DESERT SPRING
BEHAVIORAL HEALTH

Psychiatric Medication Management/Psychotherapist-Patient Service Agreement

Psychiatric Medication Management / Psychotherapist-Patient Services Agreement

Welcome to my practice. This document (otherwise referred to as your Agreement) contains essential information about my professional services and business policies. It also contains a summary of information about the Health Insurance Portability and Accountability Act. (HIPAA), a new federal law that provides privacy protections, and new patient rights with regards to the use and disclosure of your protected Health Information (PHI). The PHI is 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 PHI (Personal Health Information) in greater detail. The law requires that I obtain your signature acknowledging that I have provided you with this information. It is very important that you read the information carefully. We can discuss any questions you have about the procedures. When you sign this document, it will also represent 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 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.

Limits on Confidentiality

The law protects the privacy of all communications between a patient and a health professional. In most situations, I can only release information about your treatment to others is you sign a written Authorization form that meets certain legal requirements imposed by HIPAA. There are other situations that require only that you provide written, advanced consent. Your signature on this agreement provides consent for those activities as follows:

- I may occasionally find it helpful to consult other health and mental health professionals about a case. During a consultation, I make every effort to avoid revealing the identity of my patient. The other professionals are also legally bound to keep the information confidential. If you don't object, I will not tell you about these consultations unless I feel that it is important to our work together.
- Note that I practice with other independently practicing mental health professionals. We share office space and employ administrative staff. In most cases, I need to share protected information with these individuals for both clinical and administrative purposes, such as scheduling, billing and quality assurance. Each of the health professionals are bound by the same rules of confidentiality. All staff members have been given training about protecting your privacy and have agreed not to release any information outside of the practice without the permission of a professional staff member.
- Disclosures required by health insurers or to collect overdue fees are discussed elsewhere in this agreement.
- If a patient threatens to harm himself/herself, I may be obligated to seek hospitalization for him/her or to contact family members or others who can help provide protection.

There are some situations where I am permitted or required to disclose information without either your consent or authorization:

- If you are involved in a court proceeding and a request is made concerning the professional services I provide you, such information is protected by the mental health professional-patient privilege law. I cannot provide any information without your (or your legal representatives') written authorization, or a court order. If you are involved in, or contemplating litigation, you should consult with your attorney to determine whether a court would be likely to order me to disclose information. If a government agency is requesting the information for the health oversight activities, I am required to provide it to them.
- If a patient files a complaint or lawsuit against me, I may disclose relevant information regarding that patient in order to defend myself.
- If a patient files a workers compensation claim, I must, upon appropriate request, provide a copy of the patients record to the appropriate parties, the patients' employer, the workers compensation insurance carrier or the Labor Commission.
- If a communicable disease is reported to me, I am required to report this to the Utah State Department of Health.

There are some situations in which I am legally obligated to take action in which my professional judgement is necessary to attempt to protect others from harm and I may have to reveal some information about a patient's treatment. Such situations are:

- If I have reason to believe that a child has been or is likely to be subjected to incest, molestation, sexual exploitation, sexual abuse, physical abuse, or neglect, the law requires that I immediately notify the Division of Child and Family Services or an appropriate law enforcement agency. Once such a report is filed, I may be required to provide additional information.

DESERT SPRING
BEHAVIORAL HEALTH

Psychiatric Medication Management/Psychotherapist-Patient Service Agreement

- If I have reason to believe that any vulnerable adult has been the subject of abuse, neglect, abandonment or exploitation, I am required to immediately notify Adult Protective Services intake. Once such a person is filed, I may be required to provide additional information.
- If a patient communicates an actual threat of physical violence against an unidentifiable victim, I am required to take protective actions. These actions may include notifying the potential victim and contacting the police, and/or seeking hospitalization for the patient.

If such a situation arises, I will make every effort to fully discuss it with you before taking action and I will limit my disclosure to what is necessary.

