Benson
psychological services
1308 23rd Street S
Fargo, ND 58103
Phone: 701-297-7540 Fax: 701-297-6439

OUTPATIENT SERVICES CONTRACT
2018

Welcome to Benson Psychological Services, PC. This document contains important information about our professional services and business policies. Please read it carefully and jot down any questions you might have so that we can discuss them at our next meeting. When you sign this document, it will represent an agreement between us.

Therapy is a relationship that works in part because of clearly defined rights and responsibilities held by each person. This frame helps to create the safety to take risks and the support to become empowered to change. As a client in psychotherapy, you have certain rights that are important for you to know about because this is your therapy, and the goal is your well-being. There are also certain limitations to those rights that you should be aware of. As a therapist, I have corresponding responsibilities to you.

PSYCHOLOGICAL SERVICES

Psychotherapy is not easily described in general statements. It varies depending on the personalities of the therapist and patient, and the particular problems you bring forward. 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 will have to work on things we talk about both during our sessions and at home.

Psychotherapy can have benefits and risks. Since therapy 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 also been shown to have benefits for people who go through it. Therapy often leads to better relationships, solutions to specific problems, and significant reductions in feelings of distress. But there are no guarantees of what you will experience.

Our first few sessions will involve an evaluation of your needs. By the end of the evaluation, I will be able to offer you some first impressions of what our work will include and a treatment plan to follow, if you decide to continue with therapy. You should evaluate this information along with your own opinions of whether you feel comfortable working with me. Therapy involves a large commitment of time, money, and energy, so you should be very careful about the therapist you select. If you have questions 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, either inside our clinic or at another clinic in the same geographical area, for a second opinion.

CONTACTING YOUR THERAPIST

I am often not immediately available by telephone, because I do not answer the phone when I am with a patient. When I am unavailable, my telephone is answered by either voice mail or my secretary. I check voice mail frequently. I will make every effort to return your call on the same day you make it, with the

exception of weekends and holidays. If you are difficult to reach, please inform me of some times when you will be available. If you are unable to reach me and feel that you can't wait for me to return your call, contact your family physician, the nearest emergency room and ask for the psychologist/psychiatrist on call, the crisis line at 211, or the National Suicide Hotline 1-800-273-8255. If I will be unavailable for an extended time, I will provide you with the name of a colleague to contact, if necessary.

MINORS

If you are under eighteen years of age, please be aware that the law may provide your parents the right to examine your treatment records. It is my policy to request an agreement from parents that they agree to give up access to your records. If they agree, I will provide them only with general information about our work together, unless I feel there is a high risk that you will seriously harm yourself or someone else. In this case, I will notify them of my concern. I will also provide them, if they ask for it, with a summary of your care, your diagnoses, your treatment plan, your progress towards these goals, my best estimate about how much time it may take to meet these goals and what they can do to support these goals. Before giving them any information, I will discuss the matter with you, if possible, and do my best to handle any objections you may have with what I am prepared to discuss.

If you are the parent or legal guardian of a minor child you are referring for me to see for therapy please know that by signing this you are agreeing to allow me, as your child's therapist, to determine what information I do and do not share with you. If I feel your child is at a high risk to seriously harm themselves or someone else, I will notify you. I will provide you, at your request, with a summary of your child's care, your child's diagnoses, their treatment plan, their progress toward these goals, my best estimate about how much time it may take to meet their goals and what you can do to support these goals. As their parent or legal guardian, your role is critical to your child's care. I welcome your partnership in your child's therapy and invite and encourage you to take an active role in their treatment.

Furthermore, by consenting to have your child seen by me for therapy, you are also agreeing that my role is limited to providing treatment and that you will not involve me in any legal dispute, especially a dispute concerning custody or custody arrangements (visitation, etc.).

