5 minutes, I will tell you, because sessions that are extended beyond 5 minutes will be charged on a prorated basis.

Psychological testing services: Psychological testing fees include the time spent with you, the time needed for scoring and studying the test results, and the time needed to write a report on the findings. The amount of time involved depends on the tests used and the questions the testing is intended to answer. This service will be charged on a prorated basis based on my hourly fee.

When a health insurance is used to meet this financial obligation and if I am a provider on your insurance company, I will file your insurance claim(s) but you are responsible for deductibles, co-insurance, and co-payments. If I am not a provider on your insurance company and you wish to use your insurance, I will provide you with a billing statement that provides the information necessary that enables you to receive the benefits to which you are entitled. Given that you (not your insurance company) are responsible for full payment of my fees, it is very important that you find out exactly what mental health services your insurance policy covers.

I accept cash or checks. There is a $25.00 fee for returned checks. In circumstances of unusual financial hardship, I may be willing to negotiate a payment installment plan. If your account has not been paid for more than 60 days and arrangements for payment have not been agreed upon, I have the option of using legal means to secure the payment. Your signature below indicates that you agree to pay for all professional services rendered. Necessary forms will be completed to help expedite insurance carrier payments when insurance is used. However, you are responsible for all fees (within 60 days) regardless of insurance coverage. In the event that collection agency or attorney fees are incurred in order to collect on your account, you will be held responsible for said fees.

I will assume that our agreed-upon fee-paying relationship will continue as long as I provide services to you and/or your child. I will assume this until you tell me in person and/or in writing that you wish to end it. You have a responsibility to pay for any services you receive, or any appointments that you miss without providing 48 hours notice, before you end the relationship.

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 a health insurance policy, it will usually provide some coverage for mental health treatment. 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. Of course, I will provide you with whatever information I can, based upon my experience.

Due to the rising costs of health care, insurance benefits have increasingly become more complex. It is sometimes difficult to determine exactly how much mental health coverage is available. "Managed Health Care" plans such as HMOs and PPOs often require authorization before they provide reimbursement for mental health services. These plans are often limited to short-term treatment approaches designed to work out specific problems that interfere with a person's usual level of functioning. It may be necessary to seek approval for more therapy after a certain number of sessions. While much can be accomplished in short-term therapy, some patients feel that they need more services after insurance benefits end. It is important to note that some managed-care plans will not allow me to provide services to you once your benefits end. If this is the case, I will do my best to find another provider who will help you continue your psychotherapy.

You should also be aware that your contract with your health insurance company requires that I provide it with information relevant to the services that I provide to you. I am required, at a minimum, to provide a clinical diagnosis. Sometimes I am required to provide additional clinical information such as treatment plans or summaries, or copies of your entire Clinical Record. In such situations, I 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 and will probably be stored in a computer. 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. In some cases, they may share the information with a national medical information databank. I will provide you with a copy of any report I submit, if you request it.

Letters/Forms:

It is my office policy to charge a fee for the dictation and transcription of letters, extensive disability forms, insurance forms (other than claim forms) and copies of Clinical Record. The fee is generally $25.00, but can be higher. Fees will be discussed at the time of the request. The processing of requested letters/forms can take up to two weeks, and may take longer. Please provide sufficient notice.

Property Damage:

Any damage to facility property, caused by you and/or your family member(s) or representative(s) will be billed to you at the cost of repair or replacement.

Confidentiality:

The law protects the privacy of all communications between a patient/client and a psychologist. Everything you tell me will be kept entirely private and confidential. To further protect the privacy of the therapeutic relationship, I will not even disclose whether or not you are a client, and I will protect all of your therapy records by keeping them in a locked filing cabinet. Unlike me, however, you are free to reveal whatever you want about your or your child's treatment. In most situations, I can only release information about the treatment to others if you sign a written authorization form that meets certain legal requirements imposed by HIPAA. There are other situations that require only that you provide written, advance consent. Your signature on this agreement document provides consent for those activities, as follows

1. I may occasionally find it helpful to consult other health and mental health professionals about a case. During a consultation, I make every effort to avoid revealing the identity of my client. The other professionals are also legally bound to keep the information confidential. If you do not object, I will not tell you about these consultations unless I feel that it is important to our work together. I will note all consultations in the Clinical Record.