While this written summery of exceptions to confidentiality should prove helpful in informing you about potential problems, it is important that we discuss any questions or concerns that you may have now or in the future. The laws governing confidentiality can be quite complex. I am not an attorney. In situations where specific advice is required, formal legal advice may be needed.

Professional Records

You should be aware that, pursuant to HIPAA, I keep Protected Health Information about you in two sets of professional records. One set constitutes your Clinical Record; the other set your Psychotherapy Notes. Your Clinical Record includes information about your reason for seeking therapy, a description of the ways in which your problem impacts 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. Except in unusual circumstances that involve danger to yourself and/or others or where information has been supplied to me confidentialy by others, you may examine and/or receive a copy of your Clinical Record, if you request in writing. Because these are professional records, they can be misinterpreted and/or upsetting to untrained readers. For this reason, I recommend that you initially review them in my presence, or have them forwarded to another mental health professional so you can discuss the contents. In most situations, I charge a copying fee of $1.25 per page (and for certain other expenses). The exceptions to this policy are contained in the attached Notice Form. If I refuse your request for access to your Clinical Record, you have a right of review (except for information supplied to me confidentially by others), which I will discuss with you upon request.

Your Psychotherapy Notes are for my own use and are designed to assist me in providing you with the best treatment. While the contents of Psychotherapy Notes vary from client to client, they can include the contents of or conversations, my analysis of those conversations and how they impact on your therapy. They also contain particularly sensitive information that you may reveal to me that is not required to be included in your clinical record and information that is revealed to me by others where I have promised confidentiality. These Psychotherapy Notes are kept separate from your Clinical Record. Your Psychotherapy Notes are not available to you and cannot be sent to anyone else, including insurance companies without your written, signed authorization. Insurance companies cannot require your authorization as a condition of coverage nor penalize you in any way for your refusal to provide it.

Patient Rights / Notice of Privacy

HIPAA provides you with several new or extended rights with regards 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 protected information disclosures are sent; having any complaints you 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. I am happy to discuss any of these rights with you.

Minors & Parents

Patients under 14 years of age who are not emancipated and their parents should be aware that the law may allow parents to examine their child's treatment records unless I decide that such access is likely to injure the child, or we agree otherwise. Since parental involvement in therapy is important, it is my policy to request an agreement between a child patient between 14 and 18 and his/her parents allowing me to share general information about the progress of the child's treatment and his/her attendance at scheduled sessions. Any other communication will require the child's authorization, unless I feel that the child is in danger or is a danger to someone else, in which case, I will notify the parents of my concern. Before giving parents any information, I will discuss the matter with the child, if possible, and do my best to handle any objections he/she may have.

_____
Client/Guardian Initials

DESERT SPRING
BEHAVIORAL HEALTH

Psychiatric Medication Management/Psychotherapist-Patient Service Agreement

Psychiatric Medication Management / Psychotherapist-Patient Services Agreement

Mental Health Services

Psychotherapy is not easily described in general statements. It varies depending on the personalities of the mental health professional and patient, 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. Psychotherapy 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 at home.

Psychotherapy can have benefits and risks. Since therapy often involves discussing unpleasant aspects of life, you may experience uncomfortable feelings like sadness, guilt, anger, frustration, loneliness, and helplessness. On the other hand, psychotherapy 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. But there are no guarantees of what you will experience.

Our first session will involve an evaluation of your needs. During this time, I will offer you some first impressions of what our work will include. We can both decide if I am the best person to provide the services you need in order to meet your treatment goals. Therapy involves a large commitment of time, money and energy, so you should be very careful about the therapist you select. If you have questions about my procedures, we should discuss them when they arise.

Professional Fees

The appointment fees depend on the services provided. If you have insurance coverage, the amount you pay may vary depending on the coverage. If you are being seen through a community agency, fees will depend on your agreement with that agency and that agency's agreement with us to provide services to you.

