Donna Bartlett, LCSW, LCAS, CMHt

PROVIDER – PATIENT TREATMENT AGREEMENT

Welcome! This document contains important information about my practice and business policies. This document also contains brief information about the Health Insurance Portability and Accountability Act (HIPAA) a federal law designed to protect your privacy and your 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 we provide you with the additional notice of Privacy Practices that explains HIPAA and how it affects you. The law also requires that we obtain your signature acknowledging that you have received this information

Although these notices are long and complex in some places, it is very important that you read them carefully. If you have any questions, we can address them *before* your first session. When you sign this document, it will represent an agreement between you and me. You may revoke this Agreement in writing at any time. That revocation will be binding except for information already disclosed; obligations imposed on me by your health insurer in order to process or substantiate claims made under your policy, or if you have not satisfied any financial obligations you have incurred.

MENTAL HEALTH TREATMENT/HYPNOTHERAPY – Treatment methods will vary depending upon your needs and my therapeutic approaches. There are many different methods used to deal with the issues that you hope to address.

Your initial session(s) will involve an evaluation of your needs. By the end of the evaluation, I will be able to offer you some first impressions of what your work will include and a plan to follow if you decide to continue with my services. You should evaluate this information along with your own opinions of whether you feel comfortable working with me. Treatment and hypnotherapy involve a commitment of time, money, and energy, so you should be careful about the provider you select. If you have questions about procedures, you should discuss them with me whenever they arise. If your doubts persist, I will be happy to provide you with referrals so you can set up a meeting with another professional for a second opinion.

By signing this document you are agreeing to the following terms:

Psychotherapy – I understand that there can be benefits to our working together such as improved mood, communication, interpersonal relationships, insight, or methods of coping. While I expect benefits from this treatment, I fully understand that because of factors beyond our control or other factors, such benefits and particular outcomes cannot be guaranteed. I may experience emotional strains, feel worse during treatment, and make life changes that may be distressing.

Hypnotherapy - I understand that Hypnotherapy can help me to reduce stress and anxiety, to reduce fears and phobias, to change destructive ways of coping, to manage physical pain, to discover and explore past lives, and to increase insight. I further understand that hypnotherapy is non-diagnostic and does not include the practice of medicine, and will not be considered as a substitute for licensed medical or psychological services or procedures. I also understand that while hypnosis may be an effective technique for many purposes, the effectiveness may vary from individual to individual, and no specific results or progress can be promised or guaranteed. The use of hypnosis could elicit memories of past events which may or may not be literally true. Memories or images evoked under hypnosis are not necessarily accurate and may be metaphorical in nature. Without corroborating information, it is not possible to determine whether a specific memory is true or false, even if it seems true to me.

I understand that Donna Bartlett (my provider) is not providing an emergency service and if I experience a mental health emergency that I am to contact Holly Hill Respond at (919) 250-7000, or call 911, or go to my nearest hospital emergency room. I know that while I may leave a voice mail message for Donna at (919) 412-8046, that she is normally not available by telephone because of client appointments. I understand that she will check her voice mail messages and make every effort to return my call on the same day, with the exception of weekends and holidays. If I am difficult to reach, I will leave information about times when I will be available.

CONFIDENTIALITY - I understand that conversations with the therapist and my records are confidential except in the following situations:

1. I am in serious danger of harming myself or at serious risk for harming another person (when under 18, chronic or increased substance abuse or acting out behavior may constitute danger to self or others and parents may be informed).
2. I am abusing or neglecting a child, an elderly person, or a disabled person in my care or I am the recipient of that abuse or neglect.
3. A court order compelling my therapist to release records.
4. In certain supervisory or peer review situations and then my identity is concealed whenever possible.

I also understand that in the case that my insurance is filed on my behalf, that billing agency staff will have information about my treatment. As required by HIPAA, there is a formal business associate contract with this agency, in which they promise to maintain the confidentiality of this data except as specifically allowed in the contract or otherwise required by law.

Other situations where this provider is permitted or required to disclose information without either my consent or Authorization include:

1. If I am involved in a court proceeding and a request is made for information concerning the professional services that are provided to me, such information is protected by the provider-patient privilege law. Information cannot be provided without my written authorization, or a court order. If I am involved in or are contemplating litigation, I will consult with my attorney to determine whether a court would be likely to order my provider to disclose information.
2. If a government agency is requesting the information for health oversight activities, my provider may be required to provide it for them.
3. If I file a complaint or lawsuit against my provider, she may disclose relevant information regarding me in order to defend herself.
4. If I file a worker's compensation claim, and services are being compensated through workers compensation benefits, my provider must, upon appropriate request, provide a copy of my record to my employer or the North Carolina Industrial Commission.

