**THERAPEUTIC SERVICES AGREEMENT**

This document (the Agreement) contains important information about our professional services and business policies. 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). HIPAA requires us to 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, which is attached, explains HIPAA and its application to your personal health information in greater detail. The law requires that we obtain your signature acknowledging that you have been provided with this information before we can provide services. **Although these documents are long and sometimes complex, it is very important that you read them carefully before our initial session.** We can discuss any questions you have about the procedures at that time. When you sign these documents, they represent an agreement between us.

**CONSENT TO TREATMENT**

You have the right to consent to, withdraw from and refuse treatment at any time. You may also revoke consent to release information in writing at any time.

**CLIENT RIGHTS**

HIPAA provides you with new and expanded rights that includes the right to amend your record; request restrictions on what information from your clinical record is disclosed to others; request an accounting of disclosures of PHI; have any complaints you make about our policies and procedures recorded in your records; and the right to obtain a paper copy of this agreement, the attached notice form and our privacy policies and procedures. We are happy to discuss any of these rights with you.

**YOUR RIGHTS AND RESPONSIBILITIES**

Our policy is to assure the rights of each client served. As a client of TSofNC you have the right to:

* Be treated well and have your privacy respected, and freedom from mental and physical abuse, neglect, exploitation, retaliation or humiliation:
* Live as normally as possible while receiving care and treatment;
* Culturally competent treatment, including access to medical care and habilitation, regardless of age or degree of mental health services needed;
* Personalized as well as culturally and linguistically appropriate service plan that focuses on your goals, needs and abilities, strengths, preferences, and cultural background and needs;
* Exercise the civil rights available to all citizens unless these rights have been limited by a court of law;
* Confidentiality. This means no one has access to your identity or health information without written permission, except in special situations that are defined in the Notice of Privacy Practices;
* Services that are best suited for your age, level of need, linguistic needs, and cultural background;
* Be completely informed in advance of the potential risk and benefits of different service choices;
* Be free from unnecessary medication, punishment, abuse, physical restraint and seclusion

The right to consent to or refuse any service you have been offered unless: (a) in an emergency situation (b) if service was ordered by the court or (c) you are under 18 years old, and your legally responsible person gives permission, even if you object. Refusal or expression of choice may pertain to service delivery, release of information, concurrent services and composition of the service.

Some of your important responsibilities include, but are not necessarily limited to the following:

* Respecting the right and property of other clients and staff of TSofNC;
* Working toward goals on your treatment plan;
* Communicating and cooperating with TSofNC staff by giving us all the facts that are important to your care, including information about other doctors you are seeing;
* Keeping all scheduled appointments; Clients need to be on time for their scheduled appointments, if they are late the appointment may need to be rescheduled;
* Paying for services according to your own financial plan or insurance company;
* Informing staff of any medical conditions or communicable diseases;
* Requesting a copy of your treatment plan through your primary therapist, if you so desire;
* Requesting a discharge plan by your therapist, if you so desire;
* Use of tobacco products are prohibited inside the TSofNC office;
* Weapons are NOT permitted on TSofNC property;
* The uses of Alcohol or illicit drugs are prohibited on TSofNC premises.

**SERVICES**

Our first few sessions will involve an evaluation of your needs. At the end of the evaluation, we will be able to offer some initial impressions and recommendations. We encourage you to evaluate this information along with your own opinions and impressions, and should you have questions about any services offered, we can discuss them at any time. You have the right to seek a second opinion from another therapist or terminate therapy at any time.

**MEETINGS**

We usually schedule weekly to bi-weekly sessions; however, your schedule may vary based upon the type, frequency, length and time of session. Once an appointment is scheduled you will be expected to pay for it unless you provide 24 hours advance notice of cancellation. It is important to note that insurance companies do not provide reimbursement for cancelled sessions.

