Emily Nicholson, Psy.D.
148 Linden Street Suite 104A
Wellesley, MA 02482
Phone: 508-717-4898

PSYCHOTHERAPIST-PATIENT SERVICES AGREEMENT

Welcome to my practice. This document (the Agreement) contains important information about my professional services and business policies. 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. The law requires that I obtain your signature acknowledging that I have provided you with this information at the end of this session. Although these documents are long and sometimes complex, it is very important that you read them carefully before our next session. We can discuss any questions you have about the procedures at that time. When you sign this document, it will also represent an agreement between us.

PSYCHOLOGICAL SERVICES

Psychotherapy is not easily described in general statements. It varies depending on the personalities of the psychologist and patient, and the particular problems you/your child are experiencing. There are many different methods I may use to deal with the problems that you/your child hope to address. Psychotherapy is not like a medical doctor visit. Instead, it calls for a very active effort on your/your child's part. In order for the therapy to be most successful, you/your child will have to work on things we talk about both during our sessions and at home.

Our initial meeting(s) will involve an evaluation of your/your child's needs. By the end of the evaluation, I will be able to offer you some first impressions including if I believe that I would be able to be helpful to you/your child, and if so, what our work could involve. You should evaluate this information along with your own opinions of whether you feel comfortable working with me. If I do not believe that I would be able to address your/your child's concerns I will provide you with the names of alternate clinicians. If you/your child are not comfortable working with me you may request that I provide you with the names of other clinicians. If you decide to continue with therapy with me, we will regularly discuss your/your child's goals for therapy and how to meet those goals. If you have questions about my procedures, we should discuss them whenever they arise.

Psychotherapy can have benefits and risks. Since therapy often involves discussing unpleasant aspects of your/your child's life, you/your child 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.

MEETINGS

Sessions are 45 minutes in length. 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/your child need in order to meet your treatment goals. If psychotherapy is begun, we determine how frequently to meet. This decision is based on therapeutic needs, goals, financial feasibility, and a mutual agreement on what frequency best addresses your hopes and concerns. Once an appointment hour is scheduled, you will be expected to pay for it unless you provide 24 hours advance notice of cancellation. It is important to note that insurance companies do not provide reimbursement for cancelled sessions. If 24 hours notice is not provided, you will be responsible for the full session fee at our next session. If you are late for a session the remaining minutes are yours (i.e. if you are 10 minutes late for a 45 minute session, we will meet for the remaining 35 minutes).

PROFESSIONAL FEES

My session fee is $210.00 for parenting guidance and $200.00 for individual psychotherapy. 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, consulting with other professionals with your permission, preparation of records or treatment summaries, and the time spent performing any other service you may request of me. If you become involved in legal proceedings that require my participation, you will be expected to pay for all of my professional time, including preparation and transportation costs, even if I am called to testify by another party. I reevaluate my fees every January. At the time my fee does increase, I will discuss any proposed changes with you ahead of time.

CONTACTING ME

I can be reached at **508-717-4898** . As I do not answer the phone during sessions, I encourage you to leave a voicemail at this number. I check my voicemail frequently during my working hours and will make every effort to return your call on the same day you make it, with the

exception of weekends and holidays. Please remember to always leave a telephone number where you can be reached, and if you are difficult to reach, please inform me of some times when you will be available.

If you are unable to reach me and feel that you can't wait for me to return your call, contact your family physician or the nearest emergency room and ask for the psychologist or psychiatrist on call. You may also contact Psych Emergency Services' Crisis Line at 508-872-3333. If I will be unavailable for an extended time, I will provide you with the name of a colleague to contact, if necessary.

BILLING AND PAYMENTS

You will be expected to pay for each session at the time it is held, unless we agree otherwise or unless you have insurance coverage that requires another arrangement. In circumstances of unusual financial hardship, I may be willing to negotiate a fee adjustment or payment installment plan.

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.

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. I will fill out forms and 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 also be aware that your contract with your health insurance company requires that I provide it with information relevant to the services that I provide to you. I am required to provide a clinical diagnosis. Sometimes I am required to provide additional clinical information such as treatment plans or summaries, or copies of your entire clinical record. In such situations, I will make every effort to release only the minimum information about you that is necessary for the purpose requested. 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. By signing this Agreement, you agree that I can provide requested information to your carrier.

Once we have all of 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. It is important to remember that you have the right to pay for my services yourself to avoid the problems described above (unless prohibited by contract).

CONFIDENTIALITY

In general, the privacy of all communications between a patient and a psychologist is protected by law, and I can only release information about our work to others with your written permission. But there are a few exceptions.

In most legal proceedings, you have the right to prevent me from providing any information about your treatment. In some proceedings involving child custody and those in which your emotional condition is an important issue, a judge may order my testimony if he/she determines that the issues demand it.

There are some situations in which I am legally obligated to take action to protect others from harm, even if I have to reveal some information about a patient's treatment. For example, if I believe that a child, elderly person, or disabled person is being abused, I must file a report with the appropriate state agency.

