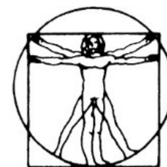
Behavioral Medicine P.C.



Cynthia Kindgren MS/LCPC
Licensed Clinical Professional Counselor
Owner - Clinical Director

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Licensed Clinical Social Worker
Independent Contract Therapist

SERVICES AGREEMENT

Welcome to Behavioral Medicine PC, the offices of Cynthia Kindgren and her contracted clinicians in Loves Park, IL. This document (the 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. HIPAA requires that we 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. 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. 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 us unless we have taken action in reliance on it; if there are obligations imposed on us by your insurance company; or if you have not satisfied any financial obligations you have incurred.

COUNSELING SERVICES

Psychotherapy is not easily described in general statements. It varies depending on the personalities of the therapist and patient, and the particular problems you are experiencing. There are many different methods your therapist may use to deal with the problems that you hope to address. Psychotherapy is not like a medical doctor visit. Instead, it calls for a very active effort on your part. In order for the therapy to be most successful, you will have to work on things we talk about both during your sessions and at home. The primary mutual obligation the therapist and patient have is to be respectful and honest with each other. You agree that every aspect of your life is potentially open for discussion in therapy, although it may not be a focus of treatment. Thus, you will bring up meaningful issues as they occur for the therapist to assess and for us to possibly discuss further.

Psychotherapy can have benefits and risks. Since therapy often involves discussing unpleasant aspects of your life, you may experience uncomfortable feelings like sadness, guilt, anger, frustration, loneliness, and helplessness. On the other hand, psychotherapy has also been shown to have many benefits. Therapy often leads to better relationships, solutions to specific problems, and significant reductions in feelings of distress. There are no guarantees, however, of what you will experience.

The first few sessions will involve an evaluation of your needs. By the end of the evaluation, your Therapist will be able to offer you some first impressions of what the work will include and a plan of treatment to follow, if you decide to continue with therapy. You should evaluate this information along with your own opinions of whether you feel comfortable working with your therapist. Therapy involves a large commitment of time, money and energy, so you should be very careful about the therapist you select. If you have questions about our procedures, we should discuss them whenever they arise. If your doubts persist, we will be happy to refer you to another mental health professional for a second opinion.

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NEUROFEEDBACK/ OPERANT CONDITIONING

It is essential to discuss the following points prior to commencing Neurofeedback training.

- The goals for Neurofeedback training are to:
  - Learn skills for increasing self-awareness
  - Increase the brain's ability to organize itself
  - Allow the brain to interrupt maladaptive patterns, and to increase quality of life and level of functioning to a more optimal level
- Many published clinical studies have demonstrated the effectiveness of Neurofeedback for treating various problems. Neurofeedback as an intervention for some problems has extensive published support, while little published support exists for other problems. As such, you should be aware that some insurance company personnel and professionals like physician and psychologists are not aware of the latest published research or may consider neurofeedback an "experimental" intervention for your problem. There are also many health care practitioners who are convinced that this intervention is not experimental. They believe that the efficacy of Neurofeedback for dealing with your problem has been adequately demonstrated. Copies of the relevant literature on Neurofeedback for your problem will be provided upon request.
- Your course of Neurofeedback will begin with a diagnostic evaluation. This will allow us to design a treatment program that will address the specifics of your brain's strengths and weaknesses of electrical function. EEG testing is not intended to be a medical diagnosis of brain abnormality. A neurologist will not be reviewing the test for seizures, tumors, or other neurological problems.
- It is rare to experience any noticeable effects from Neurofeedback prior to completion of at least 10 sessions. It is not possible to predict precisely how many sessions you will require to assist your brain to function more optimally. A range of 10 to 40 sessions is usual. The cost of each training session is listed on the fee schedule.
- Please provide Behavioral Medicine P.C. information about all medical diagnoses and treating providers to ensure informed, quality care. This information is provided so that we may, if necessary, consult your physician regarding your care. By signing this form, you are authorizing us to share and receive information about your treatment, physical status, and psychological status.
- You are advised to inform our staff about any history of dissociative symptoms, post-traumatic stress, bipolar disorder, schizophrenia, and/or seizures.
- If you undergo Neurofeedback/Operant Conditioning training, you will be asked to sign an additional consent form.

