Nicole DeRobertis, LCSW, LLC

Psychotherapy Services Agreement

Welcome to my practice. This 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 federal law that provides for privacy protections and client 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, which accompanies this agreement, explains HIPAA and its application to your personal health information in detail. As required by law, on the last page of this agreement you are asked for your signature acknowledging that I have provided you with this information. When you sign this document, it will represent an agreement between us. You may revoke this Agreement in writing at any time.

Description of Professional Services:

Psychotherapy services may include the following: Initial Evaluation, Individual, and Family Psychotherapy, Telephone Conferences, Clinical Consultation. The purpose of psychotherapy services is to promote healthy individual and relational functioning. Multiple treatment modalities and methods may be utilized depending on the issues you are hoping to address. While the course of psychotherapy is designed to be helpful, it may, at times, be difficult and uncomfortable. Psychotherapy requires an active effort on your part in order to be most successful.

Specific Information on Appointments:

Each therapy appointment lasts approximately 50 minutes. Psychotherapy is generally relatively brief, however this is not always the case. Ongoing evaluation of the treatment goals leads to a decision about lengthening or discontinuing treatment. Both the adolescent and the parent/guardian will be part of that decision process.

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Fee Policies:

My Initial Assessment/Evaluation fee is $180, moving forward my hourly fee for Individual and/or Family Therapy or Parent Support is $120. Some insurance is accepted, please check with your insurance company for coverage. In addition to weekly appointments, I charge this amount for other professional services you may need. The hourly rate will be broken down if I work for periods of less than one hour. Other services may include report writing, telephone conversations lasting longer than 15 minutes, attendance at meetings with other professionals you have authorized, preparation of records or treatment summaries, and the time I spend 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 my professional time ($150/hour) even if I am called to testify by another party.

Billing and Payments:

You are expected to pay for each session at the time it is held unless your insurance coverage requires another arrangement or we have agreed otherwise. For your convenience I accept cash, check and/or credit card (Visa, MasterCard, Discover and American Express) for payment of fees.

If your account has not been paid for more than 60 days and arrangements for payment have not been agreed upon, I have the option of using legal means to secure the payment. This may involve hiring a collection agency or going through small claims court. If such legal action is necessary, its costs will be included in the claim. In most collection situations, the only information I release regarding a patient's treatment is his/her name, the nature of services provided, and the amount due.

Professional Records:

You/Your child should be aware that, pursuant to HIPAA, I keep Protected Health Information about you in one set of professional records. 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. The laws and standards of my profession require that I keep treatment records and

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maintain them for seven years past your final date of treatment with me. I use an Electronic Health Record (EHR) for documentation and, when applicable, billing. The systems I use for EHR documentation and billing are TheraNest and Office Ally both of which are HIPAA compliant, confidential systems.

Your Rights:

HIPAA provides you/your child 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 restrictions 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 the protected information disclosures are sent; having any complaints that you/your child 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.

Phone and Emergency Contact:

If you need to contact me by phone my number is 203-644-0557. I typically return phone calls within 24 business hours. If I am unavailable for an extended period of time, I will provide you with the name of a colleague to contact, if necessary. In emergencies, always contact 911 first. If there is no danger, however you feel you need immediate mental health support, please call me during business hours and I will return your call as soon as possible. If you are unable to reach me, it is outside business hours, or a weekend and you feel you are unable to to wait for me to return your call, you have a number of options; contact your family physician or the nearest emergency room and ask for the psychologist or social worker on call; call 211 to be connected to a local crisis hotline; or call the National Suicide Prevention Hotline 1-800-273-8255 (TALK). When we speak it will be important for us to develop a plan to work on preventing and recovering from mental health crises. Should you anticipate the need for additional support we can work on a specific plan to help in those situations.

Minors:

If you are a client under the age of 18, please be aware that the law provides your parents/guardians the right to examine your treatment records and to ask

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me questions regarding our treatment sessions. It is my policy to request that parents/guardians agree to give up this access to your records. I also ask them to agree not to ask for detailed information about what we discuss in therapy. I will provide them with general information regarding our work together and any concerns regarding high risk behavior that could harm yourself or someone else.

It is my policy to discuss any disclosure of information, whenever possible, with you prior to doing so in order to address any of your concerns and/or questions. At discharge I will prepare a summary of our work together to provide them, and we will discuss before it is sent.

Confidentiality:

In general, the law protects the privacy of all communication between a patient and psychotherapist, and I can only release information about our work to others with your written permission. However, there are a few exceptions. Please review the Notice of Privacy Practices for details regarding these exceptions.

Freedom to Withdraw:

You have the right to end your/your child's therapy at any time. If you wish, I will give you the names of other qualified therapists.

Informed Consent:

I have read and understood the preceding statements. I have an opportunity to ask questions about them, and I agree to enter a professional psychotherapy relationship with Nicole DeRobertis, LCSW.

_____ _____

Client Signature Date

_____ _____

Parent or Guardian Signature Date

_____ _____

Nicole DeRobertis, LCSW Date

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RELEASE OF INFORMATION FOR INSURANCE BILLING & DIRECT PAYMENT TO NICOLE DEROBERTIS, LCSW:

I authorize the release of information for claims, certification/case management/ quality improvement and other purposes related to benefits of my Health Plan. I further authorize payment of medical benefits from my Health Plan directly to Nicole DeRobertis, LCSW.

_____ _____

Client Signature Date

_____ _____

Parent or Guardian Signature Date