**PROFESSIONAL FEES**

Our customary hourly fee will be explained to you at the time of intake. In addition to individual appointments, we may charge for other professional services such as report writing, telephone conversations, consultation with other professionals, preparation of records or treatment summaries, or time spent performing additional services at your request. If you become involved in legal proceedings that require our participation, we will discuss what our participation will entail and then draft a separate financial agreement. All charges will be explained to you in writing.

**NO SHOW POLICY**

If you are unable to keep an appointment for any reason, please give us at least 24hours notice. Appointments are in high demand, so it is important you show up on time and call to cancel if you are unable to keep a scheduled session. Your early cancellation will give another person the possibility to have access to our therapists.

If you miss two scheduled appointments without canceling in advance, you will no longer be able to schedule an appointment. An appointment will be counted as “no show” if you do not call to cancel a scheduled appointment. At that time, you will be placed on “Walk-In” status.

**WALK-IN STATUS PROCESS**

On “walk-in” status, you may call the office at the beginning of the day to see if your therapist is in and ask to be seen as a “walk-in”. You may be seen if your provider has a cancellation during the day, but there is no guarantee that you will be seen that day.

**RECURRING APPOINTMENTS**

For clients who are scheduled on a recurring basis, it is your responsibility to keep track of when those appointments are coming close to an end. When you see that you only have a few appointments left, please make sure that you let the office staff know so that more appointments can be scheduled for you.

**OFFICE HOURS**

Our office is open Monday through Friday from 8:30 am to 5:00 pm; however, each therapist makes his/her own hours and may schedule outside of these days and times. These hours will be explained to you at the time of your intake. Office staff is in Monday through Thursday and some Fridays to take calls and handle administrative needs.

**CONTACTING TSofNC (Emergency and Non-emergency)**

During our scheduled workdays we are generally not available. All calls are answered by office staff or voice mail. We will make every effort to return your call as soon as possible if it is related to a clinical matter. General questions about appointments and finances should be directed to office staff. If you are difficult to reach, please inform us of times when you will be available. If an emergency arises after hours, please call our office. A therapist will be on-call. Please leave a message and either your therapist or the therapist on call will return your call as quickly as possible. If it is a life-threatening emergency, please go to your nearest emergency room or call 911 before trying to reach us.

**LIMITS OF CONFIDENTIALITY**

The law protects the privacy of all communications between a client and a therapist. In most situations we can only release information about your treatment if you provide written authorization that meets certain legal requirements imposed by HIPAA. There are other situations that require only that you provide advance written consent. **Your signature on this agreement provides consent for those activities as follows**:

* We may find it helpful to consult other healthcare and mental health professionals about your case. During consultations we make every effort to avoid revealing your identity. The other professional, with whom we are consulting, is also legally bound to keep the information discussed confidential.
* You should be aware that we practice with other mental health professionals and employ administrative staff. In most cases, we share PHI with these individuals for both clinical and administrative purposes, such as scheduling, billing and quality assurance. Staff members are bound by the aforementioned rules of confidentiality. All staff members have received training to protect your privacy and are bound by aforementioned rules of confidentiality.
* We also have business contracts that require business associates to maintain confidentiality of your PHI except as specifically allowed in the contract or otherwise required by law.
* Disclosures required by health insurers or to collect overdue fees are discussed elsewhere in the agreement.
* If we believe that a client presents an imminent danger to his/her health/safety or to someone else’s health/safety, we may be obligated to seek hospitalization for him/her or to contact family members or others who can help provide protection.

There are some situations where we are permitted or required to disclose information without either your consent or authorization.

* If you are involved in a court proceeding and a request is made for information concerning the professional services we have provided, we cannot provide any information without your written authorization or a court order. If you are involved in or contemplating litigation you should consult your attorney to determine whether a court would likely order us to disclose information.
* If a government agency is requesting the information for health oversight activities, we may be required to provide information to them.
* If your insurance company requests information in order to obtain billing and/or during a routine audit (see below).
* If a patient files a complaint or lawsuit against us, we may disclose relevant information regarding the patient in order to defend ourselves.
* If a patient files a worker’s compensation claims and our services are being compensated through worker’s compensation benefits, we must provide a copy of the patient’s record to the patient’s employer or the North Carolina Industrial Commission.
* A facility may disclose the fact of admission or discharge of a client to the client's next of kin whenever the responsible professional determines that the disclosure is in the best interest of the client.

