Client/Therapist Services Agreement

Welcome!
This is a Long and detailed letter, however, all the information is very important for your review.
You will be asked to sign a Consent form in another letter, stating that you have fully reviewed and understood all the following:

This document contains important information about my professional services and business policies.
It also contains summary information about the Health Insurance Portability and Accountability Act (HIPAA), 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 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 in greater detail.
The law requires that I obtain your signature acknowledging that I have provided you with this information at our first session.

Although these documents are long and sometimes complex, it is very important that you read them carefully before our next session.
We can discuss any questions you have about the procedures at any time.

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 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.

PSYCHOTHERAPY SERVICES

Psychotherapy is not easily described in general statements. It varies depending on the personalities of the provider and patient, and the particular problems you are experiencing. There are many different methods I may use to address the problems that you are experiencing.
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 session and at home.

CLIENT RESPONSIBILITIES

By signing your treatment contracts with this therapist, you are agreeing to the following responsibilities:
1. To abide by the following rules; infractions of which will be reviewed by the therapist during peer supervision and may result in administrative discharge from treatment:
   a. No use of alcohol or illicit drugs during scheduled sessions.
   b. No violence or threats of violence against Kim Wright, LCSW or property.
2. To report to my therapist any changes in my condition, medication, employment, living arrangements, insurance or other support systems or other personal situations, which may affect my treatment.
3. To attend and participate in all sessions and to work sincerely toward my treatment goals.
4. To contact Kim Wright, LCSW, 24 hours in advance for cancellation of any session.
   a. If I give less than 24 hours notice, I realize I will be charged in full for the session missed.
   b. This cannot be submitted to insurance and will be out of pocket.
   c. This will be the FULL FEE ($165/$250).
5. Termination of treatment may occur as a result of repeated, unannounced absences.
6. To dress in appropriate street clothing for sessions.
7. To encourage my spouse, significant other, or parents/guardians (as appropriate) to participate in the educational and support programs provided or recommended.
8. To treat Kim Wright, LCSW with courtesy and respect, understanding that I retain the right to voice objection to the therapist's behavior or file a grievance as described under the client's rights.
9. To abide by Kim Wright, LCSW's payment arrangement as described in the policies and procedures I have previously signed.
10. Telemedicine sessions ARE NOT TO BE RECORDED WITHOUT PRIOR WRITTEN CONSENT by Kim Wright, LCSW and is grounds for immediate termination if found otherwise.

CLIENT RIGHTS

All of your rights are important when you enter into treatment. You are further protected by the following rights:

- To maintain the legal rights entitled to you under the Laws of Pennsylvania and New Jersey or the United States including but not limited to: the right to dispose of property; the right to execute legal instruments; the right to buy or sell; the right to enter contractual relationships; the right to register to vote and vote; the right to marry and obtain a separation, divorce or annulment; the right to hold a professional, occupational, or vehicle license.
- To not be denied treatment of services on the basis of race, national origin, orientation, sex, age, religion or handicap.
- To be treated with dignity and respect.
- To participate in the development of your treatment plan and any changes that may occur during review of your treatment plan.
- To receive confidential treatment and to have information about you maintained in a confidential manner within the limits of the law.
- To receive services according to the law, and sound therapeutic practice.
- To give consent for treatment.
- To express preferences and have them incorporated into your treatment plan and discharge plan consistent with your condition and need for treatment.
- To inspect, copy and correct your records subject to and in accordance with the provisions of Pennsylvania Law.
- To be fully informed of treatment involving significant risk.
- To receive treatment/services in the least restrictive environment.
- To be informed of your responsibilities with regard to receiving treatment with this therapist prior to the start of treatment.
- To apply for other services to which you are entitled.
- To be informed of your rights; to ask questions about your rights, to receive help with your rights; to have complaints addressed.

IF YOU FEEL THAT YOUR RIGHTS ARE BEING VIOLATED YOU MAY TALK WITH ME,
Kim Wright, LCSW 267.888.7511

IF YOU FEEL THAT YOU NEED OUTSIDE ASSISTANCE, CALL THE LOCAL MENTAL HEALTH ENTITY ADVOCATE, YOUR LOCAL CRISIS HOTLINE OR 911

Notice of HIPAA Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.
PLEASE REVIEW THIS NOTICE CAREFULLY.

Your health record contains personal information about you and your health. This information about you that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services is referred to as Protected Health Information (“PHI”).

This Notice of Privacy Practices describes how I may use and disclose your PHI in accordance with applicable law and the NASW Code of Ethics. It also describes your rights regarding how you may gain access to and control your PHI. I am required by law to maintain the privacy of PHI and to provide you with notice of my legal duties and privacy practices with respect to PHI. I am required to abide by the terms of this Notice of Privacy Practices. I reserve the right to change the terms of my Notice of Privacy Practices at any time. Any new Notice of Privacy Practices will be effective for all PHI that I maintain at that time. I will provide you with a copy of the revised Notice of Privacy Practices by sending a copy to you via email upon request or providing one to you at your next appointment.

