

## MPC Patient Policies and Information Agreement

### Services

I agree to discuss the goals and potential consequences of assessment and therapy with my doctor. I understand this is a joint effort between the doctor and the patient, the results of which cannot be guaranteed. Progress depends on many factors, including motivation, effort, and other life circumstances, such as interactions with family, friends, and others. I also understand that there are risks to such treatment, and that I might at times feel sadness, guilt, anger, frustration or even loneliness and helplessness. The benefits are that I may be able to have better relationships and significantly reduce my feelings of distress. If I am bringing in my minor child, I recognize that he or she is also subject to the same risks and benefits. If I feel I am not making adequate progress, I will discuss my concerns with my doctor immediately.

I understand that the first session will be an evaluation of my needs (or the needs of my child, if I am bringing a child in for treatment), and that further treatment recommendations will be made to me after that first evaluation session. Treatment sessions consist usually of one 45-50-minute session, which constitutes one billable hour. I recognized that I may terminate services at any time. My doctor can refer me to another professional who can assist me, if I request it. If I fail to attend 2 consecutive sessions without notifying my doctor, he will assume that I wish to terminate services and discharge me without notice. Cancellation Policies and Charges will also apply, as relevant. My doctor may also terminate me for other reasons, providing referral information so I may continue services elsewhere, if I so choose.

### Cancellation Policy and Charges

I have received a copy of the MPC Policy on Cancellations and the fees that may be charged if I do not provide sufficient advance notice of cancellation for therapy, testing or consultation services. I understand that any cancellation fees that are posted are not billable to my insurance, such that I personally am responsible for paying them. Please notify our office as soon as possible if you need to cancel or change an appointment, as it is not our wish to post such charges.

### Concealed Weapons

While we respect the privilege afforded individuals with a State permit to carry concealed weapons, the doctors feel it is not appropriate for individuals in a medical setting to possess firearms or other weapons, as defined by Idaho Code. As such, possession of concealed weapon at the Meridian Psychological Center is not permitted. If you have one, it should be left at home, or in your vehicle. Our intent is to insure a safe, secure environment for healthy change.

### Confidentiality

The law protects the privacy of all communications between a patient and a psychologist. In most situations, your doctor can only release information about your treatment to others if you sign a written Authorization form that meets certain legal requirements imposed by HIPAA (the Federal Health Insurance Portability and Accountability Act) and/or Idaho law. In certain instances, however, your doctor may be required by ethical standards or law to disclose confidential information, such as if:

- Your doctor determines that you are at imminent risk to inflict serious physical harm or death on yourself. In such cases your doctor may be required to take protective actions, such as calling the police or attempting to arrange hospitalization.
- The court or a third party has appointed your doctor to evaluate or treat you.
- If you are involved in a court proceeding and a request for information concerning the professional services I provided, I cannot provide any information unless you provide proper legal authorization or I am provided with a valid court order.
- You disclose that a minor, elderly, or disabled person is the victim of abuse or neglect.
- If a lawsuit is filed by you against your doctor for breach of duty, your doctor may disclose relevant information regarding your treatment in order to defend himself or herself.
- A court order or other legal proceeding requires disclosure.
- If a government agency is requesting the information for health oversight activities, I may be required to provide it for them
- You waive your rights to confidentiality or give your consent to disclosure of confidential information.

If such a situation arises, your doctor will attempt to fully discuss it with you before taking any action, and will limit disclosure to what is necessary.

If you are not the primary insured person on your insurance, reports on health benefits paid may be sent to the primary insured, including your diagnosis. You also need to be aware that insurance representatives may request diagnoses, reports, and case records in order to review services provided, if they are paying for the services. You may, however, choose to protect your privacy by paying cash "out of pocket" for psychological services and not have your insurance billed at all.

Also, you need to be aware that your doctor practices with other mental health professionals, and sometimes consult with them on cases to utilize their expertise. The group of current doctoral clinical psychologists include: Dr. Arnold, Dr. Lefavour, and Dr. Sombke, as well as a consulting physician, Dr. Vicki Wooll. At times, a clinical assistant may also be involved in some aspect of your services. There are also other administrative and bookkeeping staff who help process your records. All these individuals are bound by the same rules of confidentiality, and have agreed not to release any information outside of the practice without specific authorization. All of the doctors have agreed to maintain confidentiality as required by law.

