Psychotherapy Associates: SERVICE AGREEMENT for Counseling Services

Payment Agreement:

1. **Copayments/deductibles/self-pay costs are due at the date of service**
2. **A 24 hour cancellation policy** will apply unless there is a true emergency. If an appointment is missed or cancelled giving *less than 24 hours* without good cause, the client will be charged for the session and the cost is not billable to the insurance. All clients are required to leave a valid credit card on file for charging no show and late cancellation fees as part of our Agreement
3. **Credit Card on file will be charged for copays/deductibles** upon receipt of insurance Explanation of Benefits
4. All relevant insurance information must be updated as needed.
5. **Checks** returned for Non-sufficient Funds will be charged $25 plus the NSF amount.
6. **A balance of $50 or more must be paid** before rescheduling a session
7. Legal consults/subpoenas/court time must be paid in a retainer before services can be rendered
8. **Contracted secondary insurances** will be billed, however if payment is not received within 3 months, the client will be billed and responsible to pay the balance.

Service provide/CPT code billed to insurance and FEES:		Self Pay clients only:
Initial Evaluation (55-60 minutes) **90791**	$	**165 /** Self pay: Initial( )
Individual Therapy (38-45 minutes) **90834**	$	**100 /** Self pay: ( )
Individual Therapy (53-60 minutes) **90837**	$	**150 /** Self pay: Initial ( )
Family Therapy (60 minutes) **90847**	$	**150 /** Self pay: ( )
Written Report (Self-Pay only)	$	**50 - 150**
Consult with School (Self-Pay only)	$	**150 per hour**
Legal consult/subpoenas/court time (Self-pay only)	$	**1500 Retainer ($300 per hour)**
Phone consult (10-15 minutes/ Self-Pay only)	$	65
No Show or Late Cancellation	$	**100 evaluation and 50 appointment**
****PLEASE NOTE***: Our credit card system has an* ***4% surcharge*** *unless it is run as a DEBIT. Health Spending Cards are run on a different system and there is no surcharge; please specify if you are using a HSA or FSA card.*		

Treatment Process:

Initial Evaluation will involve gathering information, reviewing clinical impressions, and discussing treatment options.

Treatment will involve participation between therapist and client to facilitate change. Sometimes there is a level of discomfort and difficulty as treatment progresses- this is normal. Treatment must be understood as a PROCESS. If your condition has not improved over a reasonable period of time, please discuss this with your therapist.

Services are based on the therapist's training and expertise. Discuss this with your therapist. The therapist will tell you if he/she is qualified to deal with your condition. If not, you will be given an appropriate referral.

Confidentiality: Mental Health records are protected under HIPPA which is more stringent than medical records. You are entitled to confidentiality under State and Federal Law. There are *exceptions to confidentiality* which include (1.) a written release to a specific provider, (2.) disclosure from a child or adolescent of abuse or neglect, (3.) danger to self, and (4.) danger to others. Client records are only released to another provider and never to a client. A client may review their chart with their provider present, but copies of the chart are never given.

TECHNOLOGY POLICY: Psychotherapy Associates recognizes the importance to adhere to *HIPPA guidelines*. As technology grows, our profession must keep up with ethical guidelines to protect client information.

PHONE- General office number for both Canonsburg and Pittsburgh 724 -884- 0466

Phones are the **safest method** - messages are password protected for our staff. Office voicemail messages are checked on a regular basis weekdays 9 – 5 pm and periodically on weekends. Some providers, usually therapists, may choose to give you a cell phone number. Cell phone numbers are mainly for scheduling and emergencies. In a **TRUE emergency*** and you have not heard back from your provider using the office number or a provider's cell, we ask that you contact:

1. Emily Heim (Owner) 724-288-1164
2. Allegheny county RESOLVE 888-796-8226
3. Washington County Southwestern PA Human Services 877-225-3567
4. Beaver County Crisis Hotline 1-800-400-6180
5. National Suicide Prevention Crisis Line 1-800-273-8255
6. 911 or go to nearest Emergency Room

EMAIL- General email for both Canonsburg and Pittsburgh *pa@psychassociatesinc.com*

Email is a convenient way to communicate about general issues (billing, scheduling, prescription refills, etc…). Emails are checked frequently during the week and once a day on weekends/holidays. Please note that Email is not secure and should *NEVER BE USED IN AN EMERGENCY.* Our office has an automated email appointment reminder system through ***Patient Fusion*** and you will receive a reminder a week prior and one day prior to your appointment.