HOW I MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

Your PHI may be used and disclosed by those who are involved in your care for the purpose of providing, coordinating or managing your health care treatment and related services. This includes consultation with clinical supervisors, peer consultants and/or other treatment team members. I may disclose PHI to any other consultant only with your authorization. I may also contact you to remind you of your appointments or to provide information to you about treatment alternatives or other health-related benefits and services that may be of interest to you.

For Payment
I may use and disclose PHI so that I can receive payment for the treatment services provided to you.
This will only be done with your authorization. Examples of payment-related activities are: making a determination of eligibility or coverage for insurance benefits, processing claims with your insurance company, reviewing services provided to you to determine medical necessity, or undertaking utilization review activities.
If it becomes necessary to use collection processes due to lack of payment for services, I will only disclose the minimum amount of PHI necessary for purposes of collection.

For Health Care Operations
I may use or disclose, as needed, your PHI in order to support my business activities including, but not limited to, quality assessment activities, employee review activities, licensing, and conducting or arranging for other business activities. For example, I may share your PHI with third parties that perform various business activities (e.g., billing, office management or typing services) provided that I have a written contract with the business that requires it to safeguard the privacy of your PHI. For training or teaching purposes PHI will be disclosed only with your authorization.

Public Health
If required, I may use or disclose you PHI for mandatory public health activities to a public health authority authorized by law to collect or receive such information for the purpose of preventing or controlling disease, injury, or disability, or if directed by a public health authority, to a government agency that is collaborating with that public health authority.

Public Safety
I may disclose your PHI if necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. If information is disclosed to prevent or lessen a serious threat it will be disclosed to a person or persons reasonably able to prevent or lessen the threat, including the target of the threat.

Research
PHI may only be disclosed after a special approval process.

Verbal Permission
I may also use or disclose your information to family members that are directly involved in your treatment with your verbal permission.

With Authorization
Uses and disclosures not specifically permitted by applicable law will be made only with your written authorization, which may be revoked at any time.

YOUR RIGHTS REGARDING YOUR PHI
You have the following rights regarding PHI I maintain about you.
To exercise any of these rights, please submit your request in writing to Kim Wright, LCSW:

• Right of Access to Inspect and Copy
You have the right, which may be restricted only in exceptional circumstances, to inspect and copy PHI that is maintained in a "designated record set." A designated record set contains mental health/medical and billing records and any other records that are used to make decisions about your care. Your right to inspect and copy PHI will be restricted only in those situations where there is compelling evidence that access would cause serious harm to you. I may charge a reasonable, cost-based fee for copies. If your records are maintained electronically, you may also request an electronic copy of your PHI.

• Right to Amend
If you feel that the PHI I have about you is incorrect or incomplete, you may ask me to amend the information although I am not required to agree to the amendment. If I deny your request for amendment, you have the right to file a statement and will provide you with a copy. Please contact Kim Wright, LCSW if you have any questions.

• Right to Request of Disclosures
You have the right to request an accounting of certain disclosures that I make of your PHI. I may charge you a reasonable fee if you request more than one accounting in any 12-month period.

• Right to Request Restrictions
You have the right to request a restriction or limitation on the use or disclosure of your PHI for treatment, payment, or health care operations. I am not required to agree to your request unless the request is to restrict disclosure of PHI to a health plan for purposes of carrying out payment or health care operations, and the PHI pertains to a health care item or services that are paid for out of pocket. In that case, I am required to honor your request for a restriction.

• Right to Request Confidential Communication
You have the right to request that I communicate with you about medical matters in a certain way or at a certain location. More under confidentiality.

CONFIDENTIALITY
The confidentiality of the material discussed in therapy will be upheld at all times. As a general rule, as your mental health provider, I will not release any information without your written or verbal consent.

