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PSYCHOTHERAPIST-CLIENT SERVICES AGREEMENT

This document (the Agreement) 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 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 (the Notice) for use and disclosure of PHI for treatment, payment and health care operations. The Notice explains HIPPAA 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. Although these documents are long and sometimes complex, it is very important that you read them carefully. We can discuss any questions you have about the procedures at the next session. When you sign this document, it will also represent an agreement between us. You may revoke this Agreement in writing at any time. That revocation will be binding on me unless I have taken action in reliance on it; if there are obligations imposed on me 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.

PSYCHOLOGICAL SERVICES

Psychotherapy is not easily described in general statements. It varies depending on the personalities of the psychologist and client, and the particular problems you are experiencing. There are many different methods I may use to deal with the problems that you hope to address. Psychotherapy is not like a medical doctor visit. Instead it calls for a very active effort on your part. In order for the therapy to be most successful, you will have to work on things we talk about both during our sessions and at home.

Psychotherapy can have benefits and risks. Since therapy often involves discussing unpleasant aspects of your life, you may experience uncomfortable feelings like sadness, guilt, anger, frustration, loneliness, anxiety, and helplessness. People also sometimes make life changing decisions such as career changes and divorces. 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 feeling of distress. But there are no guarantees of what you will experience.

I normally conduct an evaluation that will last the first 2-4 sessions. During this time, either you or I can decide if I am the best person to provide the services you need in order to meet your treatment goals. Therapy involves a large commitment of time, money, and energy, so you

should be very careful about the therapist you select. If either you or I decide that I will not be your therapist, I will provide you with the names of other mental health professionals.

TeleHealth:

For the convenience of clients, I sometimes use vieo-conferencing/tele-health.

- There are potential benefits and risks of video-conferencing (e.g. limits to patient confidentiality) that differ from in-person sessions.
- Confidentiality still applies for telepsychology services, and nobody will record the session without the permission from the others person(s).
- We agree to use the video-conferencing platform selected for our virtual sessions, and the psychologist will explain how to use it.
- You need to use a webcam or smartphone during the session.
- It is important to be in a quiet, private space that is free of distractions (including cell phone or other devices) during the session.
- It is important to use a secure internet connection rather than public/free Wi-Fi.
- It is important to be on time. If you need to cancel or change your tele-appointment, you must notify the psychologist in advance by phone or email.
- We need a back-up plan (e.g., phone number where you can be reached) to restart the session or to reschedule it, in the event of technical problems.
- We need a safety plan that includes at least one emergency contact and the closest emergency room to your location, in the event of a crisis situation.
- If you are not an adult, we need the permission of your parent or legal guardian (and their contact information) for you to participate in telepsychology sessions.
- You should confirm with your insurance company that the video sessions will be reimbursed; if they are not reimbursed, you are responsible for full payment.
- As your psychologist, I may determine that due to certain circumstances, telepsychology is no longer appropriate and that we should resume our sessions in-person.

PROFESISIONAL FEES

The initial session (diagnostic interview) lasts approximately one hour and is $120. After this session, I usually schedule one 45-50 minute session per week. This 45-50 minute session, whether individual or conjoint, is $100. If you request a longer session, or if treatment may require it, we will discuss the fee. You will be expected to pay a $50 fee if you do not cancel within 24 hours or if you fail to show for a scheduled appointment, unless we both agree that you were unable to attend the session due to circumstances beyond your control. It is important to know that insurance companies do not provide reimbursement for cancelled or failed to keep appointments. In addition to therapy appointments, I charge $130 per hour for other professional services you may need, though I will break down the hourly cost if I work for periods of less than one hour. Other services include report writing, telephone conversations lasting longer than 10 minutes, consulting with other professionals with your permission, preparation of records or treatment summaries, and the time spent performing any other service you may request of me. If you become involved in legal proceedings that require my participation, you will be expected to pay for all of my professional time, including preparation and transportation costs, even if I am called to testify by another party. Because of the difficulty of legal involvement, I charge $175

per hour for preparation and attendance at any legal proceeding. Any check returned from the bank results in a $30 redeposit fee. You will be expected to pay for each session at the time it is held, unless we agree otherwise or you have insurance that requires another arrangement.

