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GARIN DOUGLAS VICK, PSY.D.

CLINICAL & FORENSIC PSYCHOLOGY

Psychotherapist-Client Services Agreement

Welcome to our practice. This document contains important information about my professional services and business policies. We also comply with the Health Insurance Portability and Accountability Act (HIPAA), a recent federal law that provides new privacy protections and new client rights with regard to the use and disclosure of your Protected Health Information (PHI). HIPAA requires that we provide you with a Notice of Privacy Practices for use and disclosure of PHI for treatment, payment, and health care operations. This notice, which is attached to this contract, explains HIPAA and its application to your personal health information in detail. The law requires that we obtain your signature acknowledging that we have provided you with this information. When you sign this document, it also represents an agreement between us. Please read it carefully and note any questions that you might have so we can discuss them at our next meeting. Your signature below indicates that you have read and understand the information in this document and agree to abide by its terms during our professional relationship. In addition, you agree that you have read and understood my "Notice of Privacy Practices" and agree to participate in treatment under the terms set forth.

Psychological Services

The first few sessions will involve an evaluation of you or your child's needs. By the end of the evaluation, we will be able to offer you some initial impressions of what our work will include and an initial treatment plan to follow, if you decide to continue. You should evaluate this information along with your own assessment of whether you feel comfortable working with us. Therapy involves a large commitment of time for both child and family, money, and energy, so you should be very careful about the therapist you select. If you have questions about my procedures, we should discuss them whenever they arise.

Meetings

If using insurance and therapy is initiated, we will usually schedule one appointment of **45** minutes per week at a mutually agreed upon time, although sometimes sessions will be longer or scheduled more or less frequently. For self-paying clients, therapy sessions will be scheduled for **60** minutes in duration. Once appointments are scheduled, you will be expected to pay for them unless you provide **24-hour** advance notice of cancellation. **It is important to note that insurance companies do not provide reimbursement for cancelled sessions.**

Professional Fees

My hourly fee is **$200.00** for an intake evaluation, **$200.00** for individual/family therapy, and **$200.00** per hour for testing. If at any time my financial situation changes, I agree to discuss this with my therapist. In addition to weekly appointments, I charge this amount for other professional services you may need, though I will break down the hourly cost if I work for periods less than one hour. Other services include report writing, 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 Dr. Vick becomes involved in litigation (including any subpoena), which requires his professional participation, I accept I will be required to pay for the professional time required (including phone calls), even if Dr. Vick is compelled to testify by another party. I acknowledge professional fees will apply to any service that relies on Dr. Vick's professional training, is for my benefit, and for which I am liable. I understand: charges will be based on **$400.00** hourly rate; billing will be charged by the minute; and charges for depositions or court appearances will be portal to portal.

_____ **Initials**

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Appearance in court involves your permission to testify, OR the court's permission to allow my testimony. If requested by the court, or if I myself request to testify for any reason, you agree to pay my standard fee of **$400.00/hour** at the percentage ordered by the court, for any and all time expended in preparation, travel, or testimony. In the event that I serve as a witness, expert witness or any other role in any litigation or hearing or other legal proceeding, you agree to pay my standard fee of **$400.00/hour** for any time expended in such testimony. This includes preparation time, travel, testimony time, or time waiting to testify, whether or not my testimony is actually taken. You agree not to request or subpoena for any reason any of my personal notes, interview summaries, records, drafts, or any documents used in the course of your or your child(s) treatment. Should any signatory of this agreement seeks to compel me to provide information in a court proceeding or elsewhere, you agree in advance that this person will compensate me, at the rate of **$400.00/hour**, for any and all time expended in response to this request for release or subpoena of information, including preparation and court time, document review and phone calls, all travel time (portal to portal), all time expended invoicing, correspondence, etc…plus the cost of all legal services which I may employ to defend the integrity of this process. If requested to testify by the court or any party to this case, you authorize me to testify to the court regarding any and all specifics contained within my case file and/or the process of reaching my conclusions and recommendations. You agree to pay my normal compensation fee of **$400.00/hour**, which shall include any and all time expended in the course of any and all court appearances associated with this process. You also understand and agree that any court appearance will require an additional retainer of **$2500.00** by the requested party before I will appear to testify. If additional time not covered by this retainer is required in the course of any court appearance, you agree to compensate me for all additional time expended, at my normal fee of **$400/hour**, upon presentation of final invoice. If both parties request my presence in court, the retainer fee and any additional fees can be split according to percentage agreed upon between the parties or as ordered by the court. Any unused portion of the retainer will be returned to appropriate party or parties upon completion of all court action.