THERE ARE SOME EXCEPTIONS TO THE CONFIDENTIALITY RULE:
When a child is in treatment and the parents are divorced, and the parents have joint custody, the PA Attorney General's Office has advised us that as psychotherapists, we are obligated to inform both parents that the child is in treatment and the nature and course of treatment.
If a therapist suspects that child abuse or neglect has occurred, the law requires that it be reported to the proper authorities. Child abuse includes sexual exploitation and physical or mental injuries that result in impaired functioning. Child neglect includes failure to provide for the basic needs of the child (including medical care) and inappropriate discipline.
If a therapist believes you to be a clear and imminent danger to yourself or another person, she must take steps to prevent that occurrence. These steps may require breaking confidentiality. In a legal proceeding, client-therapist communications are privileged. A judge can, however, order the therapist to divulge confidential information if this information is deemed necessary for the proper administration of justice.
Your records can be released without your consent to prove to the appropriate agencies that, as your mental health provider, I am in compliance with federally mandated HIPAA privacy laws. Your records can be released without your consent upon request from the military for purposes of national security.
Filing insurance always requires giving the insurance company, or third party payor, a diagnosis and the date of service. If you are covered through an employee group health plan, this information may come back to an insurance administrator at your place of employment. Sometimes insurance companies or third party payers require more extensive information, such as progress notes, before processing claims. This does not usually come back to the employer. If you are concerned about this, you should check to see how your company protects insurance information.
If the use of a collection agency or attorney is necessary to collect a past due balance, your right to confidentiality is curtailed. While no clinical information would be revealed, your name, your employer, etc. and the amount owed, becomes available to these agents. If you have any concerns regarding confidentiality, please feel free to discuss them with me.
Understand that sessions with Kim Wright, LCSW, have been either authorized through an EAP or approved through a Managed Care Insurance program. This may mean that sessions are free of charge to you, or at reduced rates and/or copayments. The client agrees to pay all appropriate copayments as well as applicable deductibles and for services disallowed for any reason by your EAP/MC program or insurance company.
You agree that if you pay by check, your account will be debited electronically for both the face amount and returned check fee ($35.00) if it is returned unpaid. You also understand that you are financially responsible for any collections fees/court costs involved in collecting your past due account. You understand that you are financially responsible for all phone calls longer than 15 minutes. Payment is required at the time service is provided; however, insurance information will be obtained at the first session and insurance will be filled as a courtesy to you for sessions following the initial intake session.

Release and Assignment:
Signing this contract in the separate consents form, will authorize any plan benefits to be paid directly to Kim Wright, LCSW. Clients will be financially responsible for non-covered services, including those for which authorization or payments have been denied, either by my EAP/Managed Care plan or other payor.
If a claim is made by the client, Kim Wright, or a business associate providing billing services to any insurance company or companies, or to any other third party payor, the client does not object to the release by mail, fax, telephone or computer modem, any records or other information about the client, or child, or the services which are provided, including without limitation, the complete case record, information concerning any personal, psychological and medical history, information concerning diagnosis and treatment by Kim Wright, LCSW, and information concerning billing and payment for such services. All such information shall be subject to review by such insurance company or third party payor during the period of the client or child's treatment by Kim Wright, LCSW, or at any other time thereafter. If the parents of a child are separated or divorced and there is joint custody, the other parent's notification of treatment of the child will be as advised by the PA Attorney General's Office.

Electronic Consent Form: (please see additional forms for this Specific Consent)

FEE INFORMATION
Fees are an important issue to anyone receiving professional services.
This fact sheet has been prepared to clarify the policies.

FEES:
My usual and customary fees are $175 for an initial intake, $165 per 55 minute Individual session and $250 per 55-minute session for 2+ people. The fees are subject to vary depending on the specific needs of each client. This will have been discussed with you during the Initial phone consultation or at the 1st session.
Payment is due at the time services are rendered by personal check, credit card, PayPal/Venmo.

INSURANCE:
As a courtesy, I am able to file your insurance for you. **However, the client is expected to pay for non-covered services and deductibles, as well as co-payments, at the time services are rendered. If the insurance payment is not received within 90-days after claim is filed, the client will become responsible for payment of the total amount due. It is your responsibility to follow-up with your insurance carrier for delayed payments or other concerns.**

BILLING:
Bills are mailed monthly after insurance has been filed. This is a reminder of your balance due and is an informational statement to keep you up-to-date regarding the status of your account. My usual and customary collection procedures will be followed in order to collect unpaid balance and copayments due.

MISSED APPOINTMENTS:
IF YOU ARE UNABLE TO KEEP AN APPOINTMENT, PLEASE NOTIFY ME ASAP BY CONTACTING ME VIA 267.888.7511 (Text or Voicemail) or send me an Email at Kim@kimwrightwellness.com

IF AN APPOINTMENT IS CANCELED OR MISSED WITHOUT A 24 HOUR NOTICE, AND YOU ARE UNABLE TO DO A MAKEUP SESSION DURING THE SAME WEEK (pending availability), YOU WILL BE CHARGED FOR THAT SESSION TIME in the **FULL FEE OF $165/$250.**

YOU MAY LEAVE A MESSAGE ON MY VOICEMAIL 24/7
INSURANCE DOES NOT PAY FOR MISSED APPOINTMENTS; THEREFORE, YOU WILL BE FINANCIALLY RESPONSIBLE FOR THE FULL FEE.

RESPONSIBILITY:
The client or referring parent (in the case of minors) is considered responsible for payment of the professional fee. It is the client's responsibility to know the amount of their deductible or co-payment. When I am requested to bill a third party, such as a divorced spouse, relative, or insurance company, and that third party fails to make timely payments, payment is expected from the referring parent that signed the consent for services. The client will be responsible for claims that are denied due to "filing past the insurance carriers time limit" or that are the result of failure by the client to inform this office of changes in insurance coverage. If you have questions or concerns about anything, please discuss them with me.

Thank you for taking the time to read all of this information.

Let us Begin!