Although my responsibility to your child may require my involvement in conflicts between the two of you, I need your agreement that my involvement will be strictly limited to that which will benefit your child. This means, among other things, that you will treat anything that is said in session with me as confidential. Neither of you will attempt to gain advantage in any legal proceeding between the two of you from my involvement with your children. In particular, I need your agreement that in any such proceedings, neither of you will ask me to testify in court, whether in person, or by affidavit. You also agree to instruct your attorneys not to subpoena me or to refer in any court filing to anything I have said or done.

Note that such agreement may not prevent a judge from requiring my testimony, even though I will work to prevent such an event. **If I am required to testify, I am ethically bound not to give my opinion about either parent's custody or visitation suitability.** If the court appoints a custody evaluator, guardian ad litem, or parenting coordinator, I will provide information as needed (if appropriate releases are signed or a court order is provided), but I will not make any recommendation about the final decision. Furthermore, if I am required to appear as a witness, the party responsible for my participation agrees to reimburse me at the rate of $250 per hour for time spent traveling, preparing reports, testifying, being in attendance, and any other case-related costs.

_____

CONFIDENTIALITY

With the exception of certain specific exceptions described below, and those outlined above for minor clients, you have the absolute right to the confidentiality of your therapy. I cannot and will not tell anyone else what you have told me, or even that you are in therapy with me without your prior written permission. I will always act so as to protect your privacy even if you do release me in writing to share information about you. You may direct me to share information with whomever you chose, and you can change your mind and revoke that permission at any time.

You are also protected under the provisions of the Federal Health Insurance Portability and Accountability Act (HIPAA). This law insures the confidentiality of all electronic transmission of information about you. Whenever I transmit information about you electronically (for example, sending bills or faxing information), it will be done with special safeguards to insure confidentiality. If you elect to communicate with me by email at some point in our work together, please be aware that email is not completely confidential. All emails are retained in the logs of your or my internet service provider. While under normal circumstances no one looks at these logs, they are, in theory, available to be read by the system administrator(s) of the internet service provider. Any email I receive from you, and any responses that I send to you, will be printed out and kept in your treatment record. From time to time our clinic will communicate within the clinic by email. This may include the receptionist informing your therapist that you called to cancel, questions about benefits or bills, or other information to help coordinate patient care. Furthermore, there may be occasions that we communicate with people outside of the agency (assuming you have signed a release allowing this communication) such as informing your attorney as to the status of your case, discussions with your case manager, correspondence with your child's teacher, etc. By your signature at the end of this document you are consenting to this.

The following are legal exceptions to your right to confidentiality. I would inform you of any time when I think I will have to put these into effect.

1. If I believe that a patient is threatening death or serious bodily harm to another; I may be required to take protective actions. These actions may include notifying the potential victim, contacting the police, or seeking hospitalization for the patient. If the patient threatens to harm himself/herself, I may be obligated to seek hospitalization for him/her or to contact family members or others who can help provide protection.

2. If I have reasonable cause to suspect that you are abusing or neglecting a child or vulnerable adult, or if you give me information about someone else who is doing this, as a mandated reporter, I must inform Child Protective Services. Please note, any reports or supporting documentation provided for the purpose of making a report to child or adult protective services will not be released in response to requests for records under HIPAA or any other data disclosure law. Release of such protected information in response to litigation discovery demands will be made only in accordance with the professional guidelines of the American Psychological Association and as ordered by a judge in a court of law.

3. To comply with North Dakota State law, ND Century code 23-01-41 and Administrative Code 33-03-34 which establishes Autism Spectrum Disorder as a mandatory reportable condition, which must be reported within 30 days of diagnosis, or if previously diagnosed, within 30 days of the first patient encounter with reporter.

4. If I believe that you are in imminent danger of harming yourself, I may legally break confidentiality and call the police or the county crisis team. I will explore all other options with you before I take this step. If at that point you were unwilling to take steps to guarantee your safety, I will call the crisis team.