There are some situations in which we are legally obligated to take actions which we believe are necessary to attempt to protect others from harm and we may have to reveal some information about a patient’s treatment. These situations are unusual in our practice.

* If we have cause to suspect that a child under 18 is being abused or neglected, or if we have reasonable cause to believe a disabled adult is in need of protective services, the law requires that we file a report with the Department of Social Services. Once a report is filed, we may be required to provide additional information.
* If we believe that a client presents an imminent danger to the health and safety of another, we may be required to disclose information in order to take protective actions, including initiating hospitalization, warning the potential victim, if identifiable, and/or calling the police.
* Upon request the legally responsible person of a client shall have access to confidential information in the client's record; except information that would be injurious to the client's physical or mental well-being as determined by the attending therapist or, if there is none, by the facility director or the client’s designee.
* In case of an emergency or for other exceptions as detailed in the General Statues or in 45 CFR 164512 of HIPAA (The Privacy Rule permits covered entities to disclose protected health information, without authorization, to public health authorities who are legally authorized to receive such reports for the purpose of preventing or controlling disease, injury or disability. This would include, for example, the reporting of a disease or injury; reporting vital events, such as births or deaths; and conducting public health surveillance, investigations, or interventions.).

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.

**PROFESSIONAL RECORDS**

The laws and standards of our profession require that we keep PHI about you in your clinical record. Due to the nature of these records they can be misinterpreted and/or upsetting to untrained readers. For this reason, should you wish to review your records we recommend that you have them forwarded to another mental health professional to assist in interpreting the contents. If, in our professional opinion, your PHI does not present a danger to yourself and/or others or the records do not make reference to another person, you may examine your clinical record if you provide an advanced written request.

**TREATMENT PLANS**

You will have the opportunity to participate in the planning of your treatment. Your input will be an important part of this process. The treatment plan will be developed when you begin services and will be reviewed annually. It can be revised at any time. You have the right to request a copy of your treatment plan at any time by contacting your therapist.

**MINORS & PARENTS/GUARDIANS**

While privacy in treatment is very important, particularly with teenagers, parental involvement is also essential to successful treatment and this requires that some private information be shared with parents/guardians. It is also our policy not to treat a child under 18 years of age without parental or guardian consent. In addition, we do not treat a child under 18 years of age unless he/she agrees that we can share whatever information we consider necessary with his/her parent. Parent/child signatures at the end of this patient services agreement serve as consent. Before giving parents any information, we will discuss the matter with the child and do our best to handle any objections they may have.

**BILLING & PAYMENTS (for non-Medicaid covered services)**

You are expected to pay all non-covered charges each session at the time it is held unless we agree otherwise, or unless you have insurance coverage that requires another arrangement. Payment schedules for other professional services will be discussed when they are requested. In circumstances of unusual financial hardship, we may be willing to negotiate a fee adjustment or payment installment plan. **If your account has not been paid for more than 60 days and arrangements for payment have not been agreed upon, we have the option of using legal means to secure the payment**. This may involve hiring a collection agency or going through small claims court which will require us to disclose otherwise confidential information. In most collection situations the only information we release regarding a patient’s treatment is his/her name, the nature of services provided, and the amount due. If such legal action is necessary, the costs will be included in the claim.

**INSURANCE REIMBURSEMENT/MEDICAID**

In order 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 coverage for mental health treatment. We will provide you with whatever assistance we can in helping you receive the benefits to which you are entitled; however, if you have insurance coverage, you, not your insurance company, are responsible for full payment of fees. It is very important that you find out exactly what mental health services your insurance policy covers. You should carefully read the section in your insurance coverage booklet that describes mental health and/or behavioral health services. If you have questions about the coverage call your plan administrator. If it is necessary, we are willing to call the company on your behalf.

