PSYCHOLOGIST-CLIENT SERVICES CONTRACT

Welcome to my psychology practice. This contract contains important information about my professional services and business policies. When you sign this document, it is a binding agreement between us. You may revoke this contract in writing at any time. In addition, The Health Insurance Portability and Accountability Act (HIPAA) requires that I provide you with a Notice of Privacy Practices and that I obtain your signature acknowledging that I have provided you with this information. The Notice is attached to this Agreement.

PSYCHOLOGICAL SERVICES

Psychotherapy is not easily described in general statements. It varies depending on the personalities of the psychologist and client, and the particular problems you are experiencing. There are many different methods I may use to deal with the problems that you hope to address. Psychotherapy 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 our sessions and at home.

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. But there are no guarantees of what you will experience.

If you have questions about my procedures, we should discuss them whenever they arise.

MEETINGS

Each session typically lasts 60 minutes. If you are late for a session, that time is lost from your session. Scheduling presents a special problem in private therapy because once a given hour is blocked out for a particular person, it cannot be filled again on short notice. Once an appointment hour is scheduled, you will be expected to pay for it unless you provide 24 (preferably 48) hours advance notice of cancellation, under all circumstances. It is important to note that insurance companies do not provide reimbursement for cancelled sessions.

CONTACTING ME

Due to my work schedule, I am often not immediately available by telephone. When I am unavailable, my telephone is answered by voice mail that I monitor frequently. I will make every effort to return your call on the same day you make it or within 24 hours, with the exception of weekends and holidays. If you are difficult to reach, please inform me of some times and contact information when you will be available. If there is a crisis or an emergency situation and you are unable to reach me (as I am not a critical care service), please utilize your local hospital emergency room, police department, etc. If I will be unavailable for an extended time, I will provide you with the name of a colleague to contact, if necessary.

You may also contact Dr. Lichti via email at: drlou@cityparkpsychological.com.

PROFESSIONAL FEES

- Initial evaluations are **$ 200.00** per 60-minute session.
- Follow-up sessions are **$ 170.00** per 60-minute session.

PSYCHOLOGICAL ASSESSMENT (Including report preparation):

- Attention Deficit Disorder Assessment **$1200.**

Fifty (50) % of the above assessment fees are due on the date the testing is initiated, with the remainder due when the results are presented to you.

You will receive a final report. Please do not alter or edit this report in any manner, as psychological assessment findings may be misinterpreted. I will be happy to prepare an appropriate brief summary report to be sent to your school, physician or anyone else at your request for my usual hourly rate.

COURT FEES: The rate for all court-involved services is **$350.00** per hour, with a four-hour minimum **($1400.00)**, to be paid in advance. This includes preparation time, travel, and waiting time.

PHONE CALLS & EMAIL COMMUNICATION & OTHER SERVICES: At the hourly rate of **$170.00**, beginning with a minimum **$50** charge per contact (call, text, email or other) that is clinical in nature and not brief scheduling or billing matters. Please be advised that I will charge for the time involved in transcribing voice mails and/or transferring emails/texts to medical records. I will charge this amount for other professional services you may need, though I will break down the hourly cost if I work for periods of less than one hour (rounded up in 5 min increments). Other services include report writing, telephone conversations lasting longer than 5 minutes, texting, emailing, consulting with other professionals and family members or friends with your permission, preparation of records or treatment summaries, and the time spent performing any other service you may request of me.

BILLING AND PAYMENTS

PAYMENT. ***All fees are payable each session at the time of service***. I accept cash, checks, and credit cards (Visa, MasterCard and Discover Card). Please bring payment with you to each session and payment will be processed at the beginning of the session. I do not accept insurance as a form of payment for services. I do not participate with Medicare or Medical Assistance. If you have Medicare, in order to see me, you must sign a contract with me to pay directly for my services and agree not to submit your sessions with me to Medicare for reimbursement.