APPOINTMENTS

Psychotherapy appointments are usually scheduled once weekly for 45-50 minutes, but this will be modified if necessary based on your needs. Neurofeedback sessions are scheduled between 1 and 4 sessions per week. **Once an appointment is scheduled, you must provide 24 hours advance notice of cancellation (unless we both agree that you were unable to attend due to circumstances beyond your control). You will be charged $100 per hour for the missed appointment. It is important to note that insurance companies do not provide reimbursement for cancelled appointments. INITIAL_____________** You agree to be present for the full length of the session, unless modified previously by the therapist and you. You will bring other persons to sessions only by prior agreement with the therapist. If you decide to terminate therapy, you agree to discuss this with your therapist during a scheduled session. If you arrive more than fifteen minutes late for your appointment it is up to the therapist's discretion for you to be seen on that date. If you are not seen you may also be charged a fee for a missed appointment.

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PROFESSIONAL FEES

Please refer to the current fee schedule. If you have question about the type of services you may receive, you may speak with your therapist about this issue. Phone calls for purposes other than information or scheduling will be charged a fee. This fee will be listed on our fee schedule and based upon the length of phone call. You will also be charged fees for other services including report preparation, consulting with other professionals at your request, preparation of records or treatment summaries, and any other service you may request of us. These fees are listed on the fee schedule and are based upon the length of the service. You agree to direct payment to Behavioral Medicine PC, of any insurance benefits payable to or on your behalf for the above listed services. In the event your insurance carrier does not reimburse Behavioral Medicine PC, **you will ultimately be responsible for all charges. INITIAL____________. At times your therapist may need to provide you with additional services on your behalf including: consultation with others, phone calls, and generation of reports. These services are generally not covered by insurance, but are required in order to provide you with the care that you need. Any additional services that are not covered by insurance will be your responsibility. INITIAL_______.**

Participation in legal proceedings is billed at $500.00 per hour in 15 minute increments. Billable hours will include preparation, travel time, and participation in the proceedings. If we have to travel to provide services or participate in legal proceedings, there will be an additional charge of $0.50 per mile.

USUAL AND CUSTOMARY RATES

We are committed to providing quality care. Our fees are based on what is usual and customary for our geographical location. Due to HIPAA regulations and regulation standards set by government agencies, it is unlawful to provide discounts for co-pays or deductibles determined to be the patient's responsibility by third party payors.

CONTACTING US

Due to their work schedules, clinicians are not available by telephone. When we are unavailable, our phone is answered by a receptionist or voice mail system that we monitor frequently. If we are in the office, we will make every effort to return your call the same day you make it. If we are out of the office when you call, we will return your call the next day we are in the office. **Behavioral Medicine PC is an outpatient facility and does NOT provide emergency services. If an emergency arises and you cannot reach us, you should contact your physician, dial 911, or go to the nearest hospital emergency department. INITIAL_________**

LIMITS ON CONFIDENTIALITY

The law protects the privacy of all communications between a patient and a mental health professional. In most situations, we can only release information about your treatment to others if you sign a written Authorization form that meets certain legal requirements imposed by HIPAA and/or Illinois law; however, in the following situations, no authorization is required:

- We may occasionally find it helpful to consult other health and mental health professionals about a case. During a consultation, we make every effort to avoid revealing the identity of the patient. The other professionals are also legally bound to keep the information confidential. If you don't object, we will not tell you about these consultations unless we feel it is important to our work together. We will note all consultations in your clinical record (or "PHI" in the Notice).
- We have a contract with Office Ally and Rockford Mercantile Agency. As required by HIPAA, we have a formal business associate contract with this service, in which they promise to maintain the confidentiality of this data except as specifically allowed in the contract or otherwise required by law.

