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PROFESSIONAL SERVICE AGREEMENT

Dear Patient:

Welcome. We appreciate the opportunity to provide service to you. We have prepared this letter of agreement for professional services in order to outline our practice policies. We promise at all times to do our very best to serve your needs, to perform promptly, to be informed, to keep you informed and to be available to you regarding your particular matter. We request and expect that you will contact us immediately should any questions arise. Accordingly, we invite you to discuss frankly with us any questions or problems regarding our services or fees.

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 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.

Confidentiality still applies for telehealth services. Sessions will not be recorded without the written permission from the other person(s). For communication between sessions, we will primarily use phone voicemail. We will use text or email messaging with your permission only for administrative matters, such as setting and changing appointments and billing matters. Thus, clinical information will not be discussed by text or email and these forms of communication should not be used even in case of emergency. If your clinical concern is urgent, page your clinician with the emergency pager number that was provided to you or have someone drive you to the nearest emergency room.

The law requires that we obtain your signature acknowledging that we have provided you with this information. Although these documents are long and sometimes complex, it is very important that you read them carefully before your next session. We can discuss any questions you have about the procedures at that time. When you sign this document, it will also represent an agreement between us. As a patient, you agree to the following terms:

1. Payment for treatment including all copays and coinsurance is due at the time services are rendered. We accept cash, checks, and credit cards for amounts over $50.00. Services may be terminated due to non-payment. Any payments received from coinsurance payers (i.e., insurance companies or any other party) will be promptly credited to your account. Our office does not file to secondary insurance, except for Medicare. We will provide you with the documentation of your visit necessary for you to file to your secondary insurance.

2. Once an appointment is scheduled, you will be expected to pay for the time. If you choose to cancel your appointment, we require 24 hours advance notice, unless decided otherwise between you and your therapist. **A $50.00 fee will be charged for cancellations less than 24 hours. A $150.00 fee will be charged for failure to show for an appointment without notification.** IT IS IMPORTANT TO NOTE THAT INSURANCE COMPANIES DO NOT PROVIDE REIMBURSEMENT FOR CANCELLED OR NO SHOW APPOINTMENTS. THIS WILL BE YOUR RESPONSIBILITY. Please note that our services may be terminated at our discretion due to multiple missed appointments.

3. Assignment of benefits to the insurance company does not release the patient/parent/guardian from responsibility for payment. If for some reason your insurance does not cover services received, you will be responsible for the remaining balance. **Any outstanding insurance balance beyond 90 days will be billed to the appropriate responsible party and is due upon receipt.**

4. The patient/parent/guardian is and shall remain responsible for any amounts due and owing. It is also agreed that you, as the patient/parent/guardian, shall be responsible for any legal fees, costs and/or expenses incurred by us in collecting any amount past due. These sums will be added to any outstanding balance due and owing. We reserve the right to add a $30 monthly service charge to your account on any outstanding balance due and owing. The fee for returned or insufficient funds checks is $40.00 per occurrence.

5. **In cases of divorce**, the parent/or guardian who brings a child to treatment is responsible for any amount due and owing regardless of the divorce agreement. The parent/or guardian is responsible for collecting any monies from the other parent/or guardian. This is <u>not</u> the responsibility of B & K.

6. Our services may include, but are not limited to: individual, marital, family and group psychotherapy, and psychological evaluation. We reserve the right to assign services to our associates in order to ensure appropriate and timely care. Other billable services include: report and letter writing, telephone conversations lasting longer than 10 minutes, consulting with other professionals with your permission, preparation of records or treatment summaries, and the time spent performing any other service you may request of us. If you become involved in legal proceedings that require our participation, you will be expected to pay for all professional time, including preparation and transportation costs, even if your therapist is called to testify by another party.

   Clinical services will be charged to you based upon the following fee schedule. Telephone conferences greater than ten minutes and report and letter writing will be invoiced at the appropriate regular fee.

FEE SCHEDULE

Diagnostic Interview – 50 Minutes	$200.00
Psychotherapy- 60 Minutes	$175.00
Psychotherapy – 45 Minutes	$125.00
Psychotherapy – 30 Minutes	$ 85.00
Family Therapy – 45 Minutes	$150.00
Extended Psychotherapy – 90 Minutes	$250.00
Group Psychotherapy	Charged by Group
Psychological Testing	Charged by Test
Telephone Consultations	Charged by Time
Report and Letter Writing Preparation	Charged by Time
***Appointment Not Kept/No Show**	**$150.00**
***Late Appointment Cancelled/Less 24 hrs**	**$ 50.00**
***Returned Checks or NSF**	**$ 40.00**

***These fees can not be charged to your insurance company and are your responsibility for payment.**

7. We reserve the right to change, modify, or alter any of the terms of this Agreement in the future.

The best psychotherapeutic experience is based upon a friendly, mutual understanding between the clinician and patient.

Thank you for the opportunity to work with you.

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