The initial therapy-session is $275.00, for a 50-minute session. Subsequent therapy-sessions are $150.00 for a 30-minute session. **Your payment or co-pay is due at the time of service**. We charge $150.00 per hour for other professional services you may need, though we may break down the hourly cost if we work for periods of less than one hour. Other services include report writing, consulting with other professionals with your permission, preparation of records, forms, or treatment summaries, and the time spent performing any other service you may request of me.

If you become involved in legal proceedings that require our participation, you will be expected to pay for all professional time, including preparation and transportation costs, even if we are called to testify by another party. We charge $300.00 per hour for preparation and attendance at any legal proceeding.

_____
Client/Guardian Initials

Contacting Me

I am usually in my office between 8:30 AM and 4:00 PM, Monday – Thursday. I am often not immediately available by telephone. I will not answer my phone when I am with a patient. When I am unavailable, my telephone is answered by my Medical Assistant or my answering service. I will do my best to return your call on the same day you make it, except for weekends and holidays. In emergencies, if you are unable to reach me and feel that you need immediate assistance, contact your family physician or the emergency room at Dixie Regional Medical Center – Phone # (435) 251-1000. If I will be unavailable for an extended time, I have someone who will take emergency calls. If you cannot reach them, follow the emergency procedure above.

Insurance Reimbursement

You-not your insurance company – are responsible for full payment of my fees. If, for any reason your insurance company, or other payer source, does not pay, you must. If 90 days lapse without receiving payment from your insurance company, you will be asked to pay in full for services rendered to that point in time and at the time of any additional services. It is very important that you find out exactly what mental health services your insurance policy covers. You should carefully read the section in your insurance coverage booklet that describes mental health services. If you have questions about coverage, call your plan administrator.

Due to rising costs of health care, insurance benefits have increasingly become more complex. It is sometimes difficult to determine exactly how much mental health coverage is available. "Managed Health Care" plans such as HMOs and PPOs often require authorization before they provide reimbursement for mental health services. These plans are often limited to short-term treatment approaches designed to work out specific problems that interfere with a person's usual level of functioning. It may be necessary to seek approval for more therapy after a certain number of sessions. While much can be accomplished in short-term therapy, some patients feel that they need more services after insurance benefits end. It is important to remember that you

_____
Client/Guardian Initials

DESERT SPRING
BEHAVIORAL HEALTH

Psychiatric Medication Management/Psychotherapist-Patient Service Agreement

Insurance Reimbursment cont.

You should also be aware that your contract with your health insurance company requires that I provide it with information relevant to the services that I provide to you. I am required to provide a clinical diagnosis. Sometimes I am required to provide additional clinical information such as a treatment plan or summaries, or copies of your entire Clinical Record. In such situations, I will make every effort to release only the minimum information about you that is necessary for the purpose requested. This information will become part of your insurance company files and will probably be stored in a computer. Though all insurance companies claim to keep such information confidential, I have no control over what they do with it once it is in their hands. In some cases, they may share the information with a national medical information databank. I will provide you with a copy of any report I submit, if you request it. By signing the Agreement, you agree that I can provide requested information to your carrier.

Billing And Payments

You will be expected to pay for each session, or your co-pay if you have insurance, at the time of the session unless we agree otherwise or unless your services are being paid for by a community or government agency. Payment for other professional services are payable in advance of such services or by agreement between us.

If your account has not been paid for more than 60 days and arrangements for payments have not been agreed upon, I have the option of using legal means to secure the payment. This may involve hiring a collection gency or going through small claims court which will require me to disclose otherwise confidential information. 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. If such legal action is necessary, its costs will be included in the claim.

- I agree to pay all attorney's fees, court costs, filing fees, including charges or commissions that may be assessed to me by any collection agency retained to pursue this matter, and an additional collection fee up to 50% of the principal balance owing applied to the account before it is turned over to a collection agency.
- I further agree to pay interest on overdue balances at a rate of 1 ½% per month (18% per year) and to pay a service charge of $35.00 for every returned check in addition to any collection fees. I further contract and promise that this provider is guarantees the legal position of first claim to be paid and satisfied in the event of any competing claims.

