

# Well Being, LLC

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## COUNSELOR-PATIENT SERVICES AGREEMENT

Welcome to my practice. I am glad you are here and I am looking forward to doing some good, productive work together.

This document (the Agreement) contains important information about my professional services and business policies. The Health Insurance Portability and Accountability Act (HIPAA) is 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. 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 is attached to this Agreement, explains HIPAA and its application to your personal health information. While this written summary should prove helpful in informing you about potential problems, it is important that we discuss any specific questions or concerns that you may have. The laws governing confidentiality can be quite complex, it is not possible to cover every eventuality in a document like this, and I am not an attorney. In situations where specific advice is required, one or both of us may wish to obtain formal legal advice.

The law requires that I obtain your signature acknowledging that I have provided you with this information by the end of your first session. Although these documents are long and sometimes complex, it is very important that you read them carefully before the session. We can discuss any questions you have about them at that time.

When you sign this document, it represents an agreement between us. You may revoke this Agreement in writing at any time. That revocation will be binding on me unless I have taken action in reliance upon it, if there are obligations imposed on me by your health insurer in order to process or substantiate claims already made under your policy, or if you have not satisfied any financial obligations to me which you have already incurred.

## COUNSELING SERVICES

Counseling is not easily described in general terms. It varies depending on the personalities of therapist and client, and the particular problems you are experiencing. There are many different methods I may use to deal with the problems that you hope to address.

Counseling is not like a medical doctor visit. Instead, it calls for a very active effort on your part. In order for the therapy to be most successful, you will have to work on things we talk about both during our sessions and in between.

Counseling can have benefits and risks. Since therapy often involves discussing unpleasant aspects of your life, you may experience uncomfortable feelings like sadness, guilt, anger, frustration, loneliness, and helplessness. On the other hand, counseling has also been shown to have many benefits. Therapy often leads to better relationships, solutions to specific problems, and significant reductions in feelings of distress. *There are no guarantees of what you will experience.*

Our first few sessions will involve an evaluation of your needs. By the end of the evaluation, I will be able to offer you some first impressions of what our work will entail. You should evaluate this information along with your own opinions of whether you feel comfortable working with me. Therapy involves a commitment of time, money, and energy, so you should be very

careful about the therapist you select. If you have questions about me or my work, we should discuss them as they arise.

### **MEETINGS**

We will usually schedule one 50--minute session per week, although sometimes sessions may be longer or more frequent.

Once an appointment is scheduled, you will be expected to be here for it or to provide 24 hours advance notice of your absence. If you cancel an appointment without sufficient notice, or if you simply fail to appear for an appointment, you will be billed for it. The fee for the first missed appointment is \$50. The fee for second and subsequent missed appointments is \$70.

### **CONTACTING ME**

Due to the nature of my work, I am usually not immediately available by telephone. While I am generally in my office between 9 a.m. and 5 p.m., I do not answer the phone. I check messages daily, however, and make every effort to return calls within one business day. If you are going to be difficult to reach, please inform me of some times when you will be available. It is also always a good idea to leave your last name (as I may have more than one person with your first name!) and your telephone numbers with area codes. Speak slowly and distinctly. Give your name and number up front, in case you get cut off.

If, and only if, you have a *bona fide* mental health emergency, by which I mean your mental state is such that you represent imminent danger to yourself or to someone else, you should call me on my cell phone at 404.368.5552.

If you are unable to reach me and feel that you can't wait for me to return your call, you have several options. You may contact your psychiatrist, family physician, or the nearest emergency room and ask for the mental health provider on call. If you are pretty sure that you will require hospitalization, you can go ahead and call The Ridgeview Institute at 770.434.4568. In a life-threatening emergency, of course, you should call 911 and request the police and/or an ambulance.

Whenever I will be unavailable for an extended time, I will provide you with the name of a colleague to contact.

### **PROFESSIONAL RECORDS**

You should be aware that I will keep a written record of our work. This record includes your reasons for seeking therapy, your medical and social history, your treatment history, how your problem affects your life, my diagnosis, the goals for treatment, your progress, records from other providers, consultations, billing records, and reports.

