PSYCHOLOGIST/MENTAL HEALTH PROFESSIONAL
PATIENT SERVICES AGREEMENT

This document is a summary of information about Psychological Service Associates, Inc.'s (PSA) professional services and business policies (a complete copy of this Agreement is available upon request). It also contains summary information about the Health Insurance Portability and Accountability Act (HIPAA), a federal law that provides privacy protections and 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.

PSA's Associates have many different methods to use to deal with the problems that you hope to address. Therapy calls for a very active effort on your part and can have benefits and risks. Therapy may involve discussing unpleasant aspects of your life, and often leads to better relationships, solutions to specific problems, and significant reduction in feelings of distress. There are no guarantees of what you will experience.

Your first few sessions will involve an evaluation of your needs which will lead to a treatment plan. Therapy involves a commitment of time, money and energy; so you should be very careful about the therapist you select. If you have any doubts about our procedures, we should discuss them whenever they arise. Each Provider normally conducts an evaluation that will last from one to four sessions. During that time, you and your Provider can both decide if the therapist is the best person to provide the services you need in order to meet your treatment goals.

Our hourly fee varies from $90.00 to $200.00 depending upon the service provided and the provider. There are separate fees for psychological testing, report preparation, participation in legal proceedings, and the time spent performing any other service you may request.

Once an appointment is scheduled, you will be expected to keep that appointment unless this office receives a 24-hour notice of cancellation. A fee may be charged for appointments cancelled without sufficient notice, and insurance companies do not provide reimbursement for cancelled/missed sessions. You will be responsible for payment of these fees. If you do not initiate contact with your insurance carrier for pre-authorization of your appointments (when it is your responsibility to do so), you will be responsible for fees incurred for those sessions. Some therapists in this office make their own appointments. Due to work schedules, a therapist often is not immediately available by telephone. Please leave your name and a number where you can be reached, and the therapist will make every effort to return your call on the same day you leave a message.

You should be aware that pursuant to HIPAA, PSA may keep Protected Health Information about you in two sets of professional records. One set would constitute your Clinical Record, and the other set includes Psychotherapy Notes. HIPAA provides you with new or expanded rights with regard to these professional records. Patients under 18 years of age who are not emancipated from their parents should be aware that the law may allow parents to examine their child's treatment records. The limits on confidentiality are discussed in the Notice of Provider's Policies and Practices to Protect the Privacy of Your Mental Health Information.

Your signature below indicates that you have read the information in this document and the Notice of office practices and privacy efforts and agree to abide by its terms during our professional relationship.

SIGNATURE ON FILE, ASSIGNMENT OF BENEFITS, FINANCIAL AGREEMENT

1. **MEDICARE / MEDIGAP / OTHER INSURANCE:** I request that any payment of authorized Medicare benefits be made on my behalf to Psychological Service Associates, Inc. (PSA) for services furnished me by PSA. I authorize PSA to release to the Health Care Insurance Financing Administration and its agents any information needed to determine these benefits or the release of health information necessary to pay the claim. If other health insurance is indicated on other any claim forms, my signature authorizes releasing the information to the insurer or agency shown. PSA accepts the charge determination of the Medicare carrier as the full charge, and I am responsible only for the deductible, coinsurance, and non-covered services. Coinsurance and deductibles are based upon the charge determination of the insurance/Medicare carrier.

   A MediGap policy is health insurance sold by private insurance companies to fill the "gaps" in Original Medicare Plan coverage. MediGap policies help pay some of the health care costs that the Original Medicare Plan does not cover. I understand that if a MediGap policy or other health insurance is indicated on any approved claim forms, my signature authorizes release of the information to the insurer or agency shown. I request that payment of authorized secondary insurance benefits be made on my behalf to PSA if possible or otherwise to me.

2. **RELEASE OF INFORMATION:** PSA may disclose all or any part of my health record and/or financial ledger to any person or corporation (1) which is or may be liable or under contract to PSA for reimbursement for services rendered, and (2) any health care provider for continued patient care.

3. **NON-COVERED SERVICES:** The undersigned accepts full financial responsibility for all items and services which are determined by my insurance plan not to be covered. The undersigned agrees to cooperate with PSA to obtain necessary healthcare service plan authorizations.

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4. **FINANCIAL AGREEMENT:** I agree that in return for the services provided to the patient by PSA, I will pay my account at the time service is rendered or will establish financial arrangements satisfactory to PSA for payment. If an account is sent to an attorney for collection, I agree to pay collection expenses, court filing fees and reasonable attorney's fees as established by the court. I understand and agree that if my account is delinquent, I may be charged a service fee. Any benefits of any type under any policy of insurance insuring the patient or any other party liable to the patient is hereby assigned to PSA. If co-payments and/or deductibles are defined by my insurance company or health plan, I agree to pay them to PSA. It is understood that the undersigned and/or the patient are primarily responsible for the payment of my bill.

5. **DIVORCED PARENTS:** The parent bringing the child to our facility will be responsible for required co-payments, deductibles, etc. at the time of service, unless court ordered or contracted otherwise.

6. **PRIVACY PLAN:** I agree that I have been given the opportunity to read and receive a copy of the PSA "Notice of Policy and Privacy Practices."

This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original.

Patient Signature *(Signature of Parent or Guardian if Patient is a Minor)*	Relationship to Patient
Printed Name	/ / Date
Witness	/ / Date