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## THERAPIST - CLIENT SERVICE AGREEMENT

Welcome to my practice.

This document (the *Agreement*) contains important information about the professional services and business policies of Denise C. Wall, LCSW. It also contains summary information about the *Health Insurance Portability and Accountability Act (HIPAA)*, a new federal law that provides new privacy protections and client 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 (the Notice, or NPP)* 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. Keep in mind that other laws as well as court orders and contracts may affect privacy rights and the service agreement as well. The law requires that I obtain your signature acknowledging that I have provided you with the *Notice* at the end of the 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 that time. When you sign this *Agreement*, 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 already 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 services provided by Denise C. Wall, LCSW, include

- Therapeutic evaluation;
- Couples' and family therapy;
- Psychotherapy approaches to medical problems, academic and career services;
- Psycho-educational evaluation, and services related to divorce and child custody.

We will begin our work by developing an understanding of what services are being requested, and we will develop an initial plan and set of recommendations about how to go about meeting the goals of the work that is to be done. The next two paragraphs provide an overview of my services. If you request a service other than psychotherapy (e.g., testing, career or performance coaching, etc.) you may skip this description and review the description of the service you requested in the addendum to this agreement.

Psychotherapy is the treatment of emotional pain, stress, maladaptive behaviors or mental illness. Important dimensions of psychotherapy include the techniques used, the understanding of the problems to be addressed and the goals that will represent progress or resolution, and the relationship between the psychotherapist and client. A skilled therapist can work with a range of approaches and techniques, and can modify these according to what proves most useful for the particular client. I welcome a collaborative approach and encourage your feedback and questions about techniques and approaches used, as well as your own ideas about what goals you wish to work toward.

Over the first few sessions, I will be working to understand your situation, difficulties, and goals. Within that time, I will be able to offer you some first impressions of what our work together will include and an initial set of recommendations regarding frequency of sessions and therapeutic approach. You are encouraged to ask any questions you may have about this process or these recommendations. Should you choose to continue in therapy, we will review goals, progress, approach and techniques in an ongoing way and whenever you request that we do so. If you prefer not to continue, you are welcome to request a referral to another mental health professional, and I will be glad to facilitate that referral. If I think that it is in your best interest to see someone other than myself, I will let you know this, and again, I will be glad to facilitate a referral.

## MEETINGS/CANCELLATIONS

Over the course of the first few sessions, we will discuss together whether we both think I can help you to meet your treatment goals. If we decide to continue to meet together, I will recommend a frequency for our sessions. Weekly sessions are typical, although some people benefit most from more or less frequent sessions than this, and the frequency may change over the course of treatment. **Once an appointment is scheduled, you will be expected to pay a late-cancellation fee unless you provide 24 hours' advance notice of cancellation.** It is important to note that insurance companies do not provide reimbursement of these fees. If I am able to reschedule a missed appointment for the same week, I will *not* charge for the originally scheduled appointment. Fees are not charged if it is necessary for you to cancel on short notice due to sudden illness or legitimate emergency situation.

## PROFESSIONAL FEES

My fee is \$110.00 per session for Initial Assessments and \$90.00 per session for subsequent treatment visits. In addition to scheduled appointments, I charge \$90.00 per hour for other professional services you may need, though I will break down the hourly cost if I work for periods of less than one hour. Examples of "other services" include:

- Report writing;
- Telephone conversations lasting longer than 5 minutes will be billed in 15-minute increments;
- Consulting with other professionals at your request;
- Preparation of records or treatment summaries, and
- The time spent performing any other agreed-upon service you may request of me.

*Note: 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 and transportation costs, even if I am called to testify by another party. Because of the complex demands of legal involvement, I charge \$100.00 per hour for preparation and attendance at any legal proceeding.*

## BILLING AND PAYMENTS

You will be expected to pay 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 are available upon request. Notice of rate increases will be provided to current clients with at least three (3) months' notice. In circumstances of unusual financial hardship, I may be willing to negotiate a fee adjustment or payment installment plan.

If your account has not been paid for more than 60 days and arrangements for payment have not been agreed upon, I have the option of using legal means to secure the payment. This may involve hiring a collection agency 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 client'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. There is a \$40 charge for returned checks.

## 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 probably provide some coverage for mental health treatment. I will fill out forms and 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 ask my office assistant 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. Some plans 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 continued therapy after a certain number of sessions. While much can be accomplished in short-term therapy, some clients feel that they need to continue their work after insurance benefits end. Should such considerations apply in your situation, we will discuss them well in advance of the termination of your benefits.

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 in rare cases, 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 databank. 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. If you do not pay the session charge in full at the time of service (e.g., because you have a managed care plan and we are participating providers), you must authorize "*Assignment of Benefits*" on the form provided so that your insurer may pay us directly.

## CONTACTING ME

Due to my work schedule, I am typically not immediately available by telephone. While I am usually in my office between 9:00 AM and 6:15 PM, I do not answer the phone when I am with a client. When I am unavailable, my telephone is answered by my office assistant or is forwarded to my voice mail. I will make every effort to return your call within 1 to 2 business days. If you are difficult to reach, please inform me of some times when you will be available.