2. Disclosures required by health insurers or to collect overdue fees (discussed further elsewhere in this document).

3. In most cases, if the person who referred you to me is another professional, I will send a brief note of thanks or call as a professional courtesy.

There are some situations where I am permitted or required to disclose information without either your consent or authorization:

1. If you are involved in a court proceeding and a request is made for information concerning your diagnosis and treatment, such information is protected by the psychologist-patient privilege law. I cannot provide any information without your (or your legal representative's) written authorization. However, if a judge issues me a legitimate court order, or if I receive a subpoena of which you have

been properly notified and you have failed to inform me that you oppose the subpoena, I may be legally required to disclose information about you. If you are involved in or contemplating litigation, you should consult with your attorney to determine whether a court would be likely to order me to disclose information.

2. If a government agency is requesting the information for health oversight activities, within its appropriate legal authority, I may be required to provide it for them.

3. If a client files a complaint or lawsuit against me, I may disclose relevant information regarding that client in order to defend myself.

4. If a client files a worker's compensation claim, and I am providing necessary treatment related to that claim, I must, upon appropriate request, submit treatment reports to the appropriate parties, including the client's employer, the insurance carrier, or an authorized qualified rehabilitation provider.

There are some situations in which I am legally obligated to take actions in an attempt to protect you or others from harm, and I may have to reveal some information about your treatment. These situations are

1. If I know, or have reason to suspect, that a child under 18 is abused, abandoned, or neglected by a parent, legal custodian, caregiver, or any other person responsible for the child's welfare, the law requires that I file a report with the Department of Child and Family Services. Once such a report is filed, I may be required to provide additional information.

If I know or have reasonable cause to suspect, that a vulnerable adult has been or is being abused, neglected, or exploited, the law requires that I file a report with the central abuse hotline. Once such a report is filed, I may be required to provide additional information.

If I believe that there is a clear and immediate probability of physical harm to the patient, to other individuals, or to society, I may be required to disclose information to take protective action, including communicating the information to the potential victim, and/or appropriate family member, and/or the police, or seeking hospitalization of the patient.

These situations are unusual in my practice. If any should arise I will make every effort to fully discuss it with you before taking any action, and I will limit my disclosure to what is necessary.

While this written summary of exceptions to confidentiality should prove helpful in informing you about potential problems, it is important that we discuss any questions or concerns that you may have now or in the future. The laws governing confidentiality can be quite complex, and I am not an attorney. In situations where specific advice is required, formal legal advice may be needed.

Emergency Contact Information:

Please write down the name and information of your chosen contact person for me to contact in case of an emergency during our work together or if I become concerned about your personal safety:

Name: _____

Address: _____

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

Consultations:

If you could benefit from a treatment I cannot provide, I will provide you with some referral names. You have a right to ask me about such other treatments, their risks, and their benefits. Based on what I learn about your problems, I may recommend a referral for a medical exam or medication evaluation. If I do this, I will fully discuss my reasons with you, so that you can decide what is best.

What to Expect from Our Relationship:

As a professional, I will use my best knowledge and skills to help you. This includes following the standards of the American Psychological Association (APA). In your best interests, the APA puts limits on the relationship between a therapist and a client, and I will abide by these. Let me explain these limits, so you will not think they are personal responses to you.

First, I am licensed and trained to practice psychology—not law, medicine, finance, or any other profession. I am not able to give you good advice from these other professional viewpoints.

Second, state laws and the rules of the APA require me to keep what you tell me confidential. You can trust me not to tell anyone else what you tell me, except in certain limited situations. I explained what those are in the "Confidentiality" section of this document. Here I want to explain that I try not to reveal who my clients are. This is part of my effort to maintain your privacy. If we meet on the street or socially, I may not say hello or talk to you very much. My behavior will not be a personal reaction to you, but a way to maintain the confidentiality of our relationship.