5. In most legal proceedings, you have the right to prevent me from providing any information about your

treatment. However in some proceedings involving child custody and those in which your emotional condition is an important issue, a judge may order my testimony and/or release of records if he/she determines that the issues demand it.

The following are not legal exceptions to your confidentiality. However, they are clinic policy you should be aware of if you are choosing to receive care here.

6. If you, your parent, spouse, or legal guardian, files a complaint against me with my licensing board regarding your care, I will need to respond to the board's request for information in their investigation of that complaint which may include sending copies of your therapy notes or other items in your file to the requesting licensing board.

7. I may occasionally find it helpful to consult other professionals about a case. During a consultation, I make every effort to avoid revealing the identity of my patient. The consultant 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. Most often, this consultation occurs with other therapists here at Benson Psychological Services. This is done to make sure that I am providing you with the best possible care.

8. If you and your partner decide to have some individual sessions as part of the couples therapy, what you say in those individual sessions will be considered to be a part of the couples therapy, and can and probably will be discussed in our joint sessions. *Do not tell me anything you wish kept secret from your partner.* I will remind you of this policy before beginning such individual sessions.

These situations have rarely occurred in my practice. If a similar situation occurs, I will make every effort to fully discuss it with you before taking any action.

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 at our next meeting. I will be happy to discuss these issues with you if you need specific advice, but formal legal advice may be needed because the laws governing confidentiality are quite complex, and I am not an attorney.

PROFESSIONAL RECORDS

I am required to keep records of the professional services I provide. Should you choose to, you may have access to these records, unless I feel that to see them would be emotionally damaging, in which case I will provide you with a treatment summary.

VIDEO/AUDIO RESTRICTIONS

I understand that the use of any audio or video recording device by either party during session is strictly prohibited, unless both parties agree otherwise. If both parties wish to have sessions recorded in any way a separate form will need to be filled out.

DIAGNOSIS

If a third party such as an insurance company is paying for part of your bill, I am normally required to give a diagnosis to that third party in order for them to cover the service. Diagnoses are technical terms that

describe the nature of your problems and something about whether they are short-term or long-term problems. If I do use a diagnosis, I will discuss it with you. All of the diagnoses come from a book titled the ***DSM-5;*** I have a copy in my office and will be glad to let you view it and learn more about what it says about your diagnosis.

OTHER RIGHTS

You have the right to ask questions about anything that happens in therapy. I'm always willing to discuss how and why I've decided to do what I'm doing, and to look at alternatives that might work better. You can feel free to ask me to try something that you think will be helpful. You can ask me about my training in working with your concerns, and can request that I refer you to someone else if you decide I'm not the right therapist for you. You are free to leave therapy at any time.

YOUR RESPONSIBILITIES

You are responsible for coming to your session on time and at the time we have scheduled. Sessions typically last for 45 minutes. If you are late, we will end on time and not run over into the next person's session. Our hourly fee is $200 per therapy hour (45 minutes). The initial appointment, called an intake, is billed at a flat rate of $250. Testing costs $250 an hour.

In addition to weekly appointments, I charge 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. Other services include report writing, telephone conversations lasting longer than 15 minutes, attendance at meetings with other professionals you have authorized, preparation of records or treatment summaries, and the time spent performing any other service you may request of me.

If you become involved in legal proceedings that require my participation, you will be expected to pay for my professional time. Because of the difficulty of legal involvement, we charge $250 per hour for preparation and attendance at any legal proceeding.

If at any time I am placed in a position to resist disclosure of your records it will likely require the assistance of an attorney. Should this occur, the fee charged by the attorney will be passed along to you.

INSURANCE REIMBURSEMENT / 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 which requires another arrangement. Payment schedules for other professional services 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, or to refer you to other agencies that provide services on a sliding fee scale.

You will be responsible for paying any deductible and co-payments. Benson Psychological Services now asks for credit card information to be kept on file and will bill your credit card for any outstanding balance.

