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OUTPATIENT SERVICES CONTRACT

As I am interested in you and your concerns, in this document I am providing you important information about both professional services and business policies. Please read it carefully and note any questions that you might have so that we might discuss them. When you sign this document, it will represent a contract between us.

PSYCHOLOGICAL SERVICES

Psychotherapy is not easily described in general statements. It varies on the personalities of the therapist and the client and the particular problems that are brought to therapy. Your feelings about the therapy or therapist are very important. I encourage you to discuss any questions, confusion, or frustration that you experience so that they don't become obstacles to your treatment. I believe that you are the best authority on yourself and whether or not a treatment relationship will be helpful.

Our first few sessions will involve a review of your needs and problems. Throughout our evaluation process, I will be offering you some first impressions as to why you are experiencing the problems that you've presented and what treatment we will engage in if you decide to continue with therapy. You should evaluate this information along with your own opinions of whether you feel comfortable working with me.

If you have doubts about continuing, I will be happy to help you set up a meeting with another health professional.

PROFESSIONAL CONSULTATION

Professional consultation is an important part of a healthy psychotherapy practice. As such, I participate in clinical, ethical, and legal consultation with appropriate professionals. During such consultations, I do not reveal any personally identifying information regarding a client or client's family.

RECORDS AND RECORD KEEPING

I may take notes in session, and I will produce other notes and records in regard to your treatment. These are my clinical and business records, which by law, I am required to maintain. Also, by law, they are considered my sole property, and my record keeping cannot be altered at the request of a client. Should you request a copy of a record, that request must be made in writing. I reserve the right, under California law, to provide clients with a treatment summary in lieu of actual records. Under certain circumstances, I also retain the right to refuse the records, but may, as requested, provide a copy of the record to another treating health care provider.

CONFIDENTIALITY

Generally, the information you disclose to me is confidential and will not be released to any third party without your written authorization, except where required or permitted by law. Exceptions to confidentiality are not the norm in treatment, but they include, but are not limited to, reporting child, elder, and dependent adult abuse, when a client makes a serious threat of violence toward a reasonably identifiable victim, or when a client is dangerous to him/herself or the person or property of another.

While this written summary of rare exceptions to confidentiality should prove helpful in informing you about potential problems, it is important that you discuss any questions you may have with me in regard to the above information.

In addition, I want to inform you that all phone calls will be conducted via a cell phone.

PLEASE READ, SIGN, AND RETURN THIS COPY FOR MY RECORDS

CLIENT LITIGATION

I will not voluntarily participate in any litigation or custody dispute in which client and another individual, or entity, are parties. I have a policy of not communicating with clients' attorneys and will not write or sign letters, reports, declarations, or affidavits to be used in clients' legal matters. I will not generally provide records or testimony unless compelled to do so. Should I be subpoenaed, or ordered by a court of law, to appear as a witness in an action involving a client, client agrees to reimburse me for any time spent for preparation, travel, or time in which I make myself available whether the case is settled previous to testimony or rescheduled, for such an appearance at my rate of \$500.00 dollars an hour.

PSYCHOTHERAPIST-CLIENT PRIVILEGE

The information disclosed by the client, as well as any record created, is subject to psychotherapist-client privilege. The psychotherapist-client privilege results from the special relationship between therapist and client in the eyes of the law. It is akin to attorney-client privilege or the physician-patient privilege. Typically, the client is the holder of the psychotherapist-client privilege. If I receive a subpoena for records, deposition, testimony, or testimony in a court of law, I will assert the psychotherapist-client privilege on the client's behalf until instructed in writing to do otherwise by the client or the client's representative. Clients should be aware that they may be waving the psychotherapist-patient privilege with their attorneys.

MEETING AND CANCELLATIONS

Psychotherapy sessions last forty-five minutes. Once an appointment is set, you will be expected to pay for it unless you provide notice of cancellation at least forty-eight hours in advance. Cancellations should be left on my voice mail at 949.370.4726.

FEES AND PAYMENT

Payment is due at the beginning of each session. The charge for the initial, Intake appointment is \$200.00. Payment of \$190.00 is required at each subsequent appointment. I reserve the right to periodically adjust this fee, and you will be notified in advance of any fee adjustments. Checks, cash, debit, or charge cards are the accepted form of payment, and all checks are to be made out to Dr. Piper Walsh. In addition to appointments, I charge this amount for other professional services, which are prorated (other than for the purposes of scheduling). Other services include report writing, telephone conversations, attendance at meetings with other professionals you have authorized, and the time spent performing any other service that you request from me. Psychological testing services are an additional charge depending on the number and the test(s) administered.