If I believe that a patient is threatening serious bodily harm to another, I am required to take protective actions. These actions may include notifying the potential victim, contacting the police, or seeking hospitalization for the patient. If the patient 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.

These situations have rarely occurred in my practice. If a similar situation occurs, I will make every effort to fully discuss it with you before taking any action.

I may occasionally find it helpful to consult other professionals about a case. During a consultation, I make every effort to avoid revealing the identity of my patient. The consultant is 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.

ELECTRONIC COMMUNICATION POLICY

In order to maintain clarity regarding our use of electronic modes of communication during your treatment, I have prepared the following policy. This is because the use of various types of electronic communications is common in our society, and many individuals believe this is the preferred method of communication with others, whether their relationships are social or professional. Many of these common modes of communication, however, put your privacy at risk and can be inconsistent with the law and with the standards of my profession.
Consequently, this policy has been prepared to assure the security and confidentiality of your treatment and to assure that it is consistent with ethics and the law.

If you have any questions about this policy, please feel free to discuss this with me.

EMAIL COMMUNICATIONS

I use email communication and text messaging only with your permission and only for administrative purposes unless we have made another agreement. That means that email exchanges and text messages with my office should be limited to things like setting and changing appointments, billing matters and other related issues. Please do not email me about clinical matters because email is not a secure way to contact me. If you need to discuss a clinical matter with me, please feel free to call me so we can discuss it on the phone or wait so we can discuss it during your therapy session. The telephone or face-to-face context simply is much more secure as a mode of communication.

TEXT MESSAGING

Because text messaging is a very insecure and impersonal mode of communication, I do not text message to nor do I respond to text messages with clinically related information from anyone in treatment with me.

SOCIAL MEDIA

I do not communicate with, or contact, any of my clients through social media platforms like Twitter and Facebook. In addition, if I discover that I have accidentally established an online relationship with you, I will cancel that relationship. This is because these types of casual social contacts can create significant security risks for you.

I participate on various social networks, but not in my professional capacity. If you have an online presence, there is a possibility that you may encounter me by accident. If that occurs, please discuss it with me during our time together. I believe that any communications with

clients online have a high potential to compromise the professional relationship. In addition, please do not try to contact me in this way. I will not respond and will terminate any online contact no matter how accidental.

WEB SEARCHES

I will not use web searches to gather information about you without your permission. I believe that this violates your privacy rights; however, I understand that you might choose to gather information about me in this way. In this day and age there is an incredible amount of information available about individuals on the internet, much of which may actually be known to that person and some of which may be inaccurate or unknown. If you encounter any information about me through web searches, or in any other fashion for that matter, please discuss this with me during our time together so that we can deal with it and its potential impact on your treatment.

Recently it has become fashionable for clients to review their health care provider on various websites. Unfortunately, mental health professionals cannot respond to such comments and related errors because of confidentiality restrictions. If you encounter such reviews of me or any professional with whom you are working, please share it with me so we can discuss it and its potential impact on your therapy. Please do not rate my work with you while we are in treatment together on any of these websites. This is because it has a significant potential to damage our ability to work together.

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PATIENT AGREEMENTS AND AUTHORIZATIONS

CONSENT FOR TREATMENT: I hereby consent to the treatment provided by Emily Nicholson, Psy.D. I authorize the mental health care services deemed necessary or advisable by Dr. Nicholson to address my needs. (_____)

PAYMENT GUARANTEE/COLLECTION FEE: I understand that I am financially responsible to Dr. Nicholson for any covered or non-covered services, as defined by my insurer. I am aware that 24 hour notice is required for cancellations without charge. I understand that if my account balance becomes overdue and the overdue amount is referred to a collection agency, I will be responsible for the costs of collection including reasonable attorney fees. (_____)

Your signature below indicates that you have read the information in the Services Agreement document and agree to abide by its terms during our professional relationship.

_____ _____

Patient or Authorized Person's Signature Date

_____ _____

Witness Signature Date

PRIVACY POLICY: I acknowledge having received Dr. Nicholson's "Notice of Privacy Practices." And that Dr. Nicholson has given me the chance to discuss questions about the privacy of my protected health information (PHI), as required by the Health Insurance Portability and Accountability Act (HIPPA). (_____)

AUTHORIZATION FOR RELEASE OF PERSONAL HEALTH INFORMATION: I authorize use and disclosure of my personal health information for the purposes of diagnosing or providing treatment to me, obtaining payment for my care, or for the purposes of conducting healthcare operations of the practice. I authorize Dr. Nicholson to release any necessary information required in the applications for financial coverage for the services rendered. This authorization provides that Dr. Nicholson may release objective clinical information related to my diagnosis and treatment, which may be requested by my insurance company or its designated agent. I authorize the use of this signature on all insurance submissions (_____)

You have the right to revoke this authorization, in writing, at any time. However, the revocation will not affect any action that has been taken in response to this authorization.

_____ _____

Patient or Authorized Person's Signature Date

_____ _____

Witness Signature Date