DANIEL BENVENISTE, Ph.D.

Clinical Psychologist

### **PSYCHOTHERAPIST-PATIENT SERVICES AGREEMENT**

**[STATE of WASHINGTON]**

This Agreement contains important information about my professional services and business policies. It also contains summary information about the Health Insurance Portability and Accountability Act (HIPAA), a federal law that provides privacy protections and patient 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. HIPAA requires that I provide you with a Notice of Privacy Practices for use and disclosure of PHI for treatment, payment and health care operations. The law requires that I obtain your signature acknowledging that I have provided you with this information. It is important that you read them carefully. We can discuss any questions you have about the procedures at any time. When you sign this document, it will also represent an agreement between us.

# PSYCHOLOGICAL SERVICES

**Psychotherapy is a way of dealing with social emotional problems by talking about them. No two therapies are alike as they vary depending on the personalities of the psychologist and patient, and the particular problems you are experiencing. There are many different methods I may use to deal with the problems that you hope to address. These will include directed focus on specific problems and also open ended exploration of your social-emotional life as revealed in your psychological symptoms, daily concerns, relationships, family and work concerns, the thoughts and feelings that you share, your experience of the therapy and therapist, as well as your dreams, day-dreams, hobbies, and special interests. Psychotherapy is not like a medical visit. Psychotherapy requires a very active effort on your part to talk about things that are often difficult to discuss and to become aware of yourself between sessions. This awareness may include efforts to curb self-destructive behaviors, promote constructive behavior, keep a journal, track your dreams, and so on.**

**Psychotherapy often involves discussing things that are difficult to talk about so you may, from time to time, experience uncomfortable feelings such as sadness, guilt, anger, frustration, loneliness, and helplessness. But discussing these matters often leads to better relationships, solutions to specific problems, and significant reductions in feelings of distress. That said, there are no guarantees of what you will experience.**

**Our first few sessions are for an evaluation of your needs, to see if I think I can help you and to see if we are a good match. By the end of the evaluation, I will offer some first impressions of what our work will include and a treatment plan to follow, 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. Therapy involves a large commitment of time, money, and energy, so you should be very careful about the therapist you select. If you have questions about my work, please feel free to address it at any time. Therapy depends on your being open and honest about how you are feeling and thinking about the therapy**

# MEETINGS

I normally conduct an evaluation during the first 2 to 4 sessions. During this time, we can both decide if I am the best person to provide the services you need in order to meet your treatment goals. If psychotherapy is initiated, I will usually schedule one 55-minute sessions (**one appointment hour of 55 minutes duration**) per week at a time we agree on, although some treatments involve more frequent sessions of two to three times a week. **Once an appointment hour is scheduled, you will be expected to pay for it unless you provide 48 hours advance notice of cancellation. It is important to remember that insurance companies do not provide reimbursement for cancelled sessions so if insurance is paying for your treatment and you miss a session you will be responsible to pay for it out of pocket. Whenever possible, I will try to find another time to reschedule the appointment within one week.**

# PROFESSIONAL FEES

**My hourly fee is $200/session.** **I charge my full fee for no-shows and late cancellations (less than 48 hours in advance). This cancellation policy applies to patients whose therapy is paid for out of pocket and by insurance companies. Insurance companies do not pay for no shows or cancellations.** In addition to regular appointments, I charge this fee for other professional services you may require including report writing, 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.

# CONTACTING ME

**The best way to reach me is by email. Due to my schedule, I am often not immediately available by telephone but you can always leave a phone message and I will get back to you when I am available. I’ll make every effort to return your call within 48 hours, with the exception of weekends and holidays**. If you are difficult to reach, please inform me of some hours 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. If I will be unavailable for an extended time, I will provide you with the name of a colleague to contact, if necessary.