_____
Client/Guardian Initials

Treatment Sessions

Frequency of sessions will depend on your treatment needs-typically weekly or every other week – at a time we agree on. Some sessions may be longer or more frequent. **Once an appointment is scheduled, you will be expected to pay for it unless you provide 24 business hours advance notice of cancellation. It is important to note that insurance companies and other third party reimbursement sources do not provide reimbursement for cancelled sessions. You will be responsible for payment of such sessions.**

YOUR SIGNATURE BELOW INDICATES THAT YOU HAVE READ THIS AGREEMENT AND AGREE TO ITS TERMS AND SERVES AS AN ACKNOWLEDGEMENT THAT YOU HAVE RECEIVED THAT HIPPA NOTRICE FORM DESCRIBED ABOVE.

If the patient is a minor between the ages of 14 and 17 years of age, they must sign as the patient.

_____
Print Name of Patient

_____ _____
Signature of Patient Date

_____
Print Name of Parent, Guardian, or Personal Representative

_____ _____
Signature of Parent, Guardian, or Personal Representative Date

If a personal representative of the patient signs the Agreement, a description of such representative's authority to act for the patient must be provided.

_____
Client/Guardian Initials

DESERT SPRING
BEHAVIORAL HEALTH

Patient Consent Form

Patient Consent for Use and Disclosure of Protected Health Information

I hereby give my consent for **Desert Spring Behavioral Health** to use and disclose protected health information (PHI) about me to carry out treatment, payment and health care operations (TPO). (The Notice of Privacy Practices provided by **Desert Spring Behavioral Health** describes such uses and disclosures more completely.)

I have the right to review the Notice of Privacy Practices prior to signing this consent. **Desert Spring Behavioral Health** reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Lisa Roper, APRN at 640 E. 700 S. Suite 205B, St. George, Utah 84770.

With this consent, **Desert Spring Behavioral Health** may call my home or other alternative location and leave a message on voicemail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care.

With this consent, **Desert Spring Behavioral Health** may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards, and patient statements as long as they are marked “Personal and Confidential”.

With this consent, **Desert Spring Behavioral Health** may email to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that **Desert Spring Behavioral Health** restrict how it uses or discloses my PHI to carry out TPO. The practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to allow **Desert Spring Behavioral Health** to use and disclose my PHI to carry out TPO.
I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, **Desert Spring Behavioral Health** may decline to provide treatment to me.

The section below on this page are to be signed at the office.

_____

Signature of Patient or Legal Guardian

_____ _____

Print Patient’s Name Date

_____

Print Name of Legal Guardian, if applicable

DESERT SPRING
BEHAVIORAL HEALTH

Privacy and Acknowledgement Notice

Notice of Privacy Practices / Receipt and Acknowledgement of Notice

Patient/Client Name _____

Date of Birth _____

Social Security Number _____

I hereby acknowledge that I have received and/or have been given an opportunity to read a copy of Desert Spring Behavioral Health Notice of Privacy Practice and How Medical Information May Be Used and Disclosed. I understand that if I have any questions regarding the Notice or my privacy rights, I can contact Lisa Roper, APRN at 1 (435) 703-9647.

The section below on this page is to be signed at the office.

_____ _____
Signature of Patient/Client Date

_____ _____
Signature of Parent, Guardrian or Personal Representative* Date

If you are signing as a personal representative of an individual, please decribe your legal authority to act for this individual (power of attorney, healthcare surrogate, etc.).

Please submit this form **no less than 2 weeks prior** to your scheduled appointment. Insurance information will be used to check eligibility, deductible and any authorizations needed for your visit . All other information will be given to the provider We will contact you promptly with any issues or concerns.

Thank you