I understand that if I fail to cancel an appointment within 24 hours or if I fail to show for a schedule appointment, that the charge will be $50. _____Please initial.

CONTACTING ME

Due to my work schedule, I am often not immediately available by telephone. I have another position that may require travel and being out of my office. I do not answer phones when I am with clients. When I am unavailable the secretary will answer my calls or you can leave it on voice mail. I will make every effort to return your call on the same day you make it, but it may sometimes be the next business day, with the exceptions of weekends and holidays. If you are difficult to reach, please inform me when you will be available. Emergencies should be rare, but if we can anticipate one, we will arrange a plan that may include using family members, the emergency room or some other plan. If there is an emergency without this plan, you will need to call your family physician, or nearest emergency room and ask for the psychologist or psychiatrist on call.

LIMITS ON CONFIDENTIALITY

The law protects the privacy of all communications between a client and a psychologist. In most situations, I can only release information about your 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 provides consent for those activities, as follows:

- I may occasionally find it helpful to consult other health and mental health professionals about your care. During consultation, I make every effort to avoid revealing the identity of my clients. 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 consultation in your Clinical Record (which is called "PHI" in my Notice Psychologist's Policies and Practices to Protect the Privacy of Your Health Information).
- I am an independent practitioner.. PHI is not shared with those mental health professionals and records are separately stored. I only share protected information with my office staff for both clinical and administrative purposes, such as scheduling, billing and quality assurance. My staff is bound by the same rules of confidentiality, and they have been given training about protecting your privacy and has agreed not to release any information outside of the practice without my permission.

Disclosures required by health insurers are discussed elsewhere in this Agreement. There are some situations where I am permitted or required to disclose information without either your consent or Authorization:

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- If you are involved in a court proceeding and a request is made for information concerning the professional services I provided you, such information is protected by the psychologist-client privilege law. I cannot provide any information without your

written 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 me to disclose information.

- If a government agency is requesting the information for health oversight activities, I am required to provide it to them.
- If a client files a complaint or lawsuit against me, I may disclose relevant information regarding that client in order to defend myself.
- If I am treating a client who files a worker's compensation claim, I may, upon appropriate request, be required to provide otherwise confidential information to the patient's employer, the insurer, or the Workers' Compensation Commission.

There are some situations in which I am legally obligated to take actions, which I believe are necessary to attempt to protect others from harm and I may have to reveal some information about a client's treatment. These situations are unusual in my practice.

- If I receive information that gives me reason to believe that a child's physical or mental health or welfare has been or may be adversely affected by abuse or neglect, or by acts or omissions that would be abuse or neglect if committed by a parent or other caretaker, the law requires that I file a report with the county Department of Social Services. If I believe that a child has been or may be abused or neglected by any other person, I must report that to the appropriate law enforcement agency. Once such a report is filed, I may be required to provide additional information.
- If I have reason to believe that a vulnerable adult has been or is likely to be abused, neglected, or exploited, the law requires that I file a report to the Adult Protective Services Program. Once such a report is file, I may be required to provide additional information.
- If I believe that a client presents a clear and substantial risk of imminent, serious harm to another, I may be required to take protective action, including notifying the potential victim, contacting the police, and/or seeking hospitalization for the client.
- If a client threatens to harm himself/herself, I may be obligated to seek hospitalization for him/her, or to contact family members or others who can help provide protection.
- If a client reveals his or her intent to commit a crime, I may be required to take preventative action, such as calling the police.

If such a situation arises, 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.

PROFESSIONAL RECORDS

You should be aware that, pursuant to HIPAA, I may keep Protected Health Information about you in two sets of professional records, but I do not. The laws and standards of my profession require that I keep Protected Health Information about you in your Clinical Record, which is the only professional record I keep. It includes information about your reasons for seeking therapy, a description of the ways in which your problem impacts on your life, your diagnosis, the goals that we set for treatment, your progress towards those goals, your medical and social history, your treatment history, any past treatment records that I receive from other providers, reports of any professional consultations, your billing records, and any reports that have been sent to anyone, including reports to your insurance carrier. Except in unusual circumstances that involve danger to yourself and others, or where information has been supplied to me confidentially by others, or the record makes reference to another person (unless such other person is a health care worker/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, or have them forwarded to another mental health professional so you can discuss the contents. The exceptions to this policy are contained n the attached Notice Form. If I refuse your request for access to your Clinical Record, you have a right of review (except for information supplied to me confidentially by others) which I will discuss with you upon request.