On an attached form, I ask that you please provide me with credit card information. By providing this information it will simplify payment procedures in the event of a missed appointment without notice of cancellation, as well as the occasions where an appointment is cancelled without 24 hours advanced notice (48-72 hour notice is preferred). In either event, credit cards will be processed at the beginning of the scheduled appointment. Your acceptance of this policy will ensure that your payments will always be up-to-date and will be made in a timely manner.

Regardless of the payment mechanism (i.e., cash, check or credit card) payment is expected at the time services are rendered and will be collected at the beginning of each session. If you are paying by check please have the check made out in advance of the appointment, made payable to **Lou A. Lichti, Ph.D.**

Please discuss with us when financial circumstances make it difficult to pay your bill on a weekly basis as large balances may result in straining both you and me personally and in our work together. All balances due after 14 days will be subject to a 1.5% monthly charge.

If your account is more than 60 days in arrears and suitable arrangements for payment have not been made, I have the option of suspending or discontinuing treatment and after a brief time period devoted to the termination of our work, will provide the names of other therapists or clinics. I also have the option of using legal means to secure the payment. This may involve hiring a collection agency or going through small claims court which will require me to disclose otherwise confidential information. In most collection situations, the only information I release regarding a patient's treatment is his/her name, the nature of services provided, and the amount due. [If such legal action is necessary, its costs will be included in the claim.]

STATEMENTS OR SUPERBILLS: In support of our environment, I will provide statements or super-bills for your records or insurance reimbursement upon request. Upon request these can be issued on a monthly, quarterly or yearly basis. If you do not request a statement, they will not automatically be given to you. Statements may also be sent via email in pdf format with your approval (email is not secure and therefore may limit your confidentiality).

SOCIAL MEDIA

I have a Facebook Page where I may post psychological items:
City Park Psychological Services & Associates, LLC: https://www.facebook.com/DrLouLichti.
You may elect to become a fan of these pages or "like" them. I maintain a personal Facebook Page but it is my policy not to accept clients as friends. I also have a twitter account: (https://twitter.com/DrLouLichti) and linked in: http://www.linkedin.com/in/drlou
.

TELE-PSYCHOLOGY

In Maryland, tele-health services are now legally reimbursable by insurance companies, however since I am not a participating provider these will be at out of network reimbursement rates, if any. After intake and establishing a relationship, it may be determined due to convenience, distance, or other circumstance that prevents "in-person" treatment, that "face-to-face" or interactive video-conferencing may be, at times, the preferred method of receiving treatment. Video conferencing (VC) is a real-time interactive audio and visual technology that allows for delivery of service. The VC system we use meets standards of encryption and privacy protection. It may also be used when the clinician and client are in different locations. Licensure regulations only allow us to practice within the state that both client and clinician are located. There are some exceptions. Risks may involve but are not limited to: lack of reimbursement by your insurance company the technology dropping due to internet connections, delays due to connections or other technologies, or there may be a breach of information that is beyond our control. Clinical risks may include your discomfort with the face-to-face vs. in-person treatment, difficulties interpreting non-verbal communication, and importantly, access to immediate resources should you feel at risk of harming yourself or someone else.

These services, along with email and other internet and wireless communications, have limitations in confidentiality and you will need to sign the agreement at the end of this document indicating you waive the right to confidentiality with use of these services.

LIMITS ON CONFIDENTIALITY

The law protects the privacy of all communications between a patient and a psychologist. In most situations, I 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 Maryland law. However, in the following situations, no authorization is required:

