Psychiatric & Psychological Associates of Durham, PLLC

Serving Our Community For Over 40 Years

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CONSENT AGREEMENT

This Agreement contains information about the professional services and business policies of PPAD, PLLC. It also contains information about the Health Insurance Portability and Accountability Act (HIPAA), a federal law that went into effect April 14, 2003 and provides privacy protections and patient rights regarding use and disclosure of your Protected Health Information (PHI) for purposes of treatment, payment, and health care operations. Please read this *Consent Agreement* carefully. Your signature at the end signifies your consent to the Agreement. You may revoke your consent in writing at any time.

Treatment: Treatment begins with an evaluation by your clinician, which usually lasts from 2 to 4 sessions. By the end of the evaluation, your clinician will offer you some first impressions of what your work will include and a treatment plan. You should evaluate this information, along with your own opinion, and decide if you want to continue in treatment and if you are comfortable working with your clinician. If you are not comfortable, your clinician will be happy to refer you to another clinician. Because treatment involves a commitment of time, energy, and money, you should be careful about the clinician you select. If you have questions about your treatment, you should discuss them with your clinician. If your doubts persist, your clinician will help you arrange a meeting with another mental health professional for a second opinion.

Most of the services that we offer involve psychotherapy, which calls for an active effort on the patient's part. To be successful, psychotherapy requires that you work on things during and outside of your sessions. Psychotherapy can have benefits and risks. Since it often involves discussing unpleasant aspects of your life, you may experience uncomfortable feelings like sadness, guilt, anger, frustration, loneliness, and helplessness. On the other hand, psychotherapy has been shown to have benefits such as improved relationships, more productive problem solving, reduction of distress, and increased sense of well-being. There are, however, no guarantees about what you will experience. As you continue in treatment, the following practices will apply:

- **Appointments** will usually be made with the clinician. Office staff is here between 8:30 am – 5:30 pm, Monday through Friday. Voice mail is available 24 hours a day, 7 days a week.
- **Cancellations should be made <u>24 hours in advance</u> to avoid a <u>$50 late cancellation fee</u>**. The fee may be waived if there is a bona fide emergency. The missed appointment will be indicated on your billing statement, and insurance companies will not pay for it.
- **Late arrival** for sessions sometimes occurs. If the clinician is late for the appointment, you will be seen for the full appointment time if your schedule permits, or your fee will be adjusted accordingly. If you are late, you will be seen for the remaining, not the entire, appointment time.
- **Behavior** must be appropriate on the premises. Threatening, assaultive, or violent behavior is not allowed. Guns and smoking are not allowed in the building. Children must be supervised at all times.
- **Emergencies:** For emergencies and urgent problems, clinicians are available through the office staff during regular working hours. Outside of office hours, please leave a message on your clinician's confidential voice mail line, or follow other instructions they may have given to you (including pager and/or home phone number). If your clinician is out of town, coverage is provided by another clinician in the practice and the patient is instructed on how to reach that clinician. If you cannot reach a clinician, go to your nearest hospital Emergency Room and ask for the Psychiatrist on call.
- **Privacy & Confidentiality:** We follow the HIPAA (2003) and state regulations in assuring the privacy of your Protected Health Information (PHI). Please read the attached *PRIVACY NOTICE*. Your signature on this *Consent Agreement* indicates that you have read and understood the content of the Privacy Notice. Since confidentiality about your care is essential, your clinician and the staff will assume that the addresses and phone numbers you give us to reach you are secure for correspondence and messages to you. If this is not the case, please let your clinician know in writing. A clinician may occasionally use a cell phone for communicating with you. Please notify your clinician in writing if the use of a cell phone is not acceptable to you.

- **Children, Minors, or Adults Adjudicated Incompetent**. Only the custodial parent(s) or legal guardian may request or consent for treatment; request to review, inspect or amend the patient's PHI; or consent to or authorize release of information from the patient's PHI .

Payment:

- **Fees:** Current fees for most frequent charges are:

	M. D.	Ph.D./Psy.D./LCSW
Initial Diagnostic Interview (External referral/Internal referral)	$260 / $220	$165
Individual Psychotherapy (45-50 minutes)	$170	$125
Individual Psychotherapy (20-30 minutes)	$110	$ 80
Outpatient Pharmacological Management	$ 90	NA
Family Psychotherapy / Without patient	$160	$160
Family Psychotherapy / With Patient	$180	$180
Psychological Testing (per hour)	NA	$185
Special Report Writing (per hour)	$185	$185
Missed appointment without 24 hour notice	$ 50	$ 50

  Charges for procedures not listed will be discussed with you prior to providing the service. Fees are expected to be paid at the time of service in their entirety or as a co-pay if you have insurance. You will be notified by an office posting or by your clinician prior to a fee increase. There will be a $25 charge for returned checks.

- **Insurance Reimbursement**: If we are providers with your insurance or managed care company, you must obtain initial authorization, communicate your mental health benefit to us, and make your co-pay at each visit and your deductible annually. If we are not providers for your insurance company or you do not have mental health coverage, you will be responsible for the entire fee at the time of the appointment. It is your responsibility to alert us of any changes in your insurance plan. If we have made all efforts to comply with your mental health insurance carrier, but the company refuses payment, or you have exhausted the limits of your policy, you will be responsible for the entire bill.

- **Managed Care**: If your managed care plan requires utilization review (UR) to authorize continued reimbursement for services, you are consenting to PHI being reported to case managers in the form of written or verbal reports. Even if you and your clinician have complied with all of the UR requirements, there is no guarantee that your insurance company will authorize further treatment. In the case of a disagreement between your managed care plan and clinician's recommendation, your clinician will notify you about suggested next steps in your treatment process.

- **Delay of Payment:** All payments past 90 days due will be considered in default.

Health Care Operations:

- **Billing**: You will receive a billing statement at the end each month with that month's payment activity and total balance. Your primary insurance will be filed monthly. Secondary insurance claims will not be filed. We will accept automatic crossover from Medicare. The Billing Manager is available to answer any questions and assist you in seeking payment on claims.

- **Credit Balances:** Any credit balance on your account will be used to offset charges for future services. If you are not in active treatment, any credit balance will be refunded to the appropriate party.

- **Default:** If your account is declared in default, the total outstanding balance will be declared immediately due, an annual 18% interest (1.5% per month) will be added to the outstanding balance, and an attorney or credit service will be employed to pursue payment. Only your demographic information and amount owed will be disclosed for collection purposes.

Signature:

Your signature certifies that you: (1) understand, consent to, and agree to abide by the business and clinical procedures outlined in this *Consent Agreement*; (2) received a copy of, read, and understand the *Privacy Notice*: *Policies and Procedures to Protect the Privacy of Your Mental Health Information.*

____
Patient's Name Printed

____
Parent / Legal Guardian Name Printed

____
Signature of Patient or Parent / Legal Guardian

____
Date