WEBSITE- psychassociatesinc.com

Our website provides a **contact tab**. If you use the contact tab, we receive your message to our office email.

TEXT MESSAGING- Texting is an unsecure method of communication and should only be used for scheduling. Please do not text information that you would want to maintain private. It is best to leave a voicemail message on the office/ cell phone than a text message. Our office has an automated text message appointment reminder system through ***Patient Fusion****. You will only get these text messages with your consent.*

SKYPE- Skype is sometimes used *at the discretion of the provider*. Skype does not meet HIPPA guidelines. The client knowingly accepts the risks if there are any breaches in confidentiality. A separate agreement is signed for acknowledgement of risks and services **before** services are rendered.

SOCIAL MEDIA- Providers are not allowed to engage with clients on social media as part of their *Code of Ethics*. Our relationship with you is both therapeutic and professional; Social media breaches that boundary.

Definition of *true emergency- Life and death situation needing immediate attention, i.e, concerning medication reaction, suicidal thoughts or homicidal thoughts *with intent*, crisis situation with a child/adolescent . We ask that clients respect providers' time and only contact in a true emergency. *A prescription refill is not an emergency and our policy is to give five (5) business days for refills.*

Client RIGHTS AND RESPONSIBILITIES:

Client Rights:

- To be fully involved with the treatment process regarding decision-making and planning
- To privacy and confidentiality
- To be treated with respect and dignity
- To know qualifications and clinical background of the provider
- To receive information about insurance guidelines and authorizations for treatment
- To voice a disagreement with treatment

Client Responsibilities

- To keep scheduled appointments and comply with the cancellation policy
- To inform the provider of changes in address and insurance
- To participate with the provider in understanding the problem and mutually agreed upon treatment goals
- To follow the plans and instructions for care as agreed upon with the provider
- To maintain the privacy of the provider and the provider's family
- To follow the emergency procedures if there is a TRUE emergency

Emergency Procedures: In the event of a crisis involving danger to self or others, please contact your therapist or go to the Emergency Room at either St. Clair Hospital (866-248-4500), Western Psychiatric Hospital and Clinic (412-624-2100), Southwood Adolescent Psychiatric Hospital (888-907-5437) or Washington Hospital (724-225-7000). Please SIGN A **RELEASE OF INFORMATION** so that your therapist can discuss your case to the facility staff.

MINORS: (14 and under):

- BOTH parents must give authorization for a child to receive treatment at Psychotherapy Associates.
- If there is a CUSTODY AGREEMENT, Psychotherapy Associates must have a copy on file.
- The privacy of the child/youth will be maintained unless there is danger to self or others or if child abuse or neglect is disclosed.
- Parents must agree that records will not be disclosed in child custody disputes and the therapist will not be asked to participate in custody disputes in order to maintain the integrity of the therapeutic relationship.
- If a parent forces legal participation, the parent will be required to pay the retainer and to provide a Release of Information from all Parties. If there is not Releases for all Parties, the provider would have limitations to what information is shared.