INSURANCE

I am not a contracted provider with insurance companies or managed care organizations. If you have a PPO that allows you to use out-of-network providers, I will provide you with a statement that you may submit to your third-party in order to seek reimbursement of fees already paid.

MEDICARE

Please note that I am NOT a medical provider. Medicare does not cover my services and should not be billed for services rendered. If you would prefer to see a medical provider, at any point, I am happy to assist you in locating a provider.

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THERAPIST AVAILABILITY

I am generally available by telephone 949.370.4726, but I may not always be able to return your call immediately. I will make every effort to return your call in twenty-four hours or by the next business day. I am, however, unable to provide twenty-four hour crisis service. In the rare event that a client may be feeling unsafe or requires immediate medical or psychiatric assistance, I advise that s/he go to the nearest emergency room or call 911.

E-MAIL AND TEXT

Please note that e-mail and texts are not secure forms of communication. I ask that you communicate via phone. If you choose to use either e-mail or text, please only do so to enquire about appointments. Please do not send pertinent clinical information via text or e-mail.

TERMINATION OF THERAPY

Though rarely, there are occasions where I may have to terminate therapy. Reasons for termination include, but are not limited to, untimely payment of fees, failure to comply with treatment recommendations, conflicts of interest, failure to participate in therapy, client’s needs are out of the therapist’s scope of competence or practice, or client is not making progress in therapy. You, as the client, have a right to terminate therapy at your discretion.. If either of us decides to terminate therapy, I will generally recommend that you participate in one, or possibly more termination sessions. These sessions are intended to facilitate a positive termination experience and give both parties an opportunity to reflect on the work that has been done. If you desire another therapist, I will also try to facilitate your transition by offering referrals.

ACKNOWLEDGEMENT

By signing below, you are acknowledging that you have read and fully understand the terms and conditions of this agreement. In signing this agreement, you agree to abide by the terms and conditions set forth and consent to enter psychotherapy with me. In signing, you also agree to hold me free of any claims, demands, or suits for damages from any injury or complications whatsoever, save negligence, that might result from such treatment.

Client Name (please print)

Date: ___/___/___

Signature of Client (or authorized representative)

I understand that I am financially responsible for all charges incurred:

Name of Responsible Party (Please print)

Date: ___/___/___

Signature of Responsible Party

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NOTICE OF PRIVACY PRACTICES

(MEDICAL)

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY

The Health Insurance Portability & Accountability Act of 1996 (HIPAA) is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. "HIPAA" provides penalties for covered entities that misuse personal health information.

As required by "HIPAA", we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

We may use and disclose your medical records only for each of the following purposes: treatment, payment and health care operations.

- **Treatment** means providing, coordinating, or managing health care and related services by one or more health care providers. An example of this would include a physical examination.
- **Payment** means such activities as obtaining reimbursement for services, confirming coverage, billing, or collection activities, and utilization review.
- **Health Care Operations** include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would be an internal quality assessment review.

We may also create and distribute de-identified health information by removing all references to individually identifiable information.

We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer:

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.
- The right to inspect and copy your protected health information.
- The right to amend your protected health information.
- The right to receive an accounting of disclosures of protected health information.

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- The right to obtain a paper copy of this notice from us upon request.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

The notice is effective as of April, 2003 and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practices from this office.

You have recourse if you feel that your privacy protections have been violated. You have the right to file written complaint with our office, or with the Department of Health & Human Services, Office of Civil Rights, about violations of the provisions of this notice or the policies procedures of our office. We will not retaliate against you for filing a complaint.

Please contact us for more information:

For more information about HIPAA
or to file a complaint:

The US Department of Health & Human Services,
Office of Civil Rights
200 Independence Avenue, S.W.
Washington, D.C. 20201
(202) 619-0257
Toll Free: 1-877-696-6775

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PATIENT CONSENT FORM

I understand that, under the Health Insurance Portability & Accounting Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment, directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have been informed by you of your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such *Notice of Privacy Practices* prior to signing this consent. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address below to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand that you are not required to agree to requested restrictions, but if you do agree then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

Patient Name: _____

Signature: _____

Relationship to Patient: _____

Date: _____

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