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Office Policies and Procedures

Welcome to my practice. This form is provided to help you become familiar with my policies. Your clear understanding and consent to these policies is vital to our professional relationship. This form also includes summary information about the Health Insurance Portability and Accountability Act (HIPAA). You will receive a complete listing of HIPAA guidelines in the Ohio Notice Form. If you have any questions, please discuss them with me before signing the back page.

Benefits and Risks

Psychotherapy often involves discussing unpleasant aspects of your life. Thus, you may experience uncomfortable emotions, such as sadness, guilt, anger, or frustration. On the other hand psychotherapy has been proven to lead to better relationships, solutions to specific problems, and significant reductions in feelings of distress. There are no guarantees about what you will experience with me. Success in therapy is based on your motivation and participation, and I encourage you to talk with me if you feel our sessions are not helpful to you.

Fees

A. The fee for the initial assessment session is $185.00. The initial assessment process includes a direct interview and detailed history to determine current problems and concerns. Brief diagnostic tools/ questionnaires may also be used. The initial assessment session is 60 - 75minutes in duration.

B. Individual, marital/couple's & family therapy sessions are billed at $135.00 (45 minutes) and $155.00 (60 minutes).

C. Time spent providing formal psychological assessment is billed at $140.00 per hour prorated for the amount of time used. Time spent writing reports is billed at $135.00 per hour, prorated for the amount of time used.

D. Telephone calls requiring my time, including telephone therapy and professional consultations, are billed at the rate of $135.00 per hour, prorated for the amount of time used. Please note that insurance companies will not reimburse for phone time.

Payment of Fees

- My policy is that you pay for the service provided at the time of your visit.
- For those clients who have and utilize insurance, your co-payment is due at the time of service as per your insurance carrier's contract with you. Office staff will bill your insurance company.
- For "self-pay" clients, payment is due at the time of service unless otherwise arranged with your therapist. All balances must be paid in full each month, for the services that have been provided.
- It is your responsibility to remit payment for services that are not covered by your claim (including deductibles, co-payments, no-show and late cancellation charges) and insure that your insurance company remits payment.

- For your convenience, you may pay for services by check or cash. There will be a $25.00 fee assessed for all returned checks.

- In the rare event that you are experiencing extenuating circumstances that may preclude your ability to pay at the time of service, you are asked to bring this to my attention immediately. I will attempt to establish a mutually reasonable written monthly payment plan to assist you.

- Accounts in arrears of (90) ninety days will receive prompt delinquent notice and payment will be expected within (1) one week of the notice. Accounts that remain unpaid will be turned over for immediate collection action.

Insurance

- You may have health insurance that will reimburse you for payment for my services. I request that you inform the office staff and/or your therapist at the time of your initial visit, of the terms of your insurance policy's mental health coverage.

- **Precertification:** Many insurance companies now require precertification (approval before initial visit). Please make sure that you have contacted your insurance carrier prior to your initial visit to precertify your visit. Recertification requires that your therapist complete a treatment plan with the managed care company managing insurance benefits for your insurance carrier. Recertifcation is done automatically by your therapist who submits a treatment plan (usually prior to your sixth session, although this may vary). Please review your membership materials to verify your benefits and coverage. You should make sure that your therapist is a participating provider for your plan or identify whether you have out-of-network benefits that will cover services in part. Failure to follow these procedures in a timely fashion may mean that your insurance carrier could decline payment and that you will be responsible for the entire amount of your initial visit and subsequent visits, unless otherwise prohibited.

- **Office Staff:** Office staff will assist you by filing insurance on your behalf on a monthly basis. It is imperative that you provide all insurance information in both the subscriber/card holder and employee sections. Subscriber's signatures to release information and claim payment authorization signatures are essential in filing and processing insurance claims.

- **Monthly statement:** You will receive a monthly billing statement for the services that have been rendered.

- **Changes in insurance:** Any changes in insurance (status or carrier) must be brought to the attention of the office staff and your therapist, as soon as possible. Additionally, any change in demographic information (address, phone number etc.) must be brought to the attention of the office staff and your therapist, both to facilitate the timely and accurate filing of insurance.

- **Billing questions/ concerns:** Questions or concerns about your bill and insurance claims may be directed to the billing office (Hallam Management Company) and/or your therapist. Billing office hours are Monday through Thursday between the hours of 10:00AM and 4:00PM at (513) 421-4087.

- **EAP:** If you are referred from an EAP program, you may not have any fees. Your EAP benefits will explain the fees, if any, associated with this service. EAP services are usually limited to a specified number of sessions; this will be discussed with you once the authorization is received.

