PSYCHOTHERAPIST PATIENT SERVICES AGREEMENT
Franco Psychological Associates, P.C.

CONFIDENTIALITY AND PRIVACY: Welcome to Franco Psychological Associates (FPA, P.C.) This agreement contains important information about our professional services and business policies. It also contains summary information about the Health Insurance Portability and Accountability Act (HIPAA), a federal law that provides you privacy protections and patient 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.*

All of the staff of Franco Psychological Associates, P.C. is required by law to safeguard the information they learn about a patient through the course of treatment. As a patient of FPA, P.C., relevant treatment information including status of substance use may be discussed between the professional staff involved in your care to insure the best care, including supervision, consultation, and referrals between FPA, P.C. therapists *(treatment).*

HIPAA requires that we provide you with an Explanation of Privacy Practices (the Notice), which is attached. If you choose to use your health care insurance to pay for psychotherapy services, you are giving your consent for us to disclose the minimum necessary PHI to your health insurer to determine your benefits and obtain reimbursement *(payment).*

OFFICE HOURS AND CONTACTING US: Our office is staffed from Monday through Thursday, 8 A.M. until 8:30 P.M. and Friday 8 A.M. to 4:00 P.M. At other times, a 24-hour "live" answering service will take messages. It is always best to contact us by telephone. If you must contact us by email, be advised that we do not typically or consistently respond to email. In addition, it will not be possible to contact us via social networking media.

In case of emergency, the answering service will attempt to reach your therapist. If they are unable to be reached, you should contact your local crisis intervention office. We make every effort to provide appointments at convenient hours; however, there is an especially high demand for evening times. We appreciate your cooperation in arranging daytime appointments whenever possible.

FEES AND INSURANCE COVERAGE: The fee for a session of psychotherapy is $150 which is payable at the time of service unless your insurance company has a specific contract with FPA, P.C. A one-time fee of $175 is charged for the initial evaluation session. Most health insurance plans cover part of the cost of psychotherapy provided by licensed professionals. Some insurance plans and all HMO's require pre-certification for services. We expect that you will make all insurance co-pays at the time of service. Non- payment of fees may result in termination of professional services and collection activity for the amounts owed by the patient.

CANCELLATION POLICY: A charge of $55 will be made for sessions that are cancelled with less than 24 hours notice except in cases of emergency. Since insurance companies will not pay for missed appointments, it is the patient's responsibility to pay our established fee for a late cancellation or a no show.

RESPONSIBILITY FOR PAYMENT OF SERVICES: My signature below acknowledges my agreement to the following:

1) I authorize direct payment of medical benefits to Franco Psychological Associates, P.C., for services that I have received.
2) I authorize FPA; P.C. to release to my insurance carrier and its agents any PHI (Protected Health Information) needed to process these claims.
3) I realize that the services to be provided have not been guaranteed for payment under my health benefit program and therefore I agree to be responsible for fees not covered by my insurance carrier or HMO.

FOR PARENTS OF MINORS: In cases of divorce or separation of parents, the law requires us to take steps to ensure both parents have been notified of the child's involvement in treatment and have provided their consent. This applies regardless of living arrangements and visitation. There is one exception: when a parent has sole legal custody, and we have evidence of that arrangement, treatment can commence without requiring an attempt to contact the other parent.

When children are age 14 to 17, they may consent to treatment themselves, however, if the absent parent's insurance will be billed, we need the contact information noted below.

Please provide the name and contact information for your child's other parent if he/she is not living in the home:

Name _____

Address _____

_____

_____

Telephone No. _____

If you have sole legal custody of your child, please initial here_____. We will need you to provide legal documentation of the custody arrangement.

Court Appearances: As the parent, you agree that the therapist's role is limited to providing treatment and that you will not involve your child's therapist in any legal dispute, especially a dispute concerning custody or custody arrangements (visitation, etc.).

If you have any concerns, questions or objections to the above, please discuss them with your child's therapist.

I **have read the PROFESSIONAL SERVICES AGREEMENT and consent to receive psychotherapy services under the terms outlined.**

_____ _____

Client Signature Date
(If **Client is 14 or older)**

_____ _____

Signature of Responsible Party Date
(If Client is under 18)

_____ _____

Witness Signature Date

(Revised HIPAA Service Agreement 09/23)