Psychotherapy Notes contained in a file separate from your Clinical Record include the contents of our conversations, my analysis of those conversations, and how they affect your therapy.

Except in circumstances involving potential harm to you or to another person, you (or your legal representative) may examine and receive a copy of your Clinical Record upon written request. These records can be misinterpreted by and be upsetting to you. For this reason, I recommend that we initially review them together, or you could have them forwarded to another mental health professional so you can discuss the contents with him or her. Your record may reflect thoughts I have had about your situation which I have not yet shared with you: Therapeutic interventions are effective only when correctly timed. Therefore, I caution you against requesting to see your record: In my experience, whatever your concern is it can probably be dealt with to your satisfaction without opening your records. We should always try discussing your concerns first, and let reading the chart be our last resort.

I charge \$1.00 per page for copying, and I bill you for insuring and mailing your record. If I refuse your request for access to your records, you have a right of review, which I will discuss with you upon request.

### **MINORS & THEIR PARENTS**

Patients under 18 years of age (who are not emancipated) and their parents should be aware that the law allows parents to examine their child's treatment records unless I believe that doing so would endanger the minor client or s/he and I agree otherwise. Because privacy in psychotherapy is **ESPECIALLY** crucial to successful progress with teenagers, it is my policy to require an agreement from parents that they consent to give up their access to their son or daughter's records. I will provide general information about the progress of a teen's treatment and his/her attendance at scheduled sessions—and nothing else. I will also provide parents with a summary of their son/daughter's treatment when it is complete. Any other communication will require the teen's authorization, unless I feel that that s/he is in danger or is a danger to someone else, in which case of course I will notify the parents of my concern. Before giving parents any information, I will discuss the matter with the minor client, if possible, and do my best to handle any objections s/he may have.

### **PROFESSIONAL FEES**

My fees range \$75-\$95 per 50 minute sessions.

Clinical Alcohol and drug evaluations are \$125 (a \$25.00 rush charge may be applied).

### **BILLING AND PAYMENTS**

Payment is due for each session at the end of the hour, unless we agree otherwise *in advance*.

### **INSURANCE REIMBURSEMENT**

If you have a health insurance policy, it will usually provide some coverage for mental health treatment. However, you are ultimately responsible for payment of my fees. It is therefore very important that you find out exactly what mental health services your insurance policy covers before we get started, in order to avoid any unpleasant surprises.

Obtaining insurance reimbursement requires that I disclose PHI, including your diagnosis and sometimes treatment plans, summaries, or even copies of your entire record. In such situations, I release only the minimum information about you that is necessary for the purpose requested. However, this information will become part of the insurance company files and will probably be stored in a computer with all the attendant security risks. Some companies place your information in a national medical databank. I have no control over what they do with it once it is in their hands. You may therefore decide, and I recommend that you do, to pay for therapy yourself to keep your privileged information within the confines of this office.

The preceding pages are for your records.  
Please complete the following signature page and return it to me.

# Well Being, LLC

## SIGNATURE PAGE

My signature below indicates that I have read and understand the information in the Counselor-Patient Services Agreement and agree to abide by its terms during our professional relationship. MY SIGNATURE BELOW ALSO SERVES AS AN ACKNOWLEDGEMENT THAT I HAVE RECEIVED, READ, AND UNDERSTAND THE HIPAA NOTICE FORM DESCRIBED ABOVE.

\_\_\_\_\_  
Printed name of patient

\_\_\_\_\_  
DOB

\_\_\_\_\_  
Patient signature

\_\_\_\_\_  
Date

IF PATIENT IS A MINOR OR FOR OTHER REASON(S) CANNOT GIVE INFORMED CONSENT:

\_\_\_\_\_  
Printed name of parent or other responsible party

\_\_\_\_\_  
Relationship to client

\_\_\_\_\_  
Parent or other responsible party signature

\_\_\_\_\_  
Date

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