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*Individual, Group,
& Family Therapy*

PSYCHOLOGICAL SERVICES AGREEMENT

The following document contains important information about professional services and business policies. It also contains summary information about the Health Insurance Portability and Accountability Act (HIPAA), a new federal law that provides new privacy protections and new patient rights with regard to the use and disclosure of your Protected Health Information (PHI) employed for the purpose of treatment, payment and health care operations. HIPAA requires that I provide you with a Notice of Privacy Practices (the Notice) for use and disclosure of PHI treatment, payment and health care operations. The Notice, which is attached to this Agreement, explains HIPAA and its application to your personal health information in greater detail. The law requires that you provide a signature acknowledging that you were supplied with this information. When you sign this document, it will also represent an agreement between us. You may revoke this Agreement in writing at any time. That revocation will be binding on me unless I have taken action in reliance on it; if there are obligations imposed on me by your health insurer in order to process or substantiate claims made under your policy; or if you have not satisfied any financial obligations you have incurred.

Telephone Contact

My phone number is **(619) 840-5487**. If you wish to speak to me during normal working hours, I will probably not be able to take your call immediately since I do not interrupt work with a client to take phone calls. I will, however, make every effort to return your call as soon as possible, usually within 24 hours. If you are difficult to reach, please include times and numbers when you will be available. During weekends and holidays, I will generally return your call on the next working day. In case of an emergency, you can choose to contact me as well as the local county crisis line at **(800) 479-3339**. However, if a life-threatening emergency occurs, please call 911 Emergency Services. When I am out of town or if I should be unavailable for any length of time, I will arrange for a colleague to take any urgent calls; if possible, I will give you the name of this colleague prior to leaving town. If a psychiatrist, psychologist, group therapist, or other mental health professional is also treating you, you should call them if you cannot reach me or wait for me to return your call. In a situation where you feel you need immediate attention and you cannot reach me, you should call your family physician or hospital emergency room and ask for the psychologist or psychiatrist on call.

Payment and Insurance Reimbursement

Please be aware that you have the sole and primary responsibility for the payment of services provided to you. If paying with a check, and your check bounces, you will be charged a \$25 fee. Any balances outstanding longer than 30 days are subject to 1.5% interest.

If you want a bill sent to your insurance, please sign the Insurance Billing Statement at the end of this paragraph. By signing the Insurance Billing Statement, you agree that I can provide requested information to your insurance carrier.

If you want a bill to your insurance, you should be aware that most insurance agreements require you to authorize me to provide a clinical diagnosis and sometimes additional information such as a treatment plan or summary or copies of your Clinical Record. Before I can disclose this information both you and I need to receive a written notification from the insurer stating what they are requesting, why they are requesting it, how long it will be kept and what will be done with the information when they are finished with it. In such situations, I will make every effort to release only the minimum information about you that is necessary for the purpose requested. You should be aware that this information will then become part of the insurance company files, probably stored in a computer, and that it will be out of my control. I will inform you of any report that I submit or information exchanged with any parties about you.

Insurance Billing Statement (please check one):

_____ N/A

_____ I do not want to bill insurance at this time.

_____ I am requesting that insurance be billed and agree that Tara Hodgens can provide requested information to my insurance carrier.

Signature

Date

Confidentiality

At all times, I am very careful to preserve your privacy in my work. Since clients do best in therapy when they feel that they can rely on their therapist to respect their privacy and confidences, when working with you or your children individually, I usually do not provide the parents with specific details about things the child says or does in therapy. However, I do discuss my clinical impressions and recommendations and the child’s progress in therapy with the parents. I will also be happy to discuss with you any specific questions you might have about your child or how you might handle specific issues.

Because privacy in treatment is often crucial to successful progress, particularly with teenagers, and parental involvement is also essential, it is usually my policy to request an agreement with

youths aged 12 or older and their parents about access to information. This agreement provides that during treatment, I will provide parents with only general information about the progress of the treatment, and the patient's attendance at scheduled sessions. Any other communication will require the child's authorization, unless I feel the child is in danger or is a danger to someone else, in which case I will immediately notify the parents of my concern. Before giving parents any information, I will discuss the matter with the child, if possible, and do my best to handle any objections he/she may have.

In most situations, I can release information about my work with you or with your child to 3rd parties only if you sign a written Authorization Form that meets certain legal requirements imposed by state law and/or HIPAA. Occasionally, I may find it helpful to consult about a case with other professionals. In these consultations, I make every effort to avoid revealing the identity of the client, child or family. The consultant is, of course, also legally bound to keep information confidential. Unless you object, I will not tell you about these consultations. I will note all consultations in you or your child's Clinical Record (which is called PHI in my Notice of Psychologist's Policies and Practices to Protect the Privacy of Your Health Information).

