Phone: +1 (202) 415 - 4236
rachel @drrbf.com
www.drrbf.com

PSYCHOTHERAPIST-PATIENT SERVICES AGREEMENT

Welcome to my practice. I appreciate your trust and the opportunity to assist you. I am providing you with the following information to answer many of the questions people typically have when beginning psychotherapy, and to outline policies and procedures that
are specific to my work. If you have any questions, thoughts, or feelings about what is printed, please feel free to discuss them with me in our sessions.

When you sign this document, it will represent an agreement between us.

This document (the Agreement) contains important information about my 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 protection 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. HIPAA requires that

I provide you with a Notice of Privacy Practices (the Notice) for use and disclosure of PHI for 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.

PSYCHOTHERAPY

The benefits of therapy have been repeatedly and scientifically demonstrated for most people in most situations. Depending on your initial issues and symptoms, benefits might include the lessening of depressive symptoms or feeling less afraid or anxious. You may experience an increased sense of well-being and comfort with yourself. With a more thorough understanding of yourself, you are likely to be able to make changes that enhance your family or social relationships and find deeper satisfaction in them. Through the therapeutic process, you may come to better understand your personal goals and values, growing and maturing as an individual.

As with any treatment, there are both risks and benefits associated with psychotherapy. The risks of therapy can include an exacerbation of symptoms, new symptoms, the questioning of beliefs and values, possible changes in lifestyle, relationships, or employment. Other risks can include the experience of intense and unwanted feelings (including sadness, anger, fear, guilt, or anxiety) as you begin the healing process. However, these feelings may be a natural, normal, and important part of your therapy. Other risks might include recalling unpleasant life events, facing difficult thoughts and beliefs, and changes in your relationships. During our work, I hope to discuss any of your reactions to or adverse side effects of your therapy.

Our work will end once you are satisfied with your progress and we discuss this and how we will end. You may also decide to terminate our work for other reasons, but I encourage that we meet for at least one more session to discuss the ending. In addition, Ethical Standards dictate that I should terminate therapy when I do not feel it is being helpful, and if I do so, I will be sure to provide you with appropriate referrals.

MEETINGS

My services are by appointment only. I normally conduct an evaluation that will last from 2 to 4 sessions. During this time, we can both decide if I am the best person to provide the services you need in order to meet your treatment goals. If psychotherapy is begun, I will usually schedule one 45-minute session per week at a time we agree on, although some sessions may be more frequent. Due to the nature of psychotherapeutic work, I must adhere firmly to time guidelines. As such, if you are late for a scheduled session, it will end at its regularly scheduled time. If I am late for a session, I will either make up the lost time or adjust the fee accordingly.

CANCELLATION POLICY

In the event that you need to cancel an appointment, please let me know as far in advance as possible, but at least 48 hours ahead. **Because the appointment time is reserved for you, it is necessary to charge for appointments which are not cancelled 48 hours (2 business days) in advance.** Please remember that insurance companies typically do not reimburse for cancelled sessions. If you would like to reschedule a cancelled session during the same week, I will attempt to accommodate your request.

TELEPHONE & EMERGENCY POLICY

If you need to reach me between regularly scheduled appointment times, you can call me at (202) 415-4236. The voicemail at this number is confidential. I check these messages regularly and will return your call at the earliest possible opportunity. If you are unable to reach me and feel that you cannot wait for me to return your call, contact your family physician or go to the nearest emergency room. If I will be unavailable for an extended time, I will provide you with the name of a colleague to contact, if necessary.

BILLING & FEES

I charge an hourly rate for each 45 minute session. **I require payment at the time of service.** At the end of each month, I will provide you with a bill detailing the service provided and the total amount paid. (Please note that returned checks are subject to a $25.00 fee). If this billing arrangement is not feasible, I ask that you discuss this with me to work out an agreeable arrangement. If the bill is two months overdue, I reserve the right to discontinue therapy until you pay the full amount. If you cannot, I will refer you to an inexpensive alternate source of help, if necessary.

INSURANCE REIMBURSEMENT

If you plan to use out-of-network mental health coverage, I will fill out any necessary forms required of me and provide you with whatever assistance I can in helping you receive the benefits to which you are entitled. However, you (and not your insurance provider) are ultimately responsible for full payment of my fees. It is very important that you find out exactly what mental health services your insurance policy covers.

PROFESSIONAL RECORDS

The laws and standards of my profession require that I keep Protected Health Information about you in your clinical record. Except in unusual circumstances, you are entitled to receive a copy of your records if you request it in writing Because these are professional records, they can be misinterpreted and/or upsetting to untrained readers; therefore, 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.

PATIENT RIGHTS

HIPAA (Health Insurance Portability and Accountability Act) provides you with several new or expanded rights with regard to your clinical records and disclosures of protected health information. The attached form entitled “Notice of Policies and Practices to Protect the Privacy of Your Health Information” lists these rights.

CONFIDENTIALITY & PRIVACY OF INFORMATION

I will make every effort to safeguard the privacy of information concerning our work together. It is a violation of the District of Columbia Mental Health Information Act of 1978, as well as the Ethical Principles of the American Psychological Association, to disclose any information regarding the treatment of clients.

There are several specific exceptions to the rule of confidentiality. These are listed below:

- You may authorize me to release records or other information to individuals of your choosing. I may only do this with your expressed written consent.
- Under ethical and legal requirements, I may be required to break confidentiality in the event of a clear and imminent danger to yourself or another person.
- In the event that you disclose information that provides evidence of current abuse or neglect of minor children or a vulnerable adult, the law may require that I make a report to the appropriate state agency.
- In certain legal proceedings, confidential information may be disclosed by court order. This is a rare occurrence and would not happen without your knowledge.

ACKNOWLEDGEMENT

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 "Notice of Policies and Practices to Protect the Privacy of Your Health Information."

Name of Patient: _____

Signature of Patient: _____ Date: _____

Signature of Therapist: _____ Date: _____

Rachel Barbanel-Fried, Psy.D.

Please return this signed consent form to me. Thank you.