Practice Agreement for Dr. Heather Therapy, PLLC

Welcome to my practice. This document contains important information about my practice and business policies. Please read it carefully. Your signature at the end signifies that you consent to this Agreement and the Notice of Policies and Practices to Protect the Privacy of Your Mental Health Information.

PSYCHOLOGICAL SERVICES

My services vary depending on your needs. Our first few sessions will involve an evaluation of your needs. By the end of the evaluation, I will be able to offer you some initial impression of what your treatment will include and a plan to follow, if we decide to continue. If you have questions about procedures, they should be discussed with me whenever they arise. Much of my services involve therapy. Therapy requires active participation during sessions and at home. There are benefits and risks to therapy. Therapy involves discussing unpleasant aspects and may lead to uncomfortable feelings. On the other hand, therapy has many benefits such as learning strategies and reducing distress. There are, however, no guarantees of what you will experience and you are free to discontinue services at any time.

PROFESSIONAL FEE SCHEDULE

Initial Appointments	$230
Individual Therapy (45 minutes)	$150
30 minutes (pre-arranged)	$115
60 minutes	$215
Family Therapy/ Parent Education	$215
Psychological Testing & Report Writing	$200/hour (number of hours vary)
Materials fee for testing	$50

Other Fees

Legal Proceedings per hour $300
Communications (email, phone) 15 minutes $40
Form preparation 15 minutes $40
Late cancellations (less than 24 hours notice) $75
No show/missed appointment without notification $150

**I reserve the right to alter and update the Fee Schedule at any time. All clients will be notified in writing of changes in fees at least 4 weeks prior to implementation.

BILLING AND PAYMENTS

You will be expected to pay for each session at the time it is held, unless we agree otherwise. I accept the following methods of payment: check (preferred), cash or credit card. Late charges will be added to accounts with any balance over 60 days old. Late Fees are calculated at a rate of 2% monthly. If your account has not been paid for more than 90 days and you have not arranged payment, I have the option of using legal means to secure payment, including collection agencies or small claims. In most collection situations, the only information released regarding a client's treatment is his/her name, the nature of services provided, and the amount due. There will be a $25 charge for returned checks. Credit balances on your account will be used to offset charges for future services. Any credit balance remaining at the end of treatment will be refunded to you.

INSURANCE REIMBURSEMENT

I am in-network with several insurance companies, however each plan is different. It is vital that you understand your mental health benefit in order to plan for your treatment. Read the section in your insurance booklet that describes mental health, or call the toll free number on your card or your plan administrator. Ask if I am on your panel, what your co-pay and deductible are, whether your deductible has been met, how many sessions you are allowed per year, whether the service you want (e.g., testing; family therapy) is covered, and whether preauthorization is required. Please be aware that your plan may say that they cover psychological testing but may exclude such diagnoses as learning disabilities or attention problems.

Although I will try to assist you in receiving the benefits to which you are entitled, you (and not your insurance company) are responsible for full payment of your bill. If you fail to comply with your insurance company's requirements regarding choice of providers, authorization, or other issues that result in the denial of claims, you will be responsible for paying in full.

It is up to you to keep track of any authorizations that are required. It is up to you to notify me of any changes in your coverage. Dr. Heather Therapy, PLLC will file claims for you; or, if you prefer, you may file them yourself. You should be aware that your contract with your insurance company requires the provision of information relevant to the services provided to you, including a clinical diagnosis. Sometimes insurance companies also ask for additional information (e.g., progress summary, history, etc.) to determine whether you are eligible for benefits or ongoing treatment. I will release the minimum amount of information necessary to allow your claim to be processed.

24-HOURS NOTICE OF CANCELLATION POLICY

Your appointment time is reserved exclusively for you. If you are unable to keep this appointment, please notify me as soon as possible. If you cancel your appointment with at least 24 hours notice, you will not be charged for missing the appointment. However, if you cancel your appointment with less than 24-hours notice, you will be charged for half of the session fee ($75.00) unless you and I agree that it was a bona fide emergency beyond your control. If you fail to come to your appointment altogether and without any prior notification, you will be charged for the no show rate of $150.00. It is important to note that insurance companies do not provide reimbursement for late cancellation or no show charges. In the event of inclement weather, please check your email and voicemail for messages from me informing you of the day's schedule. You should also contact me directly if concerned about inclement weather.

Late arrival for sessions sometimes occurs. If I am late for the appointment, you will be seen for the full appointment time if your schedule permits. If you are late, you will be seen for the remaining, not the entire, appointment time.

