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SERVICES AGREEMENT

Welcome to my practice. This document (the Agreement) has important information about my professional services and business policies. When you sign this document, it will represent a contract between us. You may revoke this Agreement at any time in writing. That revocation will be binding on me unless I have taken action in reliance on it; if there are obligations imposed on me by your health insurer in order to process or substantiate claims made under your policy; or if you have not satisfied any financial obligations you have incurred. I will provide you a copy of this signed Agreement. You also may have a copy of the Health Insurance Portability and Accountability Act (HIPAA) Privacy Notice (the Notice) that I include in the registration materials. HIPAA is a federal law for privacy protections and patient rights concerning the use and disclosure of your Protected Health Information for the purposes of treatment, payment, and health care operations.

(1) I usually begin with a diagnostic evaluation lasting a few sessions in order to give me an educated sense of what is going on, what led up to it, and what is needed. Treatment involves psychotherapy that focuses on your needs and goals. Therapy will be as brief as possible, but complicated and long-standing problems take time.

2) My office is open on weekdays. When I am temporarily unavailable, you may leave a message on my voice mail, which I often monitor. If you can't wait for my return call or in case of an emergency, you may also contact the crisis unit of your local mental health center or go directly to the emergency room of your local hospital. When I am out of town or otherwise unavailable for an extended time, specific coverage arrangements will be explained on the office voice mail..

3) Your contacts with me are confidential. In most situations, I release information about your treatment to those outside the office only if you sign a written Authorization form, or if you are under 18 years old, with the signed authorization of at least one legal guardian. Authorization may be revoked in writing at any time, unless I have taken action in reliance on it. I make every effort to release only the minimum information necessary. To maintain confidentiality, I do not communicate clinical information to anyone, including patients and insurance companies, via the internet/e-mail, although specific exceptions may be made under special circumstances.

4) There are certain exceptions to confidentiality specified on the Notice, which I make available to you. The Notice specifies the uses and disclosures that do and that do not require authorization. There are other limits of confidentiality as well. If a patient poses an imminent threat to self or others, my first duty is not confidentiality but protection, and third parties, including family and possibly police, will be notified. If a patient files a complaint or lawsuit against me, I may disclose all information relevant to my defense. Elder and child abuse must be reported. I have the right to professional consultation with colleagues on your behalf. The laws governing confidentiality can be complex, and formal legal advice may be needed.

5) If you should choose to use your health care insurance, your company will require that I provide it with the information it deems necessary to justify its coverage of your treatment. Requirements range from the usual ones of clinical diagnosis, treatment dates, and types of services to, infrequently, your entire clinical record. Managed care companies require direct clinical management by the company. What I supply will become part of the insurance company files, over which I have no control.

6) My fee is $160 for a 45-minute face-to-face session, which insurance may help cover. I also charge $150 an hour for other professional services, such as preparation of records, treatment summaries, and detailed letters. If you become involved in legal proceedings that require my participation, I charge $300 per hour for all my professional time, including preparation,

transportation costs, and attendance, even if I am called to testify by another party. However, you are here agreeing that neither you nor those representing you will require me to appear in court and that you will pay for all my forensic time, including my attorney fees, if my participation should be mandated or if I should deem it in your best interest to resist disclosure.

7) If you are using insurance coverage, I shall file your claims. However, you will be responsible for insuring that I meet all of your carrier's requirements. Although I will provide whatever assistance I can in helping you receive the benefits to which you are entitled, YOU (not your insurance company) are responsible for full payment of my fees. Although it is likely that your company will pay if its guidelines are followed, it can't be guaranteed.

8) You are expected to pay whatever is appropriate - the full fee, the deductible, the copay, and/or the part of the full fee or the insurance adjusted fee not covered - at each appointment, with special arrangements considered upon request. Please inform me as soon as possible of payment problems. I accept payment by cash or check only.

9) Once an appointment is scheduled, you have reserved my time and are responsible for it unless you provide at least 24 hours advance notice of cancellation. Please be aware that I charge $80 for APPOINTMENTS NOT CANCELLED AT LEAST 24 HOURS in advance. The charge will be $80, not just the copay or some portion of that fee. Exceptions can be made with the MUTUAL consent of therapist and client. It is important to note that INSURANCE COMPANIES DO NOT PAY ANYTHING FOR CANCELLED OR MISSED APPOINTMENTS.

10) Any account past 90 days is subject to legal action, which may involve hiring a collection agency or attorney or going through Small Claims Court. These actions will require me to disclose otherwise confidential information and incur costs, for which you will be responsible.

OUR RELATIONSHIP IS IMPORTANT. Please bring up any concerns at any time. Also, I shall be glad to review goals and progress at your request. I look forward to working with you and hope to be of help. If I have concerns, I will bring them up with you, but be advised that failure to adhere to essential treatment recommendations can be grounds for termination.

Your signature below INDICATES THAT YOU HAVE READ THIS SERVICES AGREEMENT AND AGREE TO ITS TERMS AND ALSO SERVES AS AN ACKNOWLEDGMENT THAT YOU HAVE HAD ACCESS TO THE HIPAA PRIVACY NOTICE. It also authorizes insurance companies to pay me directly and permits me to act as your agent to obtain insurance payment. It authorizes insurance companies and I to exchange any information required to fulfill this function.

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Signature (Patient) Signature (Authorized Representative)

----------Date ----------Date

---------- Description of Authorized Representative's
Signature (Witness) authority to sign for the patient

----------Date ----------