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OUTPATIENT SERVICES AGREEMENT

Welcome. This document contains important information about my professional services and business policies. Providing this information to you is considered a standard and ethical part of practice. This form also contains information about the Health Insurance Portability and Accountability Act (HIPAA), a federal law regarding health care records. This form is somewhat lengthy, but it is important that you review it carefully, and raise any questions with me that you might have. After the initial session, keep this document handy, as you may want to refer to it later.

Introduction

Psychotherapy is not easily described in general statements. It varies depending upon the personalities of the psychologist and patient, and the particular problems and treatment goals you would like to address. There are many different methods I may use to deal with the problems that you hope to address for yourself or your child. Unlike visits to your medical doctor, psychotherapy calls for an active effort on the part of patients and parents both during the sessions and at home. Psychotherapy can have benefits and risks. Because therapy often involves discussing difficult issues, you or your child may experience some uncomfortable feelings. On the other hand, psychotherapy has been shown to have benefits for people who go through it. Therapy often leads to better relationships, solutions to specific problems, improved coping skills, and a reduction in feelings of distress. But there are no guarantees of certain results, or of what you will experience.

The initial two to four sessions will involve an evaluation of your/your child's needs. By the end of the evaluation, I will offer feedback and recommendations for you and/or your child. The evaluation period is a time for both you and me to decide if I am the best person to provide the services you need in order to meet your treatment goals. It is also a time for you to evaluate your comfort level working with me. Therapy can involve a substantial commitment of time, energy, and money, so you should be careful about the therapist you select. At the onset of the therapy phase, we will set goals and a meeting schedule. If, during the evaluation or therapy phases, you have questions or concerns about my therapeutic procedures or business policies, I encourage you to bring them up as we go along. I welcome your thoughts and feedback. If you have doubts that persist, I would be happy to facilitate a second opinion or a referral to another clinician. All sessions are 45 minutes long. I typically take care of payments (including copays), and arranging future appointments, at the beginning of each session.

Confidentiality and Limits

In general, the law protects the confidentiality of all communications between patients and a licensed psychologist. With some exceptions, information can be disclosed only with either your written consent or authorization. Your consent in advance for me to share information to conduct treatment, payment, and health care operations is obtained when you sign this agreement. (See the Massachusetts Notice Form for details.) This advance consent covers the following. First, as part of providing you with high quality care, I may periodically consult with other experienced licensed mental health professionals. During these consultations, I will share limited information, but will make every effort not to reveal your or your child's identity. The consultant is also legally bound to keep information confidential. Consultation is a standard, ethical, and accepted part of providing high quality mental health services. I will note consultations in your record. Your consent on this form also allows me to disclose information to health insurers and to collect fees (see later discussion of these topics).

I have decided that although HIPAA and state law allow for consultation with other health care providers with your signature on this form, I will ask for your specific verbal or written permission to share information with these professionals. In addition, you will always be asked to sign an authorization form when I release information to people other than health professionals, such as schools, probation officers, attorneys, relatives, and guardians ad litem. As part of providing quality care, I will typically ask for your authorization to contact your or your child's primary care physician; and if a child, the child's school. I also typically send a brief written summary to your child's pediatrician. At times, I may communicate with other providers or contacts through electronic means.

There are some situations in which the law permits or requires me to disclose information without either your consent or authorization. These circumstances include:

- **Serious or Imminent Harm to Self or Others:** When I have reason to believe that there is an imminent threat that you/your child will harm yourself/himself or another person. In order to protect you or your child, or others, from harm, I am required by law to disclose information or take other protective actions that may include contacting the police, family members, or others who can help provide protection. In addition, I may need to seek hospitalization or notify a potential victim.
- **Abuse/Neglect:** When I have reason to believe that a child, elderly, or disabled person is being or has been abused/neglected, I must report this information to the appropriate state agency. Once such a report is filed by me or another party, I may be required to provide additional information.
- **Judicial:** A judge may order me to disclose records or testify about confidential information in certain legal proceedings. This can include custody matters in divorce.
- **Health Oversight:** If a government agency (such as the Department of Health and Human Services or the State Board of Licensure for Psychologists) requests information for health oversight activities, I may be required to provide it.
- **Complaint/Lawsuit:** If a patient files a complaint or lawsuit against me, I may disclose information regarding that patient to defend myself.
- **Worker's Compensation:** If a patient files a worker's compensation claim, I must, upon appropriate request, provide information to the patient's employer, insurer, or the Department of Worker's Compensation.
- **Other:** Use and disclosure without your consent or authorization may be allowed or required under other sections of Section 164.512 of the HIPAA Privacy Rule and the state's confidentiality law. This includes

certain narrowly-defined disclosures to law enforcement agencies, to a health oversight agency (such as HHS or a state department of health), to a coroner or medical examiner, for public health purposes relating to disease or FDA-regulated products, or for specialized government functions such as fitness for military duties, eligibility for VA benefits, and national security and intelligence.