## LIMITS ON CONFIDENTIALITY

**The law protects the privacy of all communications between a patient and a psychologist. In most situations, I only release information about your treatment to others if you sign a written Authorization form that meets certain legal requirements imposed by state law and/or HIPAA.** With your signature on a proper Authorization form, I may disclose information in the following situations:

I may occasionally find it helpful to consult other health and mental health professionals about a case. If I consult with a professional who is not involved in your treatment, I make every effort to avoid revealing your identity. These professionals are 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 also have contracts with various insurance companies. As required by HIPAA, I have a formal business associate contract with these businesses, in which they promise to maintain the confidentiality of this data except as specifically allowed in the contract or otherwise required by law.

If you are involved in a court proceeding and a request is made for information concerning the professional services I provided you, such information is protected by the psychologist-patient privilege law. I cannot provide any information without 1) your written authorization; 2) you informing me that you are seeking a protective order against my compliance with a subpoena that has been properly served on me and of which you have been notified in a timely manner; or 3) a court order requiring the disclosure. If you are involved in or contemplating litigation, you should consult with your attorney about likely required court disclosures.

There are some situations where I am permitted or required to disclose information without either your consent or Authorization:

If a government agency is requesting the information for health oversight activities, I may be required to provide it for them.

If a patient files a complaint or lawsuit against me, I may disclose relevant information regarding that patient in order to defend myself.

If a patient files a worker’s compensation claim, and the services I am providing are relevant to the injury for which the claim was made, I must, upon appropriate request, provide a copy of the patient’s record to the patient’s employer and the Department of Labor and Industries.

Psychotherapy is based on confidentiality in the professional therapist-patient relationship. The following are a few exceptions to the agreement of confidentiality.

**Duty to Warn in Matters of Violence Against Others:** Therapists are mandated by law to disclose pertinent information discussed in therapy if the patient has a clear intent or plan to imminently harm another person. These disclosures may include notifying the potential victim, contacting the police, seeking hospitalization for the patient, or contacting family members or others who can help provide protection.

**Suicide/Self Harm:** Suicidal thoughts are a common human experience and subject to discussion in psychotherapy. Having suicidal thoughts does not mean a person is going to kill themselves but these are thoughts worth discussing in psychotherapy. Part of the discussion will pertain to the meaning of these thoughts in the current circumstance and part will focus on a suicide assessment. The suicide assessment will determine if the thoughts can be safely discussed in out-patient treatment or if the patient is imminently suicidal and in need of a hospitalization to ensure safety. In this situation the therapist will need to make reasonable attempts to notify the family and possible admission to psychiatric emergency services.

**Vulnerable Children and Adults:** Mental health professionals are required by law to report clear or suspected abuse of a child. Abuse includes sexual abuse, physical violence, emotional abuse, and neglect. I am also required by law to report if I have reasonable cause to believe that abandonment, abuse, financial exploitation, or neglect of a vulnerable adult has occurred. In these cases, the law requires that I file a report with the appropriate government agency, usually the Department of Social and Health Services.

**Prenatal Exposure to Controlled Substances:** In an effort to protect vulnerable populations, Mental Health Providers are required to report admitted use of controlled substances during pregnancy that are potentially harmful to the fetus.

**Minors/Guardianship:** Parents or legal guardians have the right to access a minor client’s health information. The age of consent for psychotherapy in the state of Washington is 16.

**Insurance Providers:** Information requested from insurance companies includes a diagnosis, type of treatment, and the dates and times of service. On very rare occasions, typically for administrative purposes, a description of impairments, treatment plans, treatment progress, prognosis for improvement, case notes and summaries may also be requested.

**Animal abuse:** It is required by law for mental health professionals to report animal abuse, including cases of neglect and hoarding.

## PROFESSIONAL RECORDS

You should be aware that, pursuant to HIPAA, I keep Protected Health Information about you in two sets of professional records. One set constitutes your Clinical Record. It includes information about your reasons for seeking therapy, a description of the ways in which your problem impacts on your life, your diagnosis, the goals that we set for treatment, your progress towards those goals, your medical and social history, your treatment history, any past treatment records that I receive from other providers, reports of any professional consultations, your billing records, and any reports that have been sent to anyone, including reports to your insurance carrier. Except in the unusual circumstance that I conclude disclosure could reasonably be expected to cause danger to the life or safety of the patient or any other individual or that disclosure could reasonably be expected to lead to the patient’s identification of the person who provided information to me in confidence under circumstances where confidentiality is appropriate, you may examine and/or receive a copy of your Clinical Record, if you request it in writing. Because these are professional records, they can be misinterpreted and/or upsetting to untrained readers. For this reason, I recommend that you initially review them in my presence or have them forwarded to another mental health professional so you can discuss the contents. In most situations, I am allowed to charge a copying fee of 65 cents per page for the first 30 pages and 50 cents per page after that, and a $15 clerical fee. I may withhold your Record until the fees are paid. The exceptions to this policy are contained in the attached Notice Form. If I refuse your request for access to your records, you have a right of review, which I will discuss with you upon request.

In addition, I also keep a set of Psychotherapy Notes. These Notes are for my own use and are designed to assist me in providing you with the best treatment. While the contents of Psychotherapy Notes vary from client to client, they can include the contents of our conversations, my analysis of those conversations, and how they impact on your therapy. They also contain particularly sensitive information that you may reveal to me that is not required to be included in your Clinical Record. My psychotherapy notes tend to be sporadic, meaning I do not keep psychotherapy notes on every patient or on every session. These Psychotherapy Notes are kept separate from your Clinical Record. While insurance companies can request and receive a copy of your Clinical Record, they cannot receive a copy of your Psychotherapy Notes without your signed, written Authorization. Insurance companies cannot require your Authorization as a condition of coverage nor penalize you in any way for your refusal. You may examine and/or receive a copy of your Psychotherapy Notes unless I determine that knowledge of the health care information would be injurious to your health or the health of another person, or could reasonably be expected to lead to your identification of an individual who provided the information in confidence and under circumstances in which confidentiality was appropriate, or contain information that was compiled and is used solely for litigation, quality assurance, peer review, or administrative purposes, or is otherwise prohibited by law.

**PATIENT RIGHTS**

HIPAA provides you with several new or expanded rights with regard to 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 a paper copy of this Agreement, the attached Notice form, and my privacy policies and procedures. I am happy to discuss any of these rights with you.

# BILLING AND PAYMENTS

**You will be expected to pay for sessions at the end of the month. If you are paying out of pocket, I will prepare an invoice that I will send to you and you will be expected to pay me directly with a check or with a Zelle payment. If you have an insurance carrier other than Premera or LifeWise you will be able to use my invoice to seek whatever reimbursement your insurance company may offer. If you have Premera or LifeWise I will bill them directly at the end of the month. They will process the claim, send me a check and tell me what your deductible or copay is for these services and I will pass that information on to you to pay me the required amount.**

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, a treatment code and dates of service. 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.

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

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**Patient’s Name** **Date**

**‘Good Faith Estimate’**

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Date:

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Patient Name:

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Date of Birth:

Description of Treatment Modality(ies) Used:\_\_\_Psychotherapy and counseling\_\_\_\_\_\_\_

Estimated Length of Services Provided: Length of treatment depends on the goals established and patient’s interest but treatment and its duration are always open to patient-therapist discussion and re-evaluation

Location of Patient and Clinician: \_\_On-line or Sammamish office after the pandemic\_

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Treatment Goals:

Estimated Charges for each Service Provided:\_$200/session or insurance coverage\_\_\_

Therapist:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **(Printed)** Daniel S. Benveniste, PhD

Patient Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Patient: (Printed)\_\_\_\_\_\_\_\_\_\_\_\_\_

Provider NPI number: \_\_1063851244\_\_\_\_\_\_\_\_\_ TIN: \_\_\_\_462731485\_\_\_\_\_\_\_\_