Appointments and Cancellations

Sessions must be cancelled 24 hours in advance. You will be charged a fee of $75.00, (not billable to insurance) if you cancel without 24 hours notice or fail to show up for a scheduled appointment. I have a 24-hour voicemail (513) 284-1021 to take messages regarding cancellations and rescheduling. Payment for late cancellations or missed appointments are due at the next session.

Office Hours and Emergencies

My office hours are usually in the afternoons and evenings on weekdays and on Saturdays. Non-emergency calls will be returned during these times. If you need to speak to me outside of these hours and it is an emergency, you may call (513) 284-1021 and leave a message noting the emergency. If you cannot reach me through this mechanism, please call 911 or go to the nearest emergency room.

Confidentiality

Your records are confidential and will not be sent or shown to others without a signed release from you. You may receive a copy of your signed authorization and request. I make reasonable efforts to limit the information shared to the minimum necessary to accomplish the intended purpose of the disclosure. In such instances, I make every effort to discuss this with you. However, there are some exceptions of which you need to be aware.

A. By using your insurance, you have consented for me to release information both to your insurance carrier and the billing service I use (Hallam Management Company). Your signature authorizes me to submit insurance claims for you and to collect the insurance payments due for the services provided. Additionally, your signature authorizes (if applicable) Dr. Virginia Reid to complete any requested treatment plans for your insurance company or the managed health care company, as needed. Your signature on this document authorizes me to release information to your insurance company for the length of your treatment and until all fees have been paid. You also recognize that Hallam Management Company is fully aware of and in compliance with all HIPAA rules and policies.

B. Consultations with a colleague do not require your authorization, as any consultant is also bound by the same HIPAA Privacy Policy.

C. If you balance goes unpaid and arrangements have not been made for payment, I have the option of using legal means to secure the payment, such as hiring a collecting agency or going through small claims court. Both of these actions will require me to disclose otherwise confidential information, including your name, that psychotherapy sessions were provided, and the amount due. If a court is used, its costs will be included in the claim.

D. I may also disclose your private health information without consent if I have reasonable cause to suspect that a child under 18 or a mentally handicapped or physically handicapped person faced a threat of suffering any physical or mental wound, injury, disability, or condition that reasonably indicated abuse or neglect. I am required by law to disclose such information.

E. If I believe that you pose a clear and substantial risk of serious imminent harm to yourself or another person, I may disclose your relevant information to public authorities, the potential victim, other professionals, and/or your family to protect against such harm.

Records

Your records consist of two parts, the clinical record and psychotherapy notes.

A. Your clinical record consists of your reasons for seeking therapy, diagnoses, goals, medical and

social history, treatment history, copies of other records, reports, and billing records.

B. Your psychotherapy notes are for my use and are designed to assist me in providing you with the best treatment. These notes often include the contents of our conversations, analysis of therapy, and other sensitive information. These notes, if developed, are kept separate from your clinical record to protect their confidentiality from insurance company audits.

C. While psychotherapy notes have stronger restrictions than your clinical record, authorization is not required for their release in the following situations: for my own use, to defend myself against legal action, for purposes of the Department of Health and Human Services in determining my compliance with HIPAA policy, and for the exceptions listed in the OHIO NOTICE FORM (copy provided to you).

D. You have the right to request to see or request a copy of your entire clinical record or psychotherapy notes.

Minors and Parents

The law allows parents access to their records for children under 14 who are not emancipated. However, I may refuse access to information that I determine would injure the child. Children between the ages of 14 and 18 may independently consent to and receive up to 6 sessions (within a 30-day period) without any parental access to records. Please note that in such cases the child is fully responsible for fees incurred. For minors, it is my policy to share general information about treatment only, unless the child is in danger or a threat to self or others.

Other Policies

HIPAA requires that I inform you of policies and your rights in several other areas. Restrictions and Confidential Communications, Access to and Amendment of Records, Accounting for Disclosures, Business Associates, Privacy Officer, Safeguards, Complaints, Retaliatory Action and Waiver of Rights, and Documentation. Information on all of these is printed in the OHIO NOTICE FORM.

Consent for Treatment

Your signature below indicates that you have read this agreement and consent to the policies outlined here and to receive mental health treatment from Dr. Virginia Reid. It also indicates that time has been offered to review any information that you need clarified regarding this contract and the office policies and procedures outlined therein:

Client/Guardian: _____ Date: _____

Your signature below also serves as an acknowledgement that you have received the HIPAA Ohio Notice Form referred to above and that you have reviewed the HIPAA Policies discussed therein:

Client/Guardian: _____ Date: _____

Your signature below indicates that you agree to be responsible for any and all fees incurred. You are responsible for any fees not paid by your insurance company.

Client/Guardian: _____ Date: _____