- I may occasionally find it helpful to consult other health and mental health professionals about a case. During a consultation, I make every effort to avoid revealing the identity of my patient. The other professionals are also legally bound to keep the information confidential. If you don't object, I will not tell you about these consultations unless I feel that it is important to our work together. I will note all consultations in your Clinical Record (which is called "PHI" in my Notice of Psychologist's Policies and Practices to Protect the Privacy of Your Health Information).
- You should be aware that I practice with other mental health professionals and that I may employ administrative staff. In most cases, I need to share protected information with these individuals for both clinical and administrative purposes, such as scheduling, billing and quality assurance. All of the mental health professionals are bound by the same rules of confidentiality. All staff have been given training about protecting your privacy and have agreed not to release any information outside of the practice without the permission of a professional staff member.
- If you are involved in a court proceeding and a request is made for information concerning your diagnosis and treatment, such information is protected by the psychologist-patient privilege law. I cannot provide any information without your written authorization, or 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 me to disclose information.
- If a government agency is requesting the information for health oversight activities, I may be required to provide it for them.
- If a patient files a complaint or lawsuit against me, I may disclose relevant information regarding that patient in order to defend myself.

There are some situations in which I am legally obligated to take actions, which I believe are necessary to attempt to protect others from harm and I may have to reveal some information about a patient's treatment. These situations are unusual in my practice.

- If I have reason to believe that a child or vulnerable adult has been subjected to abuse or neglect, or that a vulnerable adult has been subjected to self-neglect, or exploitation, the law requires that
- I file a report with the appropriate government agency, usually the local office of the Department Of Social Services. Once such a report is filed, I may be required to provide additional information.
- If I know that a patient has a propensity for violence and the patient indicates that he/she has the intention to inflict imminent physical injury upon a specified victim(s), I may be required to take protective actions. These actions may include establishing and undertaking a treatment plan that is calculated to eliminate the possibility that the patient will carry out the threat, seeking hospitalization of the patient and/or informing the potential victim or the police about the threat.
- If I believe that that there is an imminent risk that a patient will inflict serious physical harm or death on him/herself, or that immediate disclosure is required to provide for the patient's emergency health care needs, I may be required to take appropriate protective actions, including initiating hospitalization and/or notifying family members or others who can protect the patient.

While this written summary of exceptions to confidentiality should prove 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 I am not an attorney. In situations where specific advice is required, formal legal advice may be needed.

PROFESSIONAL RECORDS

You should be aware that, pursuant to HIPAA, I keep Protected Health Information about you in two sets of professional records. One set constitutes your Clinical Record. Except in unusual circumstances that disclosure is reasonably likely to endanger the life or physical safety of you or another person, 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, 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. In most circumstances, I am allowed to charge a copying fee (plus the cost of shipping and handling). The exceptions to this policy are contained in the attached Notice Form. If I refuse your request for access to your Clinical Records, you have a right of review, which I will discuss with you upon request. In the event that I am incapacitated or my death, my professional executor may take control of client records and contact clients regarding my status.

In addition, I also keep a set of Psychotherapy Notes. These Notes are for my own use and are designed to assist me in providing you with the best treatment. These Psychotherapy Notes are kept separate from your Clinical Record.

Insurance Record Request or Audit: You should be aware that if you decide to submit for out of network health insurance reimbursement, some insurance companies are requesting and auditing your mental health clinical records to determine medical necessity. I cannot release those records to your insurance company without your written signed consent. If your insurance company decides based on a review of records, that services already rendered are not medically necessary, they may request that you refund them for payments made to you.

MINORS & PARENTS

Patients under 16 years of age who are not emancipated and their parents should be aware that the law may allow parents to examine their child's treatment records. While privacy in psychotherapy is very important, particularly with teenagers, parental involvement is also essential to successful treatment. Therefore, it is usually my policy to request an agreement from any patient under 18 and his/her parents allowing me to share general information about the progress of treatment and their child's attendance at scheduled sessions. I will also provide parents with a summary of their child's treatment when it is complete. Any other communication will require the child's authorization, unless I feel that the child is in danger or is a danger to someone else, in which case, I will 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.