Cash or checks accepted, please make checks payable to Youth Psychological Assessment & Therapy Center, Inc. or Dr. Garin Vick. A **$25.00** fee will be charged for returned checks.

Psychological Testing

You always have the opportunity to ask questions regarding the testing process. It is important to be aware that the information and results obtained from testing can have profound implications on your child and family. No promises can be made regarding the results of the assessment. In the first session, I will inform you of the expected fee, based on the information that you have provided me. However, should it become apparent over the course of the evaluation, that more testing is necessary; we will inform you immediately of my recommendation. All psychological evaluations include a clinical interview, psychological testing, a copy of the final report, and a feedback session to you (the parents) explaining the results. Schedule and time permitting, we will also provide telephone or in person feedback to your child's school upon your request.

Billing and Payments

You will be expected to pay for each session at the time it is held, unless we agree otherwise. Payment scheduled for other services will be agreed to at the time these services are requested. If your account is more than 60 days in arrears and suitable agreements have not been made, I have the option of using legal means to secure payment, including collection agencies or small claims court. In most cases, the only information which I release about a client's treatment would be the client's name, the nature of services provided and the amount due.

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Insurance Reimbursement

In order for us to set realistic treatment goals and priorities, it is important to evaluate what resources are available to pay for treatment. If you have a health insurance policy, it will usually provide some coverage for mental health treatment. You, and not your insurance company, are responsible for full payment of the fee to which we have agreed. Therefore, it is very important that you find out exactly what mental health services your insurance policy covers. You should also be aware that most insurance agreements require you to authorize us to provide a clinical diagnosis and sometimes additional information such as a treatment plan or summary or, in rare cases, a copy of the entire record. This information will become part of the insurance company files and in all probability, some of it will be computerized. All insurance companies claim to keep such information confidential, but once in their hands, we have no control over what they do with it. In some cases, they may share the information with a national medical information data blank. If you request it, we will provide you with a copy of any report which we submit. Insurance is a complex issue. We ask clients to **call your insurance company** to discover what your mental health coverage provides.

Mental health coverage is usually different than physical health coverage. Please ask if you need precertification, what your co-pay is given my hourly rate, and how many sessions you are allowed in what period of time. We provide the courtesy of billing your primary insurance company, and ask you to make your co-payment at the time of service. We also ask that you assume responsibility for tracking the usage of allotted sessions. In this regard, you should take the initiative to discuss with Dr. Vick (1) the number of sessions remaining before further approval is needed and/or (2) when no further sessions are available under your policy.

Ultimately, you are responsible for full payment of fees that your insurance company does not agree to cover. You are responsible for discussing any disputes regarding coverage with your health insurance company. Once we have all the information about your insurance coverage, we will discuss what we can expect to accomplish with the benefits that are available and what will happen if they run out before you feel ready to end your sessions. It is important to remember that you always have the right to pay for my services yourself to avoid the problems described above [unless prohibited by contract].

Contacting your Therapist

We are often not immediately available by phone. When we are unavailable, our telephones are answered by an answering machine which we monitor at least daily. We will make every effort to return your call on the same day you make it with the exception of holidays. **It is important to note that we do not provide crisis services.** Should you require after-hours services due to mental or emotional distress, please contact your family physician or the emergency room at the nearest hospital and ask for the psychologist or psychiatrist on call. If we are unavailable for an extended time, we will provide you with the name of a trusted colleague whom you can contact, if necessary.