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Disclosures required by health insurers or to collect overdue fees are discussed elsewhere in the Agreement.

- If you are involved in a court proceeding and a request is made for information concerning your PHI, such information is protected by the privilege law. We cannot disclose any information without a court order. If you are involved in or contemplating litigation, you should consult with your attorney to determine whether a court would be likely to order us to disclose information.
- If a government agency is requesting the information for health oversight activities, we may be required to provide it.
- If a patient files a complaint or lawsuit against us, we may disclose relevant information regarding that patient in order to defend ourselves.
- If you file a worker's compensation claim, and we are providing services or treatment in accordance with the provisions of Illinois Worker's Compensations law, we must, upon appropriate request, provide a copy of your record to your employer or his/her appropriate designee.

There are some situations in which we are legally obligated to take actions, which we believe are necessary to attempt to protect others from harm, and we may have to reveal some information about a patient's treatment. These situations are unusual in our practice, and if they should arise, we will make every effort to fully discuss it with you before taking any action, and we will limit our disclosure to what is necessary.

- If we have reasonable cause to believe that a child under 18 known to us in our professional capacity may be an abused or neglected child, the law requires that we file a report with the Department of Children and Family Services. Once such a report is filed, we may be required to provide additional information.
- If we have reason to believe that an adult over the age of 60 living in a domestic situation as been abused or neglected in the preceding 12 months, the law requires that we file a report with the agency designated to receive such reports by the Department of Aging. Once such a report is filed, we may be required to provide additional information.
- If you have made a specific threat of violence against another or if we believe that you present a clear, imminent risk of serious physical harm to another, we may be required to disclose information in order to take protective actions. These actions may include notifying the potential victim, contacting the police, or seeking your hospitalization.
- If we believe that you present a clear, imminent risk of serious physical or mental injury or death to yourself, we may be required to disclose information in order to take protective actions. These actions may include seeking your hospitalization or contacting family members or others who can assist in protecting you.

While this written summary of exceptions to confidentiality should be helpful in informing you about potential problems, it is important that we discuss any questions or concerns that you may have now or in the future. The laws governing confidentiality can be quite complex, and we are not attorneys. In situations where specific advice is required, formal legal advice may be needed.

PROFESSIONAL RECORDS

The laws and standards of our profession require that we keep PHI about you in your clinical record. You may examine and/or receive a copy of your clinical record, if you request it in writing. Because these are professional records, they can be misinterpreted and/or upsetting to untrained readers. For this reason, we recommend that you initially review them in our presence, or have them forwarded to another mental health professional so you can discuss the contents. In most circumstances, we are allowed to charge a copying fee of $1.00 per page.

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PATIENT RIGHTS

HIPAA provides you with several rights with regard to your clinical records and disclosures of PHI. These rights include requesting that we amend your record; requesting restrictions on what information from your clinical record is disclosed to others; requesting an accounting of most disclosures of protected health information that you have neither consented to nor authorized; determining the location to which protected information disclosures are sent; having any complaints you make about our policies and procedures recorded in your records; and the right to a paper copy of this Agreement, the Notice form, and our privacy policies and procedures. We will be happy to discuss any of these rights with you.

MINORS AND PARENTS

Patients under 12 years of age and their parents should be aware that the law allows parents to examine their child's treatment records. Parents of children between 12 and 18 may examine their child's records without the child consents and unless we find that there are compelling reasons for denying the access. Parents are entitled to information concerning their child's current physical and mental condition, diagnosis, treatment needs, services provided, and services needed. Since parental involvement is often crucial to successful treatment, in most cases, we require that patients between 12 and 18 years of age and their parents enter into an agreement that allows parents access to certain additional treatment information. If everyone agrees, during treatment we will provide parents with general information about the progress of their child's treatment, and his/her attendance at scheduled sessions. We will also provide parents with a summary of treatment when it is complete. Any other communication will require the child's Authorization, unless we feel that the child is in danger or is a danger to someone else, in which case, we will notify the parents of our concern. Before giving parents any information, we will discuss the matter with the child, if possible, and do our best to handle any objections he/she may have.