MARYLAND NOTICE FORM

Notice of Psychologist's Policies and Practices to Protect the Privacy of Your Patient's Health Information

THIS NOTICE DESCRIBES HOW PSYCHOLOGICAL AND MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

I. Uses and Disclosures for Treatment, Payment, and Health Care Operations

I may use or disclose your protected health information (PHI), for treatment, payment, and health care operations purposes with your written authorization. To help clarify these terms, here are some definitions:

- "*PHI*" refers to information in your health record that could identify you.
- "Treatment, Payment, and Health Care Operations" ○ *Treatment* is when I provide, coordinate, or manage your health care and other services related to your health care. An example of treatment would be when I consult with another health care provider, such as your family physician or another psychologist. ○ *Payment* is when I obtain reimbursement for your healthcare. Examples of payment are when I disclose your PHI to your health insurer to obtain reimbursement for your health care or to determine eligibility or coverage.
  - *Health Care Operations* are activities that relate to the performance and operation of my practice. Examples of health care operations are quality assessment and improvement activities, business-related matters such as audits and administrative services, and case management and care coordination.
- "*Use*" applies only to activities within my [office, clinic, practice group, etc.] such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.
- "*Disclosure*" applies to activities outside of my [office, clinic, practice group, etc.], such as releasing, transferring, or providing access to information about you to other parties.
- "*Authorization*" is your written permission to disclose confidential mental health information. All authorizations to disclose must be on a specific legally required form.

II. Other Uses and Disclosures Requiring Authorization

I may use or disclose PHI for purposes outside of treatment, payment, or health care operations when your appropriate authorization is obtained. In those instances when I am asked for information for purposes outside of treatment, payment, or health care operations, I will obtain an authorization from you before releasing this information. I will also need to obtain an authorization before releasing your Psychotherapy Notes. "*Psychotherapy Notes*" are notes I have made about our conversation during a private, group, joint, or family counseling session, which I have kept separate from the rest of your medical record. These notes are given a greater degree of protection than PHI.

You may revoke all such authorizations (of PHI or Psychotherapy Notes) at any time, provided each revocation is in writing. You may not revoke an authorization to the extent that (1) I have relied on that authorization; or (2) if the authorization was obtained as a condition of obtaining insurance coverage, law provides the insurer the right to contest the claim under the policy.

III. Uses and Disclosures without Authorization

I may use or disclose PHI without your consent or authorization in the following circumstances:

- *Child Abuse* – If I have reason to believe that a child has been subjected to abuse or neglect, I must report this belief to the appropriate authorities.
- *Adult and Domestic Abuse* – I may disclose protected health information regarding you if I reasonably believe that you are a victim of abuse, neglect, self-neglector exploitation.
- *Health Oversight Activities* – If I receive a subpoena from the Maryland Board of Examiners of Psychologists because they are investigating my practice, I must disclose any PHI requested by the Board.
- *Judicial and Administrative Proceedings* – If you are involved in a court proceeding and a request is made for information about your diagnosis and treatment or the records thereof, such information is privileged under state law, and I will not release information without your written authorization or a court order. The privilege does not apply when you are being evaluated or a third party or where the evaluation is court ordered. You will be informed in advance if this is the case.
- *Serious Threat to Health or Safety* – If you communicate to me a specific threat of imminent harm against another individual or if I believe that there is clear, imminent risk of physical or mental injury being inflicted against another individual, I may make disclosures that I believe are necessary to protect that individual from harm. If I believe that you present an imminent, serious risk of physical or mental injury or death to yourself, I may make disclosures I consider necessary to protect you from harm.

IV. Patient's Rights and Psychologist's Duties

Patient's Rights:

- *Right to Request Restrictions* – You have the right to request restrictions on certain uses and disclosures of protected health information. However, I am not required to agree to a restriction you request.
- *Right to Receive Confidential Communications by Alternative Means and at Alternative Locations* – You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations. (For example, you may not want a family member to know that you are seeing me. On your request, I will send your bills to another address.)
- *Right to Inspect and Copy* – You have the right to inspect or obtain a copy (or both) of PHI in my mental health and billing records used to make decisions about you for as long as the PHI is maintained in the record. I may deny your access to PHI under certain circumstances, but in some cases you may have this decision reviewed. You have the right to inspect or obtain a copy (or both) of Psychotherapy Notes unless I believe the disclosure of the record will be injurious to your health. On your request, I will discuss with you the details of the request and denial process for both PHI and Psychotherapy Notes.
- *Right to Amend* – You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. I may deny your request. On your request, I will discuss with you the details of the amendment process.