You should also be aware that your contract with your health insurance company requires that we provide them with information relevant to the services we are providing to you. We are required to provide a clinical diagnosis. Sometimes we are required to provide additional clinical information such as treatment plans or summaries, or copies of your entire clinical record. In such situations we will make every effort to release only the minimum information about you that is necessary for the purpose requested. Though all insurance companies claim to keep such information confidential, we have no control over what they do with it. **By signing this agreement, you agree that we can provide requested information to your insurance carrier.**

**GRIEVANCE PROCEDURE**

We encourage you to speak to your therapist if you have any concerns with your therapy or therapy goals. Also, if you have any problems with our billing procedures, please see our Office Manager for help. If you find that your problem cannot be resolved within our office, please feel free to call the following numbers to address your issue.

• Concern Line (may be anonymous) - 1.888.213.9687

• Cardinal Innovations Healthcare Solutions 24 hour 800/toll free number - 1.800.939.5911

• Medicaid Fraud and Abuse Tip line at 1-877-DMA-TIP1 (1-877-362-8471)

• DHHS Customer Service Center at 1-800-662-7030

**COMPLAINTS**

If you are dissatisfied with any aspect of the counseling process, please inform us so that we can determine if our work together can be more efficient and effective, or whether a referral would be more appropriate. You may request to speak to our supervisors if we are unable to address your concerns. Unresolved issues and concerns may be directed to:

**Licensed Professional Counselors: Licensed Psychologists and Psychological Associates:**

North Carolina Board of Licensed Professional Counselors North Carolina Psychology Board

PO Box 77819 895 State Farm Rd, Suite 101

Greensboro, NC 27417 Boone, NC 28607

Phone: (844) 622-3572 or (336) 217-6007 (828) 262-2258

Fax: (336) 217-9450 [info@ncpsychologyboard.org](mailto:info@ncpsychologyboard.org)

[complaints@ncblpc.org](mailto:complaints@ncblpc.org)

**For Speech Therapists:**

North Carolina Board of Examiners for Speech-Language Pathologists and Audiologists

PO Box 16885

Greensboro, NC 27416-0885

Phone: (336) 272-1828

Fax: (336) 272-4353

<http://ncboeslpa.org/Complaint.htm>

**DISABILITY RIGHTS NORTH CAROLINA**

If at any time you feel you cannot get the information or help you need in our office, you can get help with your rights by calling the Disability Rights North Carolina at 800-821-6922 or 877-235-4210.

**PLEASE READ CAREFULLY AND COMPLETE**

\_\_\_\_*Initial* I have read the Therapeutic Services Agreement, understand and agree to the policies described above.

\_\_\_\_*Initial* I understand TSofNC Policies and Procedures Manual, including the TSofNC Cultural Competency Plan. I also

understand I can receive a copy at any time by request.

\_\_\_\_\_*Initial* I agree to the No Show Policy.

\_\_\_\_\_*Initial* I agree to keep track of my appointments and know it is my responsibility to make sure future appointments are

made.

\_\_\_\_\_*Initial* I understand and agree to the confidentiality policy.

\_\_\_\_\_*Initial*  I understand that copays are due at the time of service.

\_\_\_\_\_*Initial* I understand that final payment on behalf of the client is expected before reports or summaries (including

psychological evaluations) are released.

\_\_\_\_\_*Initial* I understand that if my account is turned over to collections or small claims court, I am responsible for any

additional charges that will be incurred by TSofNC.

\_\_\_\_\_*Initial* I acknowledge the opportunity to review the HIPAA Notice of Privacy Practices. I understand that if requested, I

may have a copy to keep.

**Your signature below indicates that you have read this contract and agree to its terms and serves as an acknowledgement that you have been offered the HIPAA notice form described above. Your signature also serves as confirmation that you have read and understand your rights as a client.**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Patient Printed Name Date**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Signature of Patient or Parent/Guardian Date**

**NOTE: You may request a copy of this agreement for your review.**