BILLING AND PAYMENTS

You will be expected to pay for each session at the time it is held, unless we agree otherwise. **Co-payments are due at the time of service.** Payment schedules for other professional services will be agreed to when they are requested. In circumstances of financial hardship, payments on an installment plan can usually be arranged.

For each date of service, we will bill your insurance company with the insurance information you provided us at the time of your initial evaluation. We will bill your primary insurance first. If we do not receive payment from your primary insurance within 60 days, the balance of your account will be your responsibility. You will receive a patient statement from our office. Your amount due will be listed in the patient balance column. Your payment **in full** will be due 30 days from receiving a patient statement. If you do not have insurance **you** are responsible for bringing payment in full to each appointment. If payment is a problem, we can often times work out a payment plan.

If your bill is not paid in a timely manner, (60 days from receipt of your patient statement) and payment arrangements have not been made, your account may be sent to a collection agency. This will require us to disclose otherwise confidential information. In most collection situations, the only information released is the patient's name, contact information, the nature of services provided, and the amount due. You will be responsible for all additional costs associated with placing your account with a collection agency. Additional cost may include but are not limited to, finance fees, collection agency commission, attorney fees and court costs. Please contact your insurance company with questions about your coverage for our services. All fees you incur from Behavioral Medicine PC are your responsibility.

INSURANCE REIMBURSEMENT

In order for us to set realistic treatment goals and priorities, it is important to evaluate what resources you have available to pay for your treatment. If you have a health insurance policy, it will usually provide some coverage for mental health treatment. We will provide you with what assistance we can in helping you receive the benefits to which you are entitled; however, you (not your insurance company) are responsible for full payment of our fees. Due to the rising costs of health care, insurance benefits have increasingly become more complex. It is sometimes difficult to determine exactly how much mental health coverage is available. "Managed Health Care" plans such as HMOs and PPOs often require authorization before they provide reimbursement. It may be necessary to seek approval for more therapy after a certain number of sessions. You are responsible for knowing or finding out exactly what mental health services your insurance policy covers, and under what conditions, and we recommend you do so.

If you would like to know if we are preferred providers for your insurance company, or to inquire about what steps are necessary to be referred or authorized to be seen at our office please contact the customer service phone number listed on your insurance card. INITIAL___________ You should be aware that your contract with your health insurance company requires that you authorize us to provide it with information relevant to the services that we provide to you. If you are seeking reimbursement for services under your health insurance policy, you will be required to sign an authorization form that allows us to provide such information. We are required to provide a clinical diagnosis. Sometimes we are required to provide additional clinical information such as treatment plans or summaries, or copies of your entire clinical record. Although insurance companies claim to keep such information confidential, we have no control over what they do with it once it is in their hands. In some cases, they may share information with a national medical information databank. We will provide you with a copy of any report we submit, if you request it.

Medicaid/Illinois Public Aid does not pay for psychological services at our office. It is your responsibility to inform us if you have Medicaid/Illinois Public Aid, or if you have applied for it. Medicaid patients must pay the entire fee at the time of service. If payment is a problem, we can often times work out a payment plan.

Once we have all the information about your insurance coverage, we will discuss what we can expect to accomplish with the benefits that are available and what will happen if they run out before you feel ready to end your sessions. You always have the right to pay for our services yourself to avoid the problems described above (unless prohibited by contract)

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 AND A COPY OF THIS AGREEMENT.

______________________________ ______________

Name D.O.B.

______________________________ ______________

Signature Date

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Address City/State Zip

If this Agreement is signed by a legal representative of the patient, a description of such representative's authority to act for the patient must be provided: ___________________________

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