Moreen W. Foster, M.A.P.C.C.
Licensed Professional Counselor

THERAPIST-PATIENT SERVICES AGREEMENT

Welcome to my practice. This agreement contains important information about my professional services and business policies. HIPAA requires that I provide you with a Notice of Privacy Practices for use and disclosure of PHI for treatment, payment and health care operations. A copy of such privacy notice is posted in the waiting room. A printed copy will be provided at your request. The law requires that I obtain your signature acknowledging that I have provided you with this information.

PSYCHOLOGICAL SERVICES

Psychotherapy or therapy is as much an art as it is a science. While many people have been shown to benefit from it, the results cannot be guaranteed. Whether or not a particular individual will benefit depends upon many factors, including how serious the problems are, how long the problems have existed, how well the person functioned before the problems began, and how much support is available from family and friends.

It is important to be aware of the possible risks of being involved in psychotherapy. Although psychotherapy is unlikely to be harmful, it may not produce any significant improvement. In addition, self-examination and exploration of one's feelings and thoughts may result in emotional pain and actually feeling worse than when treatment began during some periods of time. It is expected, however, that these periods will not last. There are also likely to be times when a person feels discouraged because noticeable progress is not being made. Progress is typically not steady, but will wax and wane.

In the course of treatment it is likely that several family members may be involved in the sessions at different points to assist in effecting therapeutic change. Regular attendance is important. The greater the commitment, the greater the likelihood that change will occur.

LIMITS ON CONFIDENTIALITY

Conversations with me are almost always confidential. The exceptions are in the area of legal responsibility. Please refer to Section III, page 2 of The Privacy Notice for more detailed explanation.

CONTACTING YOUR THERAPIST

Due to my work schedule, I am often not immediately available by telephone. You may leave a message with my secretary and I will make every effort to return your call on the same day you make it, with the exception of weekends and holidays. I do not provide a 24 hour emergency service. In the event of a psychological emergency, you are advised to go to the emergency room of a local hospital.

APPOINTMENTS

When psychotherapy is begun, I will usually schedule one session per week. Subsequent sessions may be scheduled less frequently as psychotherapy progresses.

CANCELLATION POLICY

I have a fixed and moderate patient load so that I can provide the best quality of care for you. When you have a scheduled appointment, that time is reserved solely for you. If you must cancel an appointment and do so at least 24 hours in advance, you will not be charged for your missed appointment. If you cancel less than 24 hours in advance you will be charged for the missed appointment. You may utilize the answering service on the weekends to notify me of a cancellation for a Monday appointment.

Charge for a missed appointment - $125.00

It is important to note that insurance companies do not provide reimbursement for cancelled sessions.

BILLING AND PAYMENTS

You will be expected to pay for each session at the time it is provided, unless you have insurance coverage that requires another arrangement. You will be liable for all fees owing on your account when you terminate services. If your account balance exceeds $300 and you are not making efforts to keep it below this amount, I may temporarily interrupt services until the desired balance can be reached.

There will be a charge of $10.00 in addition to the bank service charge on all returned checks.

PROFESSIONAL FEES

I charge $125.00 for 45 minutes and $140.00 for an hour. I charge for other professional services, according to the time involved. Other services include report writing, lengthy telephone conversations, and time spent performing other services you may request of me.

INSURANCE REIMBURSEMENT

It is the patient's responsibility to verify my membership as a provider on his/her insurance plan, to know the expected amount of co-pay and deductible such plan requires to be met, and to obtain a pre-authorization of services before the initial session, if required. Knowing what your policy requires and what mental health services will be covered is of great value to you. You may want to carefully read the section in your insurance coverage booklet that describes mental health services. If you have questions about your coverage, please call your plan administrator.

If you have a health insurance policy for which I am a provider, my staff will file your insurance for you and help you receive the benefits to which you are entitled. You will be asked to pay your portion of the fee at each session. You will be billed for co-pays, deductibles, non-covered services and services deemed not medically necessary (i.e. un-kept appointments, testing, phone consultations, school consultation, conjoint sessions, family without patient sessions) as your claims are adjudicated.

Verification of insurance benefits does not guarantee payment for services. Payment depends on a number of factors including the beneficiary's eligibility, benefit plan limitations and the coordination of benefits with other plans. Benefits under Managed Care insurance companies often must be pre-certified and deemed medically necessary by the clinical case manager. If my services are not considered medically necessary, you will be billed for these services (see paragraph one at top of this page)

At the time of your initial session, you will be asked to bring your insurance card to verify your enrollment. If you do not present this card at your initial session, your insurance will not be filed and you will be expected to pay the full fee. Your insurance will be filed when our office is given this information.

E-Mail Address:
You are asked to give us your e-mail address on the patient information sheet. Please be assured that this information will not be shared or given to any other party. My office is enhancing the abilities of our web site (www.ccoffices.com) and forwarding newsletters, mental health articles and other items of information that I would like to share with you will be available to you on the internet in the near future. This is a voluntary participation.

E-MAIL CONSENT

If you have given us your address, please initial the following:
I give my permission to use my e-mail address for the purpose of forwarding mental health articles, information and other news about the Counseling and Consulting Offices at Stonebridge. _____
Initial

INFORMED CONSENT

The purpose for therapy is for treatment only and not for making custody recommendations. As a clinician, it is my role to provide treatment, and not to make recommendations to courts in domestic matters. It would be a dual relationship for me to provide clinical services to a family member and then to conduct a custody evaluation by making recommendations to the Court. That would constitute a breach of professional ethics for mental health counselors.

If you are involved in domestic litigation or become a party to a divorce or custody action, you agree that you will not call me to court to testify. Courts appoint professionals who have had no prior contact with a family to conduct custody evaluations and to make recommendations to the Court. It is my policy not to testify in such cases, because experience has shown that the professional relationship is often harmed when counselors testify in divorce and custody cases. By signing this form, consenting to treatment, you agree not to call me as a witness in domestic litigation. X _____
(initial by client)

AUTHORIZATION AND ACKNOWLEDGEMENT

I do hereby seek and consent to participate in evaluation and /or treatment. I have read the above information and understand the contents. I agree to pay for professional services as they are received. If insurance is filed on my behalf, I agree to be financially responsible for any service provided which my insurance company may deem not medically necessary. I authorize Moreen Foster, M.A.P.C.C.. to release any information requested by my insurance carrier for the purpose of processing claims. I agree not to call you as a witness in domestic litigation.

I have received information regarding the notice of privacy practices which explains how this office will use and disclose my health information of the purposes of my treatment, payment for my treatment, and health care operations.
( ) I want a copy ( ) I do not want a copy

_____
Patient's full legal name (print)

_____
Signature of Patient or Legally Authorized Representative Relationship to Patient Date

_____
Witnessing Staff Signature