CONTACTING ME
Due to the nature of my work and my part-time schedule, I am often not immediately available. Please leave a message for me if you get my voicemail and I will make every effort to respond within 24 hours (with the exception of weekends and holidays). Should you decide to contact me via email, please note that this is not a secure means of communication and you are accepting the risk associated with transmitting personal information over the internet. Emails should be limited to scheduling, as they are not a means by which I can provide appropriate clinical care; please note that I offer a client portal for scheduling convenience. If you cannot reach me and feel that you have an emergency, call 911 or go to the nearest emergency room and ask for the psychiatrist on call.

CLIENT PORTAL
I offer a client portal where you will be able to view and request available appointments. My client portal can be found on my website or at https://www.therapyportal.com/p/drheather/. If you choose to use this resource, please request an invitation.

I also offer email reminders for scheduled sessions. If you would like to take advantage of this resource, please let me know and provide your email address. To reduce the chance that reminder emails will go into spam folders, please add appointmentreminders@therapyportal.com to your address book.

CONFIDENTIALITY
In general, the law protects the privacy of all communication between a client 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. However, I must also release information without consent in the following situations:
- If I believe that a client presents an imminent danger to him/herself, I may be required to seek hospitalization for the client, or contact family members or others who can help provide protection.
- If there is cause to suspect a child under 18 is abused or neglected, or reasonable cause to believe that a disabled adult is in need of protective services, the law requires that a report be filed with the appropriate agency. Once such a report is filed, additional information may be required.
- If there is reason to believe that a client presents an imminent danger to the health and safety of another, I may be required to disclose information in order to take protective actions, including initiating hospitalization, warning the potential victim, and/or calling the police.

Privacy for minors: While privacy in therapy is very important, particularly with teenagers, parental involvement is also essential to successful treatment; this requires that some private information be shared with parents. For children under 12, I share whatever information is necessary with the parents, although I will try to honor the child's wishes whenever possible. For adolescents (age 12 through 17), I ask that the client and his/her parent make an agreement about allowing the sharing of general information about the progress of the adolescent's treatment and his/her attendance at scheduled sessions. Any other communication will require the adolescent's agreement, unless I feel that the adolescent is in danger or is a danger to someone else. If possible, any information given to the parents will be discussed with the child or adolescent beforehand and an attempt made to handle his/her objections. A special case exists for N.C. adolescents who are married, emancipated, or in the military; they may control their own clinical records.

Parental Separation or Divorce: When a family is confronted by parental separation or divorce, it is very hard on everyone. It is particularly hard on children. When the parental relationship is unsafe, it is even more important that therapy presents a safe environment. That safety is particularly endangered when a child has to worry that what he says in therapy will be revealed in court and used against one of his parents. In order to protect that safety, I want us all to agree that the therapist will not be called as a witness by either party. Everyone needs to understand that a judge may decide not to honor this agreement and that I may be required to be a witness, although I will try to prevent that from happening. You should be aware that once we start treatment, it is unethical of me to give any opinion about custody or visitation arrangements, even if I am compelled to be a witness. I want your permission to provide information to anyone who the court appoints to perform a custody evaluation or to represent the legal interests of your children. I will not make any recommendation about the final decision.

CLIENT RIGHTS
HIPAA provides you with several new or expanded rights concerning your Clinical Records and disclosures of protected health information. These rights include requesting that I amend your record; requesting restrictions on what information from your Clinical Records 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 my policies and procedures recorded in your records; and the right to view and copy your records. I will be happy to discuss any of these rights with you. These rights are explained further in the Privacy Notice.

CONSENT
My signature below indicates that:
1) I understand, consent to, and agree to all terms in the above practice agreement for services provided by Heather Norman-Scott, PhD.
2) I have reviewed a copy of, read, understood, and am consenting to the policies in the HIPAA Privacy Notice Form described above. A copy of this policy has also been made available to me.
3) I consent to the use of my Protected Health Information (PHI) for treatment, payment, and health care operations as outlined in the HIPAA Privacy Notice Form described above.

_____	_____	_____
Signature of Client/Parent/Guardian	Client's/Parent's/Guardian's Name (Print)	Date

If a personal representative of the patient (i.e., not the patient him/herself) signs this authorization, a description of such representative's authority to act for the patient must be provided. Clinicians are required to ask for confirmation of custody or representation. Please circle one and specify: (1) Parent of Minor Child (2) Guardian of minor child (specify): _____
(3) Guardian of adult (specify): _____ (4) Other (specify): _____