If you or your child are involved in a court proceeding and a request is made for information about the professional services that I have provided you and/or the records thereof, such information is protected by therapist-patient privilege law. I cannot provide any information without your (or your legally-appointed representative's) written authorization, a court order, or compulsory process (a subpoena) or discovery request from another party to the court proceeding where that party has given you proper notice (when required) has stated valid legal grounds for obtaining PHI, and I do not have grounds for objecting under state law (or you have instructed me not to object). If you are involved in or contemplating litigation, you should consult with your attorney to determine whether a court would be likely to order me to disclose information.

Disclosure may also take place under the following circumstances: 1) If a government agency is requesting the information for health oversight activities pursuant to their legal authority, I may be required to provide it for them. 2) If a patient or their representative files a complaint or lawsuit against me, I may disclose relevant information regarding that patient to defend myself. 3) If a patient files a worker's compensation claim, I must, upon appropriate request, disclose information relevant to the claimant's condition, to the worker's compensation insurer.

There are some exceptions to the confidentiality rules that occur very infrequently. In certain specific, rarely occurring situations, I am legally required to take action to protect you, your child or others from harm, even if that requires revealing some information about treatment: 1) If I have knowledge of a child under age 18 or I reasonably suspect that a child under age 18 that I have observed has been the victim of child abuse or neglect, the law requires that I file a report with the appropriate governmental agency, usually the county welfare department. I also may make a report if I know or reasonably suspect that mental suffering has been inflicted upon a child or that his or her emotional well being is endangered in any other way (other than physical or sexual abuse, or neglect). Once such a report is filed, I may be required to provide additional information. 2) If a patient communicates a serious threat of physical violence against an identifiable victim, I must take protective actions, including notify the potential victim and contacting law enforcement authorities. I may also seek hospitalization of the patient, or contact others who can assist in

protecting the victim. 3) If I believe there is suicidal risk, I will of course inform you and suggest steps to be taken to try to protect you or your child. If I have reasonable cause to believe that a patient is in such mental or emotional condition as to be dangerous to him or herself, I may be obligated to take protective action. 4) If I observe or have knowledge of an incident that reasonably appears to be physical abuse, abandonment, abduction, isolation, financial abuse or neglect of an elder or dependant adult, or if an elder or dependant adult credibly reports that he or she has experienced behavior including an act or omission constituting physical abuse, abandonment, abduction, isolation, financial abuse or neglect, or reasonably suspects that abuse, the law requires that I report to the appropriate government agency. Once such a report is filed, I may be required to provide additional information.

If any of the above situations arises, I will make every effort to fully discuss it with you before taking any action and I will limit my disclosure to what is necessary. If you have any concerns or questions about confidentiality, I will discuss them with you.

Professional Records

The laws and standards of my profession require that I keep Protected Health Information (PHI) about you in your Clinical Record. You should be aware that, pursuant to HIPAA, in some cases, I keep Protected Health Information about a patient in two sets of professional records. One set constitutes your Clinical Record. It includes information about your reasons for seeking therapy or evaluation, a description of the ways in which your problem(s) impacts on your life, my diagnostic impressions, the goals we set for treatment, your progress towards those goals, your medical and social history, your treatment history, any past treatment records that I receive from other providers, reports of any professional consultations, and any reports that have been sent to anyone, including your insurance carrier. Your billing records are maintained separately but are considered part of your Clinical Record.

Except in circumstances that disclosure would endanger you and/or others or makes references to another person (unless such person is a health care provider) and I believe that access is reasonably likely to cause substantial harm to such other person or where information has been supplied to me confidentially by others, you may have a copy of your Clinical Record sent to another mental health professional, if you request it in writing. In addition, because these are professional records, they can be misinterpreted and be upsetting to untrained readers. For this reason, I recommend that you initially review them in my presence or have them forwarded to another mental health professional so you can discuss the contents. If the records are copied, there will be a processing fee. If I refuse your request for access to your records, you have a right of review, (except for information supplied to me confidentially by others) which I will discuss with you on request.

Patient Rights

HIPAA provides patients with several new or expanded rights with regard to your Clinical Records and disclosures of Protected Health Information (PHI). These rights including requesting that I amend a patient's record; requesting restrictions on what information from your Clinical Records is disclosed to others; requesting an accounting of most disclosures of PHI that you have neither consented to nor authorized; determining the location to which protected information disclosures are sent; having any complaints you make about my policies and procedures recorded in your records; and the right to a paper copy of this Agreement, the attached Notice form, and my privacy policies and procedures. I am available to discuss any of these rights with you.

YOUR SIGNATURE BELOW INDICATES THAT YOU HAVE READ THIS AGREEMENT AND AGREE TO ITS TERMS AND ALSO SERVES AS AN ACKNOWLEDGEMENT THAT YOU HAVE RECEIVED THE HIPAA NOTICE FORM DESCRIBED ABOVE.

I have read the information in this document and agree to abide by its terms during the treatment of, _____ (DOB: ___/___/___), by Tara Hodgens, M.S., LMFT.

Print Name(s)

Signature

Date

Signature

Date

Signature of Child

Date