Professional Records

You should be aware that pursuant to HIPAA, we keep PHI about you in two sets of professional records. One set constitutes your Clinical Record. It includes information about your reasons for seeking services, a description of the ways in which our problem impacts your life, your diagnosis, the goals we set for treatment, your progress towards those goals, your medical and social history, your treatment history, any past treatment records that we receive from other providers, reports of any professional consultations, your billing records, and any reports that have been sent to anyone, including reports sent to your insurance carrier. Except in unusual circumstances that disclosure would physically endanger you and/or others, or makes reference to another person (other than the health care provider) and we 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

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misinterpreted and/or upsetting to untrained readers. For this reason, we 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 in the attached Notice Form. If we refuse your request for access to your Clinical Records, you have a right of review, which we will discuss with you upon request. In addition, we also keep a set of Psychotherapy Notes. The 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. These Psychotherapy Notes 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.

Minors and Parents

Clients 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. Children between 13 and 17 may independently consent to diagnosis and treatment in a crisis situation. Since privacy in psychotherapy is often crucial to successful progress, and parental involvement is also essential, it is usually my policy to request and agreement with minors and their parents about access to information. This agreement provides that during treatment, we will provide parents only with general information about the progress of treatment, and the client's attendance as scheduled sessions. We can also provide parents with a summary of their child's treatment when it is complete. Any other communication will require the child's authorization, unless we feel that the child is in danger or is a danger to someone else. In this case, we will inform the parents of our concern.

Confidentiality

In general, the confidentiality of all communications between a client and a psychologist is protected by law, and Dr. Vick can only release information about our work to others with my written permission. However, there are a number of exceptions.

In most judicial proceedings, I have the right to prevent Dr. Vick from providing information about my treatment. However, in some circumstances such as child custody proceedings and proceedings in which an emotional condition is an important element, a judge may require Dr. Vick's testimony if he determines that resolution of the issues demands it.

There are some situations in which Dr. Vick is legally required to take action to protect others from harm, even though that requires revealing some information about a client's treatment. For example, if Dr. Vick believes that a child, an elderly person, or a disabled person is being abused, they must file a report with the appropriate state agency.

If Dr. Vick believes that a client is threatening serious bodily harm to another, they are required to take protective actions, which may include notifying the potential victim, notifying the police, or seeking appropriate hospitalization. If a client threatens to harm himself or herself, Dr. Vick may be required to seek hospitalization for the client or to contact family members or others who can help provide protection.

Dr. Vick may occasionally find it helpful to consult about a case with other professionals. In these consultations, they will make every effort to avoid revealing the identity of his client. The consultant is, of course, also legally bound to keep the information confidential.

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Unless you object, Dr. Vick will not tell you about these consultations unless he feels that it is important to your work together. 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 at our next meeting.

Courtesy Call Policy

We would like to know if you want to be on our courtesy call/message list. Please place your name, and number to call below. The only information disclosed will be the clinician's name, and the date and time of the appointment. Please fill out the following below: Please check whether you'd like to receive a courtesy call/message prior to your appointment:

___ Yes ____ No Number: (___)_____

Be aware that by signing this form you are releasing us from any liability associated with leaving information regarding your or your child's appointment.

Name (print): _____

Signature: _____ Date: _____

Assignment of Benefits

I, hereby, request that payment of authorized Medicare, Medigap, Medicaid, private commercial insurance or any other governmental insurance be made on my behalf to **Garin Vick, Psy.D. at the Youth Psychological Assessment and Therapy Center, Inc.** for any services furnished to me. I authorize a holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services, and to release all or part of my medical record be whatever means required for payment of my charges be any insurance carrier(s) or other designee(s). I also authorize release of information necessary for filing claims to the HIPPA compliant medical billing service designated by Dr. Vick. I understand that my signature below acts as a signature on file. I understand my insurance company may be contacted prior to the delivery of services if precertification is needed to authorize payment of services.

_____ _____
Signature of Client or Parent/Guardian Date

_____ _____
Signature of Client or Parent/Guardian Date

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