- *Right to an Accounting* – You generally have the right to receive an accounting of disclosures of PHI. On your request, I will discuss with you the details of the accounting process.

- *Right to a Paper Copy* – You have the right to obtain a paper copy of the notice from me upon request, even if you have agreed to receive the notice electronically.

Psychologist's Duties:

- I am required by law to maintain the privacy of PHI and to provide you with a notice of my legal duties and privacy practices with respect to PHI.
- I reserve the right to change the privacy policies and practices described in this notice. Unless I notify you of such changes, however, I am required to abide by the terms currently in effect.
- If I revise my policies and procedures, I will supply you with a revised copy of this document.

V. Complaints

If you are concerned that I have violated your privacy rights, or you disagree with a decision I made about access to your records, you may contact Lou A. Lichti, Ph.D., Psychologist, 301-401-2813.

You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services. The person listed above can provide you with the appropriate address upon request.

VI. Effective Date, Restrictions, and Changes to Privacy Policy

This notice will go into effect on April 1, 2003. Revised September 1, 2012.

I reserve the right to change the terms of this notice and to make the new notice provisions effective for all PHI that I maintain. I will provide you with a revised notice by providing you a copy of the notice upon revision.

CITY PARK
PSYCHOLOGICAL SERVICES

cityparkpsychological.com

Your signature below indicates that you have read the information in this Services Contract, including the Maryland Notice Form regarding practices to protect the privacy of your PHI, and agree to abide by its terms during our professional relationship. Your signature also acknowledges that Lou A. Lichti, Ph.D. (DBA City Park Psychological Services, LLC) may render services in an office setting with other independent professionals that are not affiliated in any way with Dr. Lichti and therefore have no liability or obligation to Dr. Lichti's clients or services rendered.

_______________________________ _______________________________
Client or Responsible Party Signature Date

_______________________________________ _______________________________________
Printed Name Email

______________________Phone No(s) for Office Contact (This authorizes me to contact you at this number)

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Address for correspondence

____
Signature above indicating agreement for tele-health psychological services including telephone, video chat (please sign the video chat agreement) or other internet and wireless psychotherapy. **ALL internet or wireless communications are not secure and therefore your signature and use of these services with Dr. Lou indicate you waive your right to confidentiality.**

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Signature regarding approval of receiving e-mail or cell text messaging from me knowing limits of confidentiality. Pdf monthly statements and appt scheduling, among other related correspondence may be sent via email to your email address or cell phone if requested. (Please be advised that **NO** e-mail or text messaging correspondence is considered confidential and may be recovered by other parties at any time. **You may lose your right to confidentiality by corresponding with me by e-mail and by receiving correspondence from me by e-mail or cell text).**

Please complete the next page.

10/18

CREDIT CARD INFORMATION

Please provide credit card information below. By providing this information it will simplify payment procedures in the event of a missed appointment without cancellation, as well as the occasions where an appointment is cancelled without 24 hour notice (48-72 hours is preferable). In either event, credit cards will be processed at the end of the scheduled appointment. Your acceptance of this policy will ensure that your payments will always be up-to-date and will be made in a timely manner.

We Accept: MasterCard ~ Visa ~ Discover ~ Debit or Credit Cards

Name exactly as appears Card: ____ (please print)

Card Number: ______________________________________

Expiration Date: _____/_______ (mm/yyyy) **Security code** (3 digits on back of card): _____

Address of Billing Address for Card:

____
(House Number and Street Name)

____
(Zip Code)

Phone Number: _______________ ______________________

By signing below, I authorize Lou A. Lichti, Ph.D., City Park Psychological Services, LLC, to charge my credit card for any services not paid for at the time services were rendered:

____ ________________________

Signature Date

10/18