Finally, you agree to any disclosures that are necessary or required by health insurers or to collect overdue or cancellation fees. You agree to ask your doctor if you have any questions about confidentiality or privacy issues.

### Professional Records and Accessibility

You may examine or receive a copy of your Clinical Record, unless it is determined that by so doing you or others would be subjected to harm. Since such records are easily misinterpreted or upsetting to untrained readers, I strongly recommend that you review the record with your doctor and discuss the contents with him or her. In most cases your doctor can charge a copying fee of \$1.50 per page (and for certain other expenses). If your doctor refuses to allow you access to records you will have a right of review, which can be discussed upon your request.

**Patient Rights**

HIPAA provides you with several new or expanded rights with regard to your Clinical Records and disclosures of 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 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, the attached Notice form, and my privacy policies and procedures. I am happy to discuss any of these rights with you.

**Minors and Parents**

Patients 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. Because privacy in psychotherapy is often crucial to successful progress, particularly with teenagers, it is sometimes our 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, we will provide them only with general information about the progress of the child’s treatment, and his/her attendance at scheduled sessions. We will 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 which case, we will notify the parents of my concern. Before giving parents any information, We will discuss the matter with the child, if possible, and do our best to handle any objections he or she may have.

**Emergencies and Crisis Management**

On rare occasions, psychological emergencies or crises emerge that require immediate attention. In these situations, my doctor typically can be reached by calling 855-0660, with paging. In the event that I cannot reach my doctor, I agree to seek assistance from other community resources, including my family physician, calling 911, or the emergency room of a local hospital.

**Service Fees and Billing**

You understand that your doctor and persons under his or her direction or supervision charge professional fees for their services and time allocated for your evaluation, consultation or treatment, including record keeping, letters or special reports. If the doctor accepts the insurance you are covered by, contractual rates may apply. You will be responsible for the deductible, any co-payments that apply, and any services deemed not medically necessary. You will be expected to pay for each session at the time it is held, unless other arrangements are made. You agree that if for any reason your insurance fails to pay that you assume full responsibility for payment. Payments may be made by cash check, or accept major credit cards (MasterCard or VISA).

Your doctor’s hourly fees range from \$100 to \$200 per hour. In addition to weekly appointments, you may be charged for other professional services you may need, though your doctor will break down the hourly cost for periods of less than one hour in 15 minute increments. Other services include report/letter writing, telephone consultations lasting longer than 5 minutes, time spent consulting with other professionals, preparation of records, completion of any insurance forms or treatment summaries, and the time spent performing any other service requested of me. If you become involved in legal proceedings that require your doctor’s participation, you will be expected to pay for all professional time, including preparation and transportation costs, even if the doctor is called to testify by another party. Because of the difficulty of legal involvement, your doctor charges \$200 per hour for preparation and attendance at any legal proceeding, with a 2 hour minimum.

If your account has not been paid for more than 60 days and arrangements for payment have not been agreed upon, your doctor is authorized to pursue legal means to secure payment. This may include hiring a collection agency or going through small claims court. In such situations your doctor is authorized to disclose necessary information about you in order to pursue payment. If such legal action is necessary, its costs will be included in the claim.

**Consent to Evaluation and Therapy**

I understand the information provided above, have asked questions for additional information and clarification as needed, and consent to psychological therapy or evaluation services with the doctor or his or her authorized assistants. I also authorize consultation with other professional when deemed necessary for my evaluation or treatment.

I hereby authorize release of any information necessary to obtain proper reimbursement from my insurance company. I also understand that I may choose not to have my insurance billed or provided any information, in which case I agree to pay in full at the time of service. \_\_\_\_\_ (Initials)

I have received the HIPAA notice for my records. \_\_\_\_\_ (Initials)

**Acknowledgement and Signature of Agreement**

With my signature below, I attest that I have been adequately informed regarding office policies, the proposed treatment, consultation, assessment or evaluation plans; and I have asked any questions needed to clarify if necessary. I agree to actively and genuinely participate with my doctor.

Print Name of Patient OR Guardian: \_\_\_\_\_

Signature of Patient, or Guardian of Patient: \_\_\_\_\_

Date: