Therapist - Patient Agreement

Therapist

1. I will adhere to the Maryland Code of Rules and Regulations for Psychologists as well as federal regulations ensuring the privacy of personal health information.

2. I will provide to you a written explanation of your rights and my duties under federal privacy regulations. If you ever have concerns or questions about the privacy of your health information, I will do my best to address these issues.

3. I will keep all information developed in our sessions strictly confidential unless you given me written permission to the contrary. The exceptions to this confidentiality rule involve the safeguarding of your life, protecting others from harm and prevention of child or elder abuse.

4. I will discuss with you and help you assess your objective(s) and goals to be achieved during treatment. A treatment plan will be discussed to create an optimal working relationship. Your progress towards therapeutic goals will be reviewed periodically with you.

5. I will begin and end sessions on time.

6. I will keep all records secure while they are in my possession and after a period of time I will ensure that all records are destroyed completely to protect confidentiality.

7. I will provide you a monthly itemized statement of fees and services rendered for the previous month.

Patient

1. I have been assured of my right to terminate participating in treatment at any time, for any reason, and without penalty. However, I understand that it is important to discuss with you in advance my desire to terminate so that there is opportunity to reach a mutual decision.

2. I will begin and end sessions on time.

3. I agree to keep all scheduled appointments. If I do not cancel my appointment at least **48** hours in advance, I understand that I will be charged for that session whether I am in attendance or not.

4. I agree to provide you with the following compensation:

_____minute_____session:_____

5. I understand that I am responsible for all payments. This can be waived if you have a managed care contract. The attached Managed Care Addendum specifies your financial responsibilities.

6. I understand that I am responsible for payment in a timely fashion. If a collection service is used for accounts with an unpaid balance over 90 days, the fee charged by the service will be passed on to the patient. The collection fee is currently_____.

Managed Care Addendum

1. By your signature, you are authorizing me to disclose personal health information to file claims and fill in forms for the managed care company to review the necessity for additional sessions. Before signing, please read the "Summary of your Privacy Rights Under HIPAA" for details about my policy about disclosing personal health information.

2. I agree to pay the applicable co-payment at the time of each session.

3. I understand that the insurance company cannot be billed for a session that was missed or canceled with insufficient notice. I agree to pay a missed visit charge equal to the amount that the insurance company specifies in my contract with them.

Date:_____

Patient(s): _____ _____

Therapist:_____