Third, in your best interest, and following the APA's standards, I can only be your therapist. I cannot have any other role in your life. I cannot, now or ever, be a close friend or socialize with any of my clients. I cannot be a therapist to someone who is already a friend. I can never have a sexual or romantic relationship with any client during, or after, the course of therapy. I cannot have a business relationship with any of my clients, other than the therapy relationship. Even though you might invite me, I will not attend your family gatherings, such as parties or weddings.

As your therapist, I will not celebrate holidays or give you gifts; I may not notice or recall your birthday; and may not receive any of your gifts eagerly.

Minor Patients:

The minor's (child under 18 years old) parent(s) or legal guardian(s) is/are always responsible for any charges incurred by the minor. Please do not ask me to bill a third party (other than insurance if you wish to use insurance). I am not a party to divorce decrees and therefore, the parent/guardian signing this form is responsible for payment.

It is important to note that Minor clients who are not emancipated should be aware that the law allows their parent(s) or legal guardian(s) to examine their treatment records. Children between 13 and 17 may independently consent to (and control access to the records) diagnosis and treatment in a crisis situation.

I view parents as the experts on their children and encourage them to be informed participants and advocates. With young children, I expect the parents to be partners in all phases of treatment and play a critical role. With teenagers, however, privacy in psychotherapy is often crucial to successful progress. Although parental involvement is also essential, it is usually my policy to request an agreement with a teenager and his / her custodial parent(s) about access to information. This agreement provides that during treatment, I will provide parents with only general information about the progress of the treatment. I will also provide parents with a summary of their child's treatment when it is complete. Any other communication will require the teenager's authorization, unless I feel that he /she is in danger or is a danger to someone else, in which case, I will notify the parent(s) of my concern. Before giving parents any information, I will discuss the matter with the child, if possible, and do my best to handle any objections he/she may have.

Professional Records and Patient Rights:

The laws and standards of my profession require that I keep Protected Health Information about you in your Clinical Record. Except in unusual circumstances that disclosure would physically endanger you and/or others or makes reference to another person (other than a health care provider) and I believe that access is reasonably likely to cause substantial harm to such other person, you may examine and/or receive a copy of your Clinical Record, if you request it in writing. Because these are professional records, they can be misinterpreted and/or upsetting to untrained readers. For this reason, I recommend that you initially review them in my presence. The exceptions to this policy are contained in the attached Notice of Privacy Policy Form. If I refuse your request for access to your records, you have a right of review, which I will discuss with you upon request.

In addition, I may keep a set of Psychotherapy Notes. These Notes are for my own use and are designed to assist me in providing you with the best treatment. While the contents of Psychotherapy Notes vary from client to client, they can include the contents of our conversations, my analysis of those conversations, and how they impact on your therapy. They also contain particularly sensitive information that you may reveal to me that is not required to be included in your Clinical Record. They also include information from others provided to me confidentially. Psychotherapy Notes if maintained are kept separate from your Clinical Record. Your Psychotherapy Notes are not available to you and cannot be sent to anyone else, including insurance companies without your written, signed authorization. Insurance companies cannot require your authorization as a condition of coverage nor penalize you in any way for your refusal to provide it.

HIPAA provides you with several new or expanded rights with regard to your Clinical Record and disclosures of protected health information. These rights include requesting that I 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 a paper copy of this agreement document, the attached Notice form, and my privacy policies and procedures. I am happy to discuss any of these rights with you.

Statement of Principles and Complaint Procedures:

It is my intention to fully abide by all the rules of the APA and by those of my state license. However, problems can arise in our relationship, just as in any other relationship. If you are not satisfied with any area of our work, please raise your concerns with me at once. Our work together will be slower and harder if your concerns with me are not worked out. I will make every effort to hear any complaints you have and to seek solutions to them. If you feel that I, or any other therapist, has treated you unfairly or has even broken a professional rule, please tell me. You can also contact the state or local psychological association and speak to the chairperson of the ethics committee

In my practice as a therapist, I do not discriminate against clients because of any of these factors: age, sex, marital/family status, race, color, religious beliefs, ethnic origin, place of residence, veteran status, physical disability, health status, sexual orientation, or criminal record unrelated to present dangerousness. This is a personal commitment, as well as being required by federal, state, and local laws and regulations. I will always take steps to advance and support the values of equal opportunity, human dignity, and racial/ethnic/cultural diversity. If you believe you have been discriminated against, please bring this matter to my attention immediately.

