

## **CLIENT SERVICES AGREEMENT**

**Mike Schaub, Ph.D.**

**Licensed Clinical Psychologist**

**5249 Duke Street, Suite 200**

**Alexandria, VA 22304**

**240-421-6518**

This agreement contains important information about the services you will receive, confidentiality, and other administrative issues. It also contains summary information about the Health Insurance Portability and Accountability Act (HIPAA), a federal law that provides privacy protections and client 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. Please read this carefully and feel free to ask questions.

### **PSYCHOLOGICAL SERVICES**

Psychotherapy is not easily described in general statements. It varies depending on the personalities of the psychologist and client, and the particular concerns you bring forward. There are many different methods I may use to deal with the concerns 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. Because 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 benefits for people who go through it. Although there are no guarantees of successful outcomes, therapy often leads to better relationships, solutions to specific problems, and significant reductions in feelings of distress.

### **EMERGENCIES**

If at any time you experience a psychological emergency in which you are concerned that you may injure yourself or someone else, you may contact me at 240-421-6518. If you are unable to get in contact with me, please dial "911" or visit the nearest hospital emergency room and request assistance.

### **SESSIONS AND FEES**

We will usually schedule one 50-minute session (one appointment hour of 50 minutes duration) per week at a time we agree on. Once an appointment hour is scheduled, you will be expected to pay for it unless you provide 24 hours advance notice of cancellation by calling me at 240-421-6518. My hourly fee is \$120 for individual therapy and \$160 for couples therapy which is due at the end of our session. In addition to weekly appointments, I 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. Other services include report writing, telephone conversations lasting longer than 15 minutes, attendance at meetings with other professionals you have authorized, preparation of records or treatment summaries, and the time spent performing any other service you may request of me. The costs of assessments will be discussed as necessary.

If your account has not been paid for more than 60 days and arrangements for payment have not been agreed upon, I 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.

## **INSURANCE REIMBURSEMENT**

If you have a health insurance policy, it may provide some coverage for mental health treatment. I will provide you with whatever assistance I can in helping you receive the benefits to which you are entitled; however, you (not your insurance company) are responsible for full payment of my fees. It is very important that you find out exactly what mental health services your insurance policy covers. You should carefully read the section in your insurance coverage booklet that describes mental health services. If you have questions about the coverage, call your plan administrator.

You should also be aware that most insurance companies require you to authorize me to provide them with a clinical diagnosis. Sometimes I have to provide additional clinical information such as treatment plans or summaries, or copies of the entire record (in rare cases). This information will become part of the insurance company files and will probably be stored in a computer. Though all insurance companies claim to keep such information confidential, I have no control over what they do with it once it is in their hands. In some cases, they may share the information with a national medical information databank. I will provide you with a copy of any report I submit, if you request it.

## **PROFESSIONAL RECORDS**

The laws and standards of my profession require that I keep treatment records. You are entitled to receive a copy of your records, or I can prepare a summary for you instead. Because these are professional records, they can be misinterpreted and/or upsetting to untrained readers. If you wish to see your records, I recommend that you review them in my presence so that we can discuss the contents. Clients will be charged an appropriate fee for any professional time spent in responding to information requests.

## **MINORS**

If you are under eighteen years of age, please be aware that the law may provide your parents the right to examine your treatment records. It is my policy to request an agreement from parents that they will give up access to your records. If they agree, I will provide them only with general information about our work together, unless I feel there is a high risk that you will harm yourself or someone else. In this case, I will notify them of my concern. I will also provide them with a summary of your treatment when it is complete. Before giving them any information, I will discuss the matter with you, if possible, and do my best to handle any objections you may have with what I am prepared to discuss.

## **CONFIDENTIALITY**

In general, the privacy of all communications between a client and a psychologist is protected by law, and I can only release information about our work to others with your written permission. There are some situations where I am permitted or required to disclose information without either your consent or authorization. These situations are unusual in my practice. (Please refer to the Virginia Notice Form for additional information about disclosures.)

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 client. 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.

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-client privilege law. I cannot provide any information without your (or your legal representative's) written authorization or a court order. If a subpoena is served on me with appropriate notices, I may have to release information in a sealed envelope to the clerk of the court issuing the subpoena. 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 client files a complaint or lawsuit against me, I may disclose relevant information regarding that client in order to defend myself.

If a client files a worker's compensation claim, I must, upon appropriate request, provide a copy of any mental health report.

If I have reason to suspect that a child is abused or neglected, the law requires that I file a report with the appropriate governmental agency, usually the Department of Social Services. Once such a report is filed, I may be required to provide additional information.

If I have reason to suspect that an adult is abused, neglected or exploited, the law requires that I report to the Department of Welfare or Social Services. Once such a report is filed, I may be required to provide additional information.

If a client threatens to harm himself/herself, I may be obligated to seek hospitalization for him/her, or to contact family members or others who can help provide protection.

If a client communicates a specific threat of immediate serious physical harm to an identifiable victim, and I believe he/she has the intent and ability to carry out the threat, I am required to take protective actions. These actions may include notifying the potential victim or his/her guardian, contacting the police, or seeking hospitalization for the client.

If such a situation 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. 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.

**VIRGINIA NOTICE FORM**

During your intake session, you will be given a copy of the Notice of Psychologists' Policies and Practices to Protect the Privacy of Your Health Information (Virginia Notice Form). By signing below, you acknowledge that you received a copy of this form.

**ACKNOWLEDGMENT**

Your signature below indicates that you have read the information in this document and agree to abide by its terms during our professional relationship. You also acknowledge receipt of the Notice of Psychologists' Policies and Practices to Protect the Privacy of Your Health Information.

\_\_\_\_\_  
Client's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent or Guardian  
(if the client is a minor)

\_\_\_\_\_  
Date