These limits may apply to all family members participating in the therapy. While this written summary of exceptions to confidentiality should prove helpful in informing you about potential problems, it is important that we discuss any questions or concerns as we go along. The laws governing confidentiality can be complex, and I am not an attorney. If you have specific concerns, you may need to seek formal legal advice.

Records

I am required by state law and by my profession's standards to keep a written record of your/your child's evaluation and treatment (Protected Health Information). There are two types of information that I keep. One set constitutes your clinical record. It includes registration information, evaluation and treatment information, billing records, records I receive from others, as well as reports I sent to insurers or others. I also keep a set of psychotherapy notes, which are notes I make during sessions to facilitate my memory or to organize material. While insurance companies can request and receive a copy of your clinical record, they cannot receive a copy of psychotherapy notes without a special signed authorization from you.

In most cases, you may directly examine and/or receive a copy of your records if you request it in writing. In most situations, I am allowed to charge a reasonable fee to prepare records.

HIPAA provides you with new and expanded rights with regard to your/your child's clinical record. These rights include, but are not limited to, requesting that I amend your record, requesting restrictions on what information in your clinical record is disclosed to others, requesting an accounting of certain disclosures, and determining the location to which information disclosures are sent. (See also the Massachusetts Notice Form.) I am happy to discuss further any of these rights with you.

In the majority of situations, parents of minor children (under 18 years of age) have the legal right to examine records. In divorce situations, both parents have equal access to their child's records, even if one parent has sole legal custody.

If you are in therapy as a couple, both parties have equal access to the medical record, and information cannot be released without the consent of both parties. If I conduct a meeting with one party in the couple, that information is not necessarily private from the other party.

Issues Specific to Children and Adolescents under 18: Consent for Treatment and Privacy

In the majority of cases, I require both parents/guardians to give consent for a child to be in therapy, even if the parents are divorced or living apart. In most cases, it is beneficial for both parents to be involved in some way in a child's therapy, and I will most likely request this. Privacy is sometimes a concern for adolescents who have individual therapy sessions. My policy regarding privacy for individual sessions with adolescents is as follows. I try to provide as much privacy as possible, with the following caveats. Any imminent or significant

safety concern regarding the adolescent or other people will definitely be communicated to parents/guardians. At the beginning of treatment, we can discuss (if relevant for that adolescent) how privacy will be handled in areas involving risk but not imminent danger, such as driving, substance use, online activity, and sexual activity. It may also be helpful at times to share or discuss information about non-safety related topics with parents. In these situations, I will discuss this with the adolescent, and usually the adolescent and I can work out a plan. However, I do reserve the right to share a topic with the parents/guardians if I deem it to be very important, even if the adolescent has not been agreeable to this. Please note that this is a very rare event.

Insurance Companies

If you use your insurance, your contract with your health insurance company grants the company access to information regarding your treatment. They will require a clinical diagnosis initially, and may later require more information after a certain number of sessions. On rare occasions, they may ask for your full record. In such situations, I will make every effort to release only the minimum information about you that is necessary for the purpose requested. Information I send to your insurance company will become part of the insurance company records, and will probably be stored in a computer. Although insurance companies try to maintain confidentiality, I have no control over their policies. By signing this agreement, you agree that I can provide requested information to your carrier. Your signature also indicates that you consent to your insurance company paying me directly for services rendered. I submit either paper claims and authorization forms (to obtain more sessions), or electronic versions of the same. Your signature indicates your consent for these transactions with your insurance company.

If your insurance plan changes, you are responsible for providing me with the new information (identification number etc.) before we meet again. I need to call and obtain insurance information (and authorization if needed) before we resume further sessions.

Contacting Me

If you need to contact me between sessions, please leave a message on my voicemail at 781-862-6200. If I call you from outside my office, the call may come in as “unidentified” or “private”. If you are experiencing a crisis or emergency and are unable to reach me, please contact your local emergency room (or the hospital with which your health insurer contracts) and ask for the psychologist or psychiatrist on call. You can also call 911. If I will be unavailable for an extended time, a colleague will be covering my practice.

I typically just use email and phone calls for scheduling, and not clinical, purposes. I am always happy to arrange an extra appointment if there is an urgent issue that comes up between sessions. To maximize privacy, all patients wanting to send and receive email messages must use the Protected Trust portal. I will send you an invite to set up a free guest account with Protected Trust. You just need to click on the link and put in a username and password. A guest account also allows you to download the phone app, so you can read and send emails on your phone. I am happy to help troubleshoot technical difficulties. If you are unable for some reason to use Protected Trust at a given time, then please use the telephone to leave a message, rather than sending from your regular email account.

Occasionally, you and I decide that for therapeutic reasons, we will have between-session phone or email contacts for clinical purposes. In this case, these contacts (and documentation of same) will be billed to the individual or family (see next section on **Collateral Service Charges**).

Fees and Payment Policy

You will receive a copy of my fee schedule. You will be expected to pay fees in full at the time of the visit, unless you are using health insurance with which I am contracted. In this case, co-payments and deductible amounts (if you have a deductible) are due at each session. Cash and checks are accepted, and can be made out to me directly. If your insurance is not in effect at a given time, you will be responsible for the full charge of the session. I will be happy to print statements for submission to insurance companies for those insurances with which I am not contracted. Checks returned by the bank for insufficient funds will incur a charge of \$20.00.

Collateral Service Charges: As part of conducting the initial evaluation or psychotherapy, it will often be beneficial to provide collateral services to you. This includes phone and email contact with other professionals, such as schools, legal professionals, adjunct mental health professionals, and some physicians. It is my policy to charge the client or family for these services (insurance companies do not pay for collateral services but do allow the provider to bill for them). This time is billed in 6-minute segments (rounded up) at \$200 per hour. Other collateral services that may incur charges include, but are not limited to, phone calls or email contacts with clients that are non-scheduling related (see above “**Contacting Me**” section), documentation of those calls/emails, travel time and preparation time/attendance at meetings, report or letter writing, review of outside records or documents, and preparation of records. All collateral services will be discussed with you in advance to obtain your authorization for them. There is no charge for contact with your or your child’s primary care physician, or psychopharmacology prescribers (if it is only for medication check-ins). However, contacts with other psychotherapists or medical specialists will be billed. If you become involved in legal proceedings that require my participation, even if I am called to testify by another party, you will be expected to pay for my professional time. This preparation, attendance, and travel time will be billed at a higher rate.

If your account is overdue by 60 days and you have not arranged for payment, your balance could be turned over to a collection agency, or action may be taken in small claims court. By law, an agency will be provided only with dates, type of service, and the charge. Costs of legal action will be included in the claim.

Cancellation Policy and Attendance Expectations

If you need to cancel an appointment, I require at least 24 hours notice to avoid a \$100 fee. This fee is billed to the patient/family; insurance companies do not pay for missed appointments. Please leave a message on my voicemail when you need to cancel. I have made a choice to bill much less than my regular fee for missed appointments and late cancellations, but to enforce the policy consistently. While I understand that there are occasions when, for good reason, you may not be able to cancel with 24 hours (the exception to this is dangerous weather conditions), I still expect that the fee will be paid. This is a business policy. This fee must be paid before the next appointment begins.

In general, separate from the 24-hour policy, I ask that patients and families attend at least 5 out of 6 of appointments that they schedule, **without canceling or rescheduling**. If you end up opting for a regularly

scheduled appointment (such as Thursdays at 3), I ask that you make a commitment to keeping this appointment on a regular basis. If, when we are scheduling, I email or call you with several appointment options, you can ask me to hold one of them for 24 hours if that is helpful. After that, if I have not heard from you, I will open that time back up for other clients.

Your signature below indicates your agreement with these terms, and your consent to receive services for yourself or your child. (If you have questions or concerns before signing, please raise them with me.) You may revoke this agreement in writing at any time. That revocation will be binding upon 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 financial obligations you may have incurred.

Name of Client (Print) Signature of Client Date

Name of Client (Print) Signature of Client Date

Signature of Mother/Father/Legal Guardian (under 18)
(Circle One) Date

Signature of Mother/Father/Legal Guardian (under 18)
(Circle One) Date