In the event of an emergency, please dial 911. You may also wish to contact the Crisis Intervention 24-hour hotline at 302-575-1112 or 800-345-6785.

#### LIMITS ON CONFIDENTIALITY

The law protects the privacy of all communications between a client and a therapist. In most situations, I can only release information about your treatment to others if 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, advance 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, it is my responsibility to avoid revealing any information that would allow the colleague to discern the identity of my client. The other professionals are also legally bound to keep the information confidential. With your agreement, I will not tell you about such consultations unless I feel that it is important to our work together. I will note any such consultations in your Clinical Record
- You should be aware that I practice with other clinicians and that I 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. All mental 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 I believe that a client presents an imminent danger to his/her health or safety, 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 for information concerning the professional services that I provided you, such information is protected by the psychologist-client privilege law. I cannot provide any information without your 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 health oversight activities, I may be required to provide it for them.
- If a client were to file a complaint or lawsuit against me, I would have the right to disclose relevant information (regarding that client only) in order to defend myself.

There are some situations in which I am legally obligated to take actions that in my professional opinion are necessary to attempt to protect others from harm, and in such cases I may have to reveal some information about a client's treatment. These situations are unusual in my practice.

- If I have cause to suspect that a child under 18 is abused or neglected, or if I have reasonable cause to believe that an elder or disabled adult is in need of protective services, the law requires that I file a report with the County Director of Social Services. Once such a report is filed, I may be required to provide additional information.
- If I believe that a client presents an imminent danger to the health and safety of another, I may be required to disclose information in order to take protective actions, including initiating hospitalization, warning the potential victim, if identifiable, and/or calling the police.

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.

#### PROFESSIONAL RECORDS

You should be aware that, pursuant to *HIPAA*, I may keep *Protected Health Information* about you in two separate sets of professional records. One set constitutes your *Clinical Record*. It includes 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. Except in unusual circumstances that involve danger to yourself and/or others or the record makes reference to another person (unless such other person is a health care provider) and I believe that access is reasonably

likely to cause substantial harm to such other person, you may examine and/or receive a copy of your *Clinical Record*, if you request it 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 circumstances, I am allowed to charge a fee for copying, 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 records, you have a right of review, which I will discuss with you upon request.

In addition, I may also keep a set of treatment notes. These *Notes* are for my own use and are designed to assist me in providing you with the best treatment. While the contents of these treatment *Notes* vary from client to client, they can include the contents of our conversations, my analysis of those conversations, and how they impact on your therapy. They may also contain particularly sensitive information that you may reveal to me which is not required to be included in your *Clinical Record* and information revealed to me confidentially by others. These *Notes* are kept separate from your *Clinical Record*. Your *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.

**CLIENT RIGHTS**

*HIPAA* provides you with several new or expanded rights with regard to your *Clinical Records* and disclosures of protected health information. These rights include requesting that I amend your record; requesting restrictions on what information from your *Clinical Records* 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 AND PARENTS**

In Delaware, children do not have the right to independently consent to and receive mental health treatment without parental consent and, in that situation; information about that treatment cannot be disclosed to anyone without the agreement of the custodial parent. While privacy in Denise my practice is very important, particularly with teenagers, parental involvement is also essential to successful treatment and this requires that information be shared with parents. I will also provide parents with a summary of their child's treatment when it is complete, upon request; I do charge for my time in preparing this summary. If in my professional opinion the child is in danger or is a danger to someone else, 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 address any questions or concerns he/she may have. It is possible that parent/minor confidentiality issues can be modified in a separate written contract upon request.

**TERMINATION:**

Termination of treatment is normally determined in advance through discussion by therapist and client. It is not unusual for appointments to be spaced out for longer periods as progress is made. A planned, final session allows for consolidation of gains, review of recommendations and closure. It is necessary that treatment be classified as *active and ongoing* or *terminated*. In instances when no formal termination or return appointment was made, and no contact has occurred in sixty days, your client account status will be changed to closed.

Your signature below indicates that you have read the document entitled "THERAPIST - CLIENT SERVICE AGREEMENT" and agree to abide by its terms during our professional relationship.

Signed: \_\_\_\_\_  
(Signature of client, parent or legal guardian; relationship to client if not self)

Date: \_\_\_\_\_

Signed: \_\_\_\_\_  
Denise C. Wall, LCSW

Date: \_\_\_\_\_

CLIENT COPY

Your signature below indicates that you have read the document entitled "THERAPIST - CLIENT SERVICE AGREEMENT " and agree to abide by its terms during our professional relationship.

Signed: \_\_\_\_\_  
(Signature of client, parent or legal guardian; relationship to client if not self)

Date: \_\_\_\_\_

Signed: \_\_\_\_\_  
*Denise C. Wall, LCSW*

Date: \_\_\_\_\_

OFFICE COPY