If you prefer to pay by cash or check **these payments are due at the time of service.** If your insurance company rejects all or part of your claim, you will be responsible for paying the balance. If your insurance carrier is a preferred provider or managed-care organization with whom we have a contractual agreement, fees will be governed by the terms of those contracts. You are responsible for paying any deductibles and co-payments. If you are not using insurance benefits, full payment is due at the time of service.

Cancelled or missed appointments with less than 24 hours notice are billed at the full therapy

hour or evaluation fee (whichever the missed appointment may have been) and must be paid in full by the next session. The clinic tries its best to provide clients with reminder calls 24 hours prior to their appointment. Please note however, that you are responsible for paying for no shows whether or not you received a reminder call.

It is agreed and understood that any charges incurred are the sole responsibility of the patient and/or the responsible party signed below. In the event that you have a past due balance older than 30 days, it will be subject to a late charge of 1.5% per month. It is agreed and understood that if this obligation should become delinquent that you, the patient or responsible party, agree to pay collection costs, attorney's fees, and any costs associated with placing your account with a collection agency and/or an attorney for litigation. In most collection situations, the only information I release regarding a patient's treatment is his/her name, contact information, the nature of services provided, and amount due. Your signature on this document indicates that you understand this, and authorize me to contact a collection agency and provide your information should your bill become delinquent.

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. Although a lot can be accomplished in short-term therapy, some patients feel that they need more services after insurance benefits end. Some managed-care plans will not allow me to provide services to you once your benefits end. If this is the case, I will do my best to find another provider who will help you continue your psychotherapy.

You should also be aware that most insurance companies require you to authorize me to provide them with a clinical diagnosis. Sometimes I have to provide additional clinical information such as treatment plans or summaries, or copies of the entire record (in rare cases). 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.

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 our sessions. It is important to remember that you always have the right to pay for my services yourself to avoid the problems described above.

EXCEPTIONS

Exceptions to this contract can be made in rare circumstances with therapist, and or, clinic owner's consent. Any exceptions will be documented in writing. By signing this form you are attesting to the fact that at this time, no exceptions to this contact have been made.

CLIENT CONSENT

I have read this statement, had sufficient time to be sure that I considered it carefully, asked any questions that I needed to, and understand it. I consent to the use of a diagnosis in billing, and to release of that information and other information necessary to complete the billing process. I agree to pay the fee of $200 per 45 minute session, after the initial $ 250 intake session, should for any reason my insurance not cover these services. I understand my rights and responsibilities as a client, and my therapist's responsibilities to me. I agree to undertake therapy with Benson Psychological Services, PC. I know I can end therapy at any time I wish and that I can refuse any requests or suggestions made by my therapist. I am making a voluntary decision to sign this consent and I attest that I have the decision making capacity to do so.

_____ _____

Client Printed Name Date

_____

Client Signature

_____ _____

Parent or Legal Guardian Printed Name Date

_____

Parent or Legal Guardian Signature

I have been given a copy of the HIPAA Notice of Privacy Practices for this agency.

_____ _____

Client Printed Name Date

_____

Client Signature

_____ _____

Parent or Legal Guardian Printed Name Date

_____

Parent or Legal Guardian Signature

CREDIT CARD PAYMENTS

We accept MasterCard and Visa. We are reducing the amount of paper generated by this office, and one way we are doing this is by reducing paper billing. As an alternative, we will store your credit card information to make payments easier for you. By completing the form below, you are authorizing us to charge your credit card for any current, outstanding, or later occurring financial responsibilities such as copayments, no show/late cancellation fees, coinsurance payments, and payments on out-of-pocket expenses. You also authorize us to store your information until your case is closed.

Signature _____ Date _____

Full name as it appears on your card _____ Card type _____

Card number _____ Expiration date _____

Verification code (*3-digit number printed on the back of your card, to the right of your card number)* _____

Billing address, if different from that provided on intake paperwork _____

Client Name, if different than card holder _____