CLIENT RIGHTS

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 restriction on what information from your Clinical Record 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 of this Agreement, the Notice form, and my privacy policies and procedures. I am happy to discuss any of these rights with you.

South Carolina provides the consumer the opportunity to file inquires with its Board of Examiners in Psychology. Board offices may be reached at: South Carolina Board of Examiners in Psychology, PO Box 11329, Columbia, SC 29211-1329.

MINOR AND PARENTS

Clients under 18 years of age who are not emancipated from their parents should be aware that the law allows parents to examine their child's Clinical Records, unless I decide that such access is likely to injure the child, or we agree otherwise. Because privacy in psychotherapy is often crucial to successful progress, particularly with teenagers, it is sometime my policy to request an agreement from parents that they consent to give up their access to their child's records. If they agree, during treatment, I will provide them only with general information about the progress of the child's treatment, and his/her attendance at scheduled sessions. Any other communication will require the child's Authorization, unless I feel that the child is in danger or is a danger to someone else, in which case, I will notify the parents 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.

BILLING AND PAYMENTS

You will be expected to pay for each session at the time it is held unless you have insurance coverage that requires another arrangement. Payment schedules for other professional services will be agreed to when they are requested. **If I am not a participating provider for the insurance company you are with, the full fee is expected until we receive a payment from your insurance.**

INSURANCE REIMBURSEMENT

You should read carefully the section in your insurance coverage booklet that describes your mental health coverage. If you have questions, call your plan administrator. Because of the increasing complexity and day to day changes in insurance plans, my secretary cannot know or be responsible for knowing about your insurance coverage. She will file your claim for you as a courtesy provided by this office, but cannot answer questions about your specific policy. She will provide you with any assistance that she can based on information that she has obtained, however, you are responsible for knowing about your coverage. You (not your insurance company) are responsible for full payment of my fees.

Please initial that you have read the following statements concerning insurance:
I am aware that even though I have met my deductible with my health coverage, I may have another deductible for mental health.

_____Please initial

I am aware that if Dr. Aucoin is not a participating provider with my insurance company, that there may be a deductible (other than my health care deductible) for seeking services from a non-participating provider.

_____Please initial

I am aware that my insurance policy may request authorization of services and that it is my responsibility to call my company prior to my initial appointment with Dr. Aucoin to obtain this authorization.

_____Please initial

I am aware that when insurance companies state that they will pay 50% of the "allowed amount," it is 50% of their allowed amount, which may be different from my charge.

_____Please initial

You should also be aware that your contract with your health insurance company requires that I provide them with information relevant to the services that I provided to you. I am required to provide a clinical diagnosis. Sometimes I am required to provide additional clinical information

such as treatment plans or summaries. 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 claims 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. *By signing this Agreement, you agree that I can provide requested information, including diagnoses and treatment notes, to you carrier.*

I am aware that a diagnosis must be given to my insurance carrier before my claim is processed and that my insurance carrier may request treatment notes and treatment summaries in addition to this diagnosis.

_____Please initial

I am aware that I may choose not to use insurance and pay for the fee in full. I am aware that I may request filing of insurance at a later time if I either change my mind or receive new insurance coverage. If I choose to have my insurance filed by this office after therapy sessions have begun, I am aware that this office will only file claims from the date I give insurance information and permission and will not file insurance for pay prior dates of service.

_____Please initial

YOUR SIGNATURE BELOW INDICATES THAT YOU HAVE READ THIS AGREEMENT AND AGREE TO ITS TERMS AND ALSO SERVES AS AN ACKNOWLEDGEMENT THAT YOU HAVE RECEIVED THE HIPAA NOTICE FORM DESCRIBED ABOVE.

_____	_____	_____
Signature	Print Name	Date
_____	_____	_____
Signature (if conjoint therapy)	Print Name	Date