☐ **Parent/Guardian Initials –** Parent has read and understands policies for Minors

I have read, understand and agree to this ***Service Agreement*** *and* ***Policies of Psychotherapy Associates****. Your signature authorizes benefit payments for you or on your behalf to remit to Psychotherapy Associates. You are responsible for payment for services rendered. Additionally, your "signature on file" authorizes the provider to release to your insurance company any medical/mental health information in order to process any claims, verify benefits, obtain authorization for treatment or review treatment for case management purposes. The records are protected under HIPPA.*

____ Date____________
Signature Client

____ Date____________
Signature of Parent/Guardian

____ Date____________
Signature Witness

☐ **Initial** if you give consent to receive text message Appointment reminders

Required Credit Card on File*:* All client must have a CC on file for copays, deductibles, and No Show/Late Cancel Fees.

I understand that I will be charged for copayments and deductibles per receipt of insurance EOBs._ Additionally, any no shows and late cancellations will be charged to my credit card. A valid card must be provided. Psychotherapy Associates Staff will protect the CC on file being saved in HIPPA secure electronic chart with only authorized staff to access it.

Valid credit card #
Expiration Date

☐ **Initial -** Responsible Party or Client initials to acknowledge I have read and will be charged for No Show/Late Cancellation

PSYCHOTHERAPY ASSOCIATES- INTAKE INFORMATION

CLIENT Name

ADDRESS

PHONE: (H)

(W)

(CELL)

Date of Birth:

If the parents are divorced, both parents of a minor (age 14 and under) must agree to counseling for their child. Custody agreements must be provided to the therapist

Parents (if minor is in in treatment) Father's Name phone Address (if different) Mother's Name phone Address (if different)

Primary Care Physician
PCP Phone

Emergency Contact Person:

How did you find out about our services?

Current Problem: Please explain:

When did it start? List stressors that may have triggered this:

Mental Health

Answer the following (**circle the correct answers**):

Sleep: #hours per night _________ Weight ____________ Height___________

- My sleep is normal..... ( ) Y ( ) N
- My eating is normal..... ( ) Y ( ) N
- My daily functioning is normal ( ) Y ( ) N
- My mood is normal ( ) Y ( ) N
- My concentration is normal ( ) Y ( ) N

If you answered no to any of the above please explain:

- I am impulsive .... ( ) Y ( ) N
- I can not stop racing thoughts ( ) Y ( ) N
- I have obsessive thoughts ( ) Y ( ) N
- I have compulsive behaviors ( ) Y ( ) N
- I have a lack of interest in activities ( ) Y ( ) N
- I have considered suicide ( ) Y ( ) N
- I feel physically bad all the time ( ) Y ( ) N
- I have mood swings ( ) Y ( ) N
- I have problems with school/work ( ) Y ( ) N
- I have problems with other people ( ) Y ( ) N
- I have anxiety ( ) Y ( ) N
- I have anger problems ( ) Y ( ) N
- I do not feel myself ( ) Y ( ) N
- I hate my body image ( ) Y ( ) N
- I have been traumatized ( ) Y ( ) N
- I have addictive behaviors ( ) Y ( ) N

If you answered yes to any of the above, please explain:

How much alcohol do you consume?

Do you use tobacco products? Explain

Do you use illegal drugs? Explain.

Have you ever been treated for a mental, emotional, or drug/alcohol problem?
( ) Yes or ( )No
If yes, please explain what/when/ and who treated you

Family Background

Father_______________________________ Mother ______________________________

Age___________ Age___________

Occupation_______________________ Occupation________________________

Parents: Married/Divorced/Separated/Remarried to another spouse
Siblings and Ages:

-
-
-

Any mental health problems, drug or alcohol problems, and family conflict in your immediate and extended family? Explain

Client Information
Marital status: Currently, I am .... *Married/ divorced/ separated/ never married*
Spouse________________________________Date Married____________
List children's names and ages:

-
-

Education: Current School/College or Employer

___

Current Grade level or Position Title

___

Medical History (surgeries, illnesses, hospitalizations, allergies...)

___

___

Current Medications (prescription and over-the-counter)

___

Personal and Social history (please explain)
Early development:

Childhood history:

Family:

Legal problems:

Significant stressors in my life: