# PROFESSIONAL SERVICES AGREEMENT

Welcome to my practice. This document contains important information about my professional services and business policies. Please read it carefully and write down any questions you might have so we can discuss them when we meet. When you sign the signature page for this document, it will represent an agreement between us.

**PSYCHOLOGICAL SERVICES**

Psychotherapy is not easily described in general statements. It varies depending on the personalities of the psychologist 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 may have to work on things we talk about both during our sessions and at home.

Psychotherapy can have benefits and risks and there are no guarantees regarding what you might experience. Individuals engaged in psychotherapy often experience uncomfortable feelings such as sadness, guilt, anger, frustration, loneliness, and helplessness when discussing unpleasant aspects of their life. Ordinarily, these are feelings that need to be expressed and understood and may lead to some of the potential benefits of therapy. These benefits often include improved relationships, finding solutions to specific problems, significant reductions in feelings of distress and a generally improved sense of well-being.

**MEETINGS FOR THERAPY EVALUATION AND SESSIONS**

I normally conduct an evaluation that will last from 1 to 3 sessions. During this time, we can both decide if I am the best person to help you meet your treatment goals. By the end of the evaluation, I will be better able to offer you some first impressions of what our work will include if you decide to continue with therapy. In this regard, therapy involves a large commitment of time, money, and energy, so you should be selective about the therapist you choose. If you have questions or concerns about my procedures, we should discuss them whenever they arise. If your doubts persist, I will be happy to help you set up a meeting with another mental health professional for a second opinion. Alternately, if you decide to begin psychotherapy, I will usually schedule one session per week at a time we agree on, although some sessions may be longer or more frequent, as agreed upon between us. If you need to cancel a scheduled appointment, it is expected that you will provide **24 hours advance notice** of cancellation. The reason for this is that I generally will be unable to fill that appointment time if I have less than 24 hours notice. It is important to note that insurance companies do not provide reimbursement for cancelled sessions. If you must cancel an appointment, I will attempt to find another meeting time within the same week. If you do not provide 24 hours notice of cancellation or if you do not show up for a scheduled appointment, you will be charged $30 for the first occurrence. If it happens again you will be charged $60 and on the third occurrence, you will be charged the full cash price for your scheduled appointment.

**PROFESSIONAL FEES**

My hourly fee for individual psychotherapy is $152 for a full 60-minute session and $114 for a 45-minute session. Initial evaluation sessions (also known as diagnostic interviews) are a full 60-minutes each, may require 1 to 3 sessions and are $170. The cost for the service of psychotherapy includes many things. First and foremost, you are paying for the time and skill of a licensed psychologist, who has many years of education, training, and experience. The cost of psychotherapy also includes the time I spend on administrative tasks, as well as, study and research to ensure that I am best informed as to how to help you resolve whatever is troubling you. In addition, I periodically spend time consulting with your other health care providers (with

your written permission) to coordinate care (with your primary care doctor or psychiatrist, for example), and may also seek consultation from professional colleagues to improve the quality of care I provide. So, you are paying for more than the psychotherapy hour itself.

In addition to weekly appointments, I charge $152 per hour for other professional services you may need, although I will break down the hourly cost if I work for periods of less than one hour. These other services may include report writing, telephone conversations lasting longer than a few minutes, preparation of records or treatment summaries, and the time spent performing other requested services or meetings.

Testing and assessment fees vary depending on the type of assessment and the amount of time required to conduct the assessment. If you become involved in legal proceedings that require my participation, you will be expected to pay for all of my professional time, including preparation, transportation costs and housing costs (if required), even if I am called to testify by another party. Because of the complexity of legal involvement, I charge $250 per hour for preparation and attendance at any legal proceeding.

**BILLING AND PAYMENTS**

You will be expected to pay me directly for each session at the time it is held, unless we agree otherwise or unless you have insurance coverage that requires another arrangement. Payment schedules for other professional services not detailed above will be agreed to when they are requested. In circumstances of unusual financial hardship, I may be willing to negotiate a fee adjustment or payment installment plan. For any fees that remain unpaid after 90 days I may need to consult a collection agency.

**INSURANCE REIMBURSEMENT**

In order for us to set realistic treatment goals and priorities, it is important to evaluate what resources you have available to pay for your treatment. If you have a health insurance policy, it will usually provide some coverage for mental health treatment. I will provide you with whatever assistance I can in helping you receive the benefits to which you are entitled; however, you (not your insurance company) are responsible for full payment of my fees. 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 the coverage, call your plan administrator. Of course, I will provide you with whatever information I can based on my experience and will be happy to help you in understanding the information you receive from your insurance company. If it is necessary to clear confusion, I will be willing to call the company on your behalf.

Due to the 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 may benefit from more services after insurance benefits end.

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 treatment plans 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 the 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 data bank. I will provide you with a copy of any report I submit, if you request it. By signing this Agreement, you agree that I can provide requested information to your carrier.

Once we have all of the information about your insurance coverage, we will discuss what we can expect to accomplish with the benefits that are available and what will happen if they run out before you feel ready to end your sessions.

**CONTACTING ME**

Due to my work schedule, I am ordinarily not immediately available by telephone. I do not take phone calls while I am meeting with a patient. When I am unavailable, my telephone is answered by voice mail. I will make every effort to return your call as soon as possible and will strive to return your call within 24 to 48 hours. Please be sure to leave your telephone number on your message. If you are difficult to reach, please inform me of some times when you will be available. If you are unable to reach me in an emergency situation and feel that you cannot wait for me to return your call, please dial 911, or proceed to the nearest hospital emergency room and ask for the psychologist or psychiatrist on call.

**INCIDENTAL ENCOUNTERS**

On occasion and by chance, you may see me in a public place or at a social event. In order to protect your privacy, I ordinarily will NOT say hello to you so that you do not feel compelled to explain who I am to your companions. Therefore, it is entirely up to you if you choose to initiate a conversation in one of these encounters.

**PROFESSIONAL RECORDS**

The laws and standards of my profession require that I keep records. These include information about your reasons for seeking therapy, a description of the ways in which your problem impacts on 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. You are entitled to receive a copy of your records upon written request unless I believe that seeing them would be damaging to you, in which case these records may be sent to another mental health professional of your choice for follow up. Because these are professional records and often use language specific to psychological issues, they can be easily misinterpreted and/or upsetting to untrained readers. For this reason, I recommend that you initially review them in my presence so we can discuss the contents. I am sometimes willing to conduct a review meeting without charge. Patients will be charged an appropriate fee for time spent preparing documents to respond to information requests. You should be aware that pursuant to Texas law, psychological test data are not part of a patient's record.

**LIMITS ON CONFIDENTIALITY**

The law protects the privacy of all communications between a patient and a psychologist. In most situations, I can only release information about your treatment to others with your written permission. There are other situations that require only that you provide acknowledgement of informed consent in advance. Your signature on this Agreement provides consent for those activities, as described below:

- At times when administrative staff members are employed in my practice, I will need to share protected information with these individuals for administrative purposes, such as scheduling, billing, payments, and processing insurance claims. All staff members will be given training about protecting your privacy and will have agreed not to release any information outside of the practice without my explicit direction.

- I may occasionally find it helpful to consult with other health and mental health professionals about how to best meet the needs of my patients. During a consultation, I make every effort to provide only information that is needed to solve the issue at hand without providing any information that could reveal the identity of my patient. The consulting professional is 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. I will note all consultations in your Clinical Record.

- Disclosures required by health insurers or other third party payers or to collect overdue fees that are discussed elsewhere in this Agreement.

*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 for information concerning your diagnosis and treatment; such information **is** protected by law. I cannot provide any information without your (or your legal representative's) written authorization **or** a court order. If you are involved in or are 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 health oversight activities, I may be required to provide it for 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 worker's compensation claim, I must, upon appropriate request, provide records relating to treatment or hospitalization for which compensation is being sought.

*There are some situations in which I am legally obligated to take action. These situations are unusual in my practice and are as follows:*

- If I have cause to believe that a child under 18 years of age has been or may be abused or neglected or that a child is a victim of a sexual offense, or that an elderly or disabled person is in a state of abuse, neglect or exploitation, the law requires that I make a report to the appropriate governmental agency, usually the Department of Protective and Regulatory Services. Once such report is filed, I may be required to provide additional information.

- If I determine that there is a probability that the patient will inflict imminent physical injury on another, or that the patient will inflict imminent physical, mental or emotional harm upon him/herself, or others, I may be required to take protective action by disclosing information to medical or law enforcement personnel or by securing hospitalization of the patient. If such a situation arises, I will make every effort to fully discuss it with you before taking any action and I will limit my disclosure to what is necessary.

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 that you may have now or in the future. The laws governing confidentiality can be quite complex, and I am not an attorney. In situations where specific advice is required, formal legal advice may be needed.

Your signature on the signature page titled "Verification of Understanding of PROFESSIONAL SERVICES AGREEMENT and NOTICE OF PRIVACY RIGHTS AND POLICIES," (at the end of this document) indicates that you have read the information in this Professional Services Agreement and agree to abide by its terms during our professional relationship.

# NOTICE OF PRIVACY RIGHTS AND POLICIES

## THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

## PLEASE REVIEW IT CAREFULLY.

**This notice is presented as follows to comply with the Health Insurance Portability & Accountability Act of 1996, as amended and supplemented (HIPAA) and to comply with the Texas State Board of Psychology Examiners Rules of Practice. If you have any questions about this notice, please contact Dr. Morris at 817-330-4132.**

This Notice of Privacy Practices describes how Pamela Morris, Ph.D. and Clear Fork Psychology Services, PLLC (the Practice) may use and disclose your protected health information (also called PHI) to carry out your treatment, payment for your health care, or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you that may identify you and that relates to your past, present, or future physical or mental health or condition and related to health care services. We are required to maintain the privacy of protected health information and to abide by the terms of this Notice of Privacy Practices. We may change the terms of our notice at any time. The new notice will be effective for all protected health information that we maintain at that time. Upon your request, we will provide you with any revised Notice of Privacy Practices via our website, www.clearforkpsych.com, or by calling the office and requesting that a revised copy be sent to you in the mail or asking for one at the time of your next appointment. Dr. Morris and Clear Fork Psychology Services, PLLC are dedicated to maintaining the privacy of your identifiable health information.

## 1. Uses and Disclosures of Protected Health Information

Your protected health information may be used and disclosed by Dr. Morris, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you. Your protected health information may also be used and disclosed to pay your health care bills and to coordinate services in the operation of the Practice.

Following are examples of the types of uses and disclosures of your protected health care information that the Practice is permitted to make. These examples are not meant to be exhaustive, but to describe the types of uses and disclosures that may be made by our Practice.

**TREATMENT:** Treatment refers to the provision, coordination, or management of healthcare including mental health related to one or more providers. The information provided to insurance and other third party payers may include information that identifies you, as well as your diagnosis, type of service, date of service, provider name/identifier, and other information about your condition and treatment.

**PAYMENT:** My practice may use and disclose your PHI in order to bill and collect payment for the services and items you may receive from us. For example, I may contact your health insurer to certify that you are eligible for benefits (and for what range of benefits), and I may provide your insurer with details regarding your treatment to determine if your insurer will cover, or pay for, your treatment. I also may use and disclose your PHI to obtain payment from third parties that may be responsible for such costs. Also, I may use your PHI to bill you directly for services and items.

**HEALTHCARE OPERATIONS:** My practice may use and disclose your PHI in order to support and operate this practice. These activities may include quality assessment activities, licensing reviews or requirements, or to conduct cost management evaluations and business plans. I may use your information to provide you with appointment reminders or information about treatment alternatives or other relevant health services that may be of interest to you. Portions of your PHI may be disclosed to business associates who are enlisted by this practice to perform services such as: billing, record keeping, telephone answering services, etc.

**HEALTH OVERSIGHT:** My practice may disclose protected health information to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies that oversee the health care system, government benefit programs, other government regulatory programs and those responsible for enforcing civil rights laws.

**CRIMES ON THE PREMISES OR OBSERVED BY ME:** Crimes that are observed by me or directed at me or occur at my business location will be reported to law enforcement.

**INVOLUNTARY CLIENTS:** Information regarding clients who are being treated involuntarily pursuant to law, will be shared with other treatment providers, legal entities, third party payers and others, as necessary to provide the care and management coordination needed.

**FAMILY MEMBERS:** Except for certain minors, incompetent clients or involuntary clients, protected health information cannot be provided to family members without the client's consent. In situations where family members are present during a discussion with the client, and it can be reasonably inferred from the circumstances that the client does not object, information may be disclosed in the course of that discussion. However, if you object, PHI will not be disclosed.

**BREACH NOTIFICATION:** We will notify affected individuals of any breach of unsecured PHI.

**EMERGENCIES:** In life threatening emergencies, I will disclose information necessary to avoid serious harm or death.

**WORKERS' COMPENSATION:** We may disclose Your PHI as authorized to comply with workers' compensation laws and other similar legally established programs.

**CLIENT AUTHORIZATION TO DISCLOSE INFORMATION:** I may not use or disclose PHI in any other way without a signed Authorization or Consent to Release Information. When you consent to release information, you may revoke it later, provided that the revocation is in writing. The revocation will apply, except to the extent I have already taken action in reliance thereon.

**DISCLOSURES REQUIRED BY LAW:** My practice will use and disclose your PHI when I am required to do so by federal, state or local law. This includes but is not limited to: reporting child abuse or neglect, reporting the abuse of the elderly or disabled, when court ordered to release information, when there is a legal duty to warn or take action regarding imminent danger to others, when the client is a danger to self, when required to report certain communicable diseases and injuries; and to a coroner or medical examiner for identification purposes, determining cause of death or for the coroner or medical examiner to perform other duties authorized by law.

**REQUIRED USES AND DISCLOSURES:** Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of the Health Insurance Portability and Accountability Act, Section 164.500 et. seq.

## 2. Your Rights

Following is a statement of your rights with respect to your protected health information and a brief description of how you may exercise these rights.

### NOTICE OF PRIVACY PRACTICES

**You have the right to inspect and copy your protected health information.** You have the right to inspect and obtain a copy of the PHI information that I have regarding you and the record. There are some limitations to this right, which will be explained to you at the time of your request, if such a limitation applies. To make such a request, please talk to me. Pamela Morris, Ph.D., Licensed Psychologist; 4971 East I-20 Service Road North, Clear Fork Psychology Building; Willow Park, TX 76087 www.ClearForkPsych.com.

**Right to Access and Notice of Electronic Health Records under Texas Law. You are hereby notified that the Practice maintains an electronic health record system for some or all of your records.** You may submit a written request to the Practice for a copy of your electronic health records that will be provided to you electronically unless you agree to accept your records in another form. Under limited circumstances, your request may be denied.

**You are hereby notified that your electronic health record is subject to electronic disclosure. You have the right to request a restriction of your protected health information.** This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply. You have the right to restrict disclosure

of PHI to a health plan where you paid out-of-pocket, in full, for the care or service provided. We are not required to agree to a restriction that you may request. If we believe it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. If we do agree to the requested restriction, we may not use or disclose your protected health information in violation of that restriction unless it is needed to provide emergency treatment. With this in mind, please discuss any restriction you wish to request with Dr. Morris.

**You have the right to request to receive confidential communications from us by alternative means or at an alternative location.** You have the right to request that you receive communications of PHI from me by alternative means or locations. For example, if you do not want bills sent to your home, you may provide a different address for written correspondence. There are limits to such requests that will be afforded to you, but we will attempt to accommodate reasonable requests. Please make this request in writing to Dr. Morris.

**You may have the right to have your protected health information amended.**
You have the right to request that I amend your PHI. I am not required to amend the record if it is determined that the record is accurate and complete or when there are other exceptions, which will be provided to you at the time of your request, along with how to pursue an appeal process.

**You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.** This right applies to disclosures for purposes other than treatment, payment or healthcare operations as described in this Notice of Privacy Practices. It excludes disclosures we may have made to you, to family members or friends involved in your care, or for notification purposes to legal or regulatory agencies. The right to receive this information is subject to certain exceptions, restrictions and limitations.

**You have the right to obtain another paper copy of this notice from us, upon request, even if you have received one previously or have agreed to accept this notice electronically.**

## 3. Questions or Complaints

If you have a question or complaint about your privacy rights, please contact Dr. Morris by phone at **817-330-4132** or by mail at 4971 East I-20 Service Road North, Clear Fork Psychology Building; Willow Park, TX 76087. If Dr. Morris is unable to resolve your complaint to your satisfaction, you may send a written complaint to the Office of Civil Rights, U.S. Department of Health & Human Services, 200 Independence Avenue, S.W., Room 509F, HHH Building, Washington, D.C. 20201. We will not retaliate against you for filing a complaint.

**This notice became effective on January 2, 2020.**

# Verification of Understanding of

# PROFESSIONAL SERVICES AGREEMENT and

# NOTICE OF PRIVACY RIGHTS AND POLICIES

*I have read, understood and received or been offered a copy of the PROFESSIONAL SERVICES AGREEMENT AND NOTICE OF PRIVACY RIGHTS AND RESPONSIBILITIES dated 1/2/2020 as it is presented for compliance with the Health Insurance Portability & Accountability Act of 1996, as amended and supplemented (HIPAA) and with the Texas State Board of Psychology Examiners Rules of Practice and as the written explanation of the privacy policies of Dr. Russ Morris's practice in clinical psychology.*

_____ _____

Signature Date

_____

Printed Name

_____ _____

Additional Signature (if needed) Date

_____

Printed Name

## OPTIONAL - AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

| **Patient's Name:** | **Date of Birth:** |
|---|---|
| | |

This form when completed and signed by you, authorizes Pamela Morris, Ph.D. to release protected information from your clinical record to the person you designate. This ordinarily your physician for the purposes of coordinating treatment or evaluation efforts, but may be used if you wish to disclose protected information to other individuals or agencies.

I _____ authorize Pamela Morris, Ph.D. to correspond and release/obtain relevant information to/from:

(Name of individual, health care provider, agency, etc.)

(Address)

(Phone & Fax)

For the purpose(s) of:

Coordinating treatment and evaluation

In authorizing the release of confidential information, I hereby waive all restrictions and privileges imposed by law and release Pamela Morris, Ph.D. from any restriction or privilege imposed by law in connection with the disclosure or release of any professional record, observation or communication.

I understand that if my protected health information is disclosed to someone who is not required to comply with the federal privacy regulations, then such information may be re-disclosed and would no longer be protected. I understand that this authorization may be revoked at any time, except to the extent that Pamela Morris, Ph.D. has already taken action to release the information. My revocation must be in writing in a letter to Pamela Morris, Ph.D., PLLC at the address listed on this authorization form. I certify that I have read and may receive a copy of this authorization upon request. This authorization supersedes any and all previous authorizations.

_____ _____

Patient's signature/Authorized Individual Date