Summary of the Agreement and Consent for Treatment:

I have chosen to receive treatment services from New Tampa Psychological Services, Inc. If insured, these treatment services are under a benefit plan managed by my insurance carrier. My choice has been voluntary and I understand that I may terminate therapy at any time.

I understand that there is no assurance that I will feel better. Because psychotherapy is a cooperative effort between me and my therapist, I will work with Dr. Tsila Abush-Kirsh in a cooperative manner to resolve my difficulties.

I understand that during the course of my treatment, material may be discussed which will be upsetting in nature and that this may be necessary to help me resolve my problems.

I understand that records and information collected about me will be held or released in accordance with state laws regarding confidentiality of such records and information.

I understand that state and local laws require that my therapist report all cases of abuse or neglect of minors or vulnerable adults.

I understand that state and local laws require that my therapist report all cases in which there exists a danger to self or others.

I understand that there may be other circumstances in which the law requires my therapist to disclose confidential information.

I understand that I may be contacted by my insurance carrier to ensure continuity and quality of my treatment, and/or after the completion of treatment, to asses the outcome of treatment.

I have read and had explained to me the basic rights of individuals whose benefit plans are managed by my insurance carrier. These rights include:

1. The right to be informed of the various steps and activities involved in receiving services.

2. The right to confidentiality under federal and state laws relating to the receipt of services.

3. The right to humane care and protection from harm, abuse, or neglect.

4. The right to make an informed decision whether to accept or refuse treatment.

5. The right to contact and consult with counsel at my expense.

6. The right to select practitioners of my choice at my expense.

I also agree to pay New Tampa Psychological Services, Inc. for all services rendered and attest that I have been notified of said charges. In the event that provided services are covered by private insurance, I hereby assign such benefits to New Tampa Psychological Services, Inc. under said policy, and I agree to pay co-payment amounts which are my responsibility. I permit a copy of this signature to be used in place of the original on the claim form. Should my account fall into arrears, I agree to pay costs should this matter be referred to an attorney or a collection agency. I further consent to the release of information necessary to obtain payment. I understand that New Tampa Psychological Services, Inc. may disclose any and all records pertaining to my treatment to my insurance representatives (and to my primary care physician), if such disclosure is necessary for claims processing, case management, quality assurance or utilization review purposes. In addition, information to be kept anonymous may be made available to qualified personnel for research, audit, or program evaluation. I understand that I can revoke my consent at any time except to the extent that treatment has already been rendered or that action has been taken in reliance on this consent, and that if I do not revoke this consent, it will expire automatically one year after all claims for treatment have been paid as provided in the benefit plan.

By signing below, I am stating that I have read and understand this policy statement and have had any questions answered to my satisfaction.

I give consent:_____ I do not give consent:_____

I accept, understand, and agree to abide by the contents and terms of this agreement and further, consent to participate in evaluation and/or treatment.

I also hereby acknowledge that I have received HIPAA Notice of Privacy Practices and the HIPAA Policies and Procedures and had an opportunity to ask questions concerning it.

Name of Patient/Client (please Print) _____

Signature of Patient/Client :_____ Date:_____

Name of Parent, Guardian, or Authorize Representative (please Print if applicable):
_____

Signature of Parent, Guardian, or Authorize Representative (if applicable):
_____ Date:_____

The information contained in this document was reviewed with the patient (and/or the patient's representative) and all questions and concerns were discussed. My observations of the person's behavior and responses give me no reason to believe that this person is not fully competent to give informed and willing consent.

_____ _____
Tsila Abush-Kirsh, Ph.D. Date
New Tampa Psychological Services, Inc.

I truly appreciate the chance you have given me to be of professional service to you, and look forward to a successful relationship with you. If you are satisfied with my services as we proceed, I (like any professional) would appreciate your referring other people to me who might also be able to make use of my services.

___ Copy accepted by client ___Copy kept by therapist