I understand that if any of these situations arise, my provider will make every effort to fully discuss them with me before taking any action and will limit disclosure to only what is necessary. I take full responsibility for bringing for discussion with my provider any questions I may have about the limits of confidentiality in our relationship.

FEES AND PAYMENTS - I agree that I am financially responsible for all session fees. I understand this if my provider agrees to file my insurance, that co-pays, deductibles and related fees are due at the time service is rendered.
Fees for an Initial Evaluation are generally $175.00. Fees for a 45 minute session are $100.00. **Fees for a session longer than 45 minutes, or that include an extra person(s) are generally $150.00. Regression Hypnotherapy usually takes from 2 to 3 hours and the fee is $100.00 per hour**. Group session fees will be negotiated. I understand that I may pay with cash or personal check. **There will be a $20.00 service charge for returned checks**. All fees are subject to change with or without prior notice.

I understand that Donna Bartlett may not be on the panel of my insurance company and if I want to use my insurance I will be responsible for any fees due her, in addition to the co-pay, if my insurance company does not reimburse in full.

If my account has not been paid for more than 60 days and I have not made arrangements for payment, my provider has the option of using legal means to secure the payment. This may include collection agency or small claims court which will require disclosing otherwise confidential information. In most collection situations, the only information released regarding a patient's treatment is his/her name, the nature of services provided, and the amount due. (If such legal action is necessary, its costs will be included in the claim.)

I agree that I will attend all agreed upon sessions and if unable to keep an appointment I will notify my therapist at least 24 hours in advance. **Failure to give 24 hours notice will result in a "no show" administrative fee of $100.00.** Continual issues with not showing up at the time of appointment can result in termination of our relationship. I understand that my insurance company will not reimburse for missed sessions, nor will they pay for the following services: Phone calls/phone sessions, letters/reports/disability paperwork. **Services that are requested but not covered by insurance will be billed directly to me at a rate of $100.00 per hour.** These include but are not limited to: phone based work that lasts over 10 minutes, letters/reports (non-routine), or disability paperwork or consultation. Travel time to and from meetings will be billed at this same rate.

I understand that court related services are not covered by insurance companies and that should Donna Bartlett be required to appear in court or court related meetings (depositions, planning, preparation, etc.) that the daily fee for court related services is **$3000.00 per day, and will be paid in advance.** I further understand that this **fee is non negotiable** and that services are not offered on a per hour basis other than **report writing, which is offered at $300.00 per hour**. I further agree to give ample notice of any need for court related services. Donna Bartlett reserves the right to refuse court related activities.

INSURANCE REIMBURSEMENT - I understand that use of my insurance benefit is my choice. I am aware that my contract with my health insurance company requires that Donna Bartlett provide them with a clinical diagnosis and information about the services provided to me. Sometimes she must provide additional clinical information such as treatment plans or summaries, or copies of my entire Clinical Record. In such situations, every effort will be made to release only the minimum information about me 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, Donna Bartlett has 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 be provided with a copy of any report submitted if I request it in writing. By my signature below, I agree to the provision of requested information to my carrier. If I need to file my own insurance, I may use either my statement or encounter form.

I understand that I always have the right to pay for services myself to avoid any of the issues described above.

If I choose not to use my insurance benefits for my treatment, I agree that I will not retroactively submit bills for my treatment to my insurance company for reimbursement, and that I expose myself to possible pre-existing conditions limitations for future treatment of similar symptoms.

I agree that I will find out exactly what mental health services are available to me through my insurance before seeking an appointment. If I have questions about my coverage I will call my plan administrator. If my failure to comply with my insurance company's requirements regarding choice of providers, authorizations, or other issues results in the denial of claims, I will be responsible for paying in full. If my coverage changes, it is my responsibility to notify Donna Bartlett and to comply with my new policy.

Once I have provided all of the information about my insurance coverage, my provider will discuss what I can expect to accomplish with the benefits that are available and what will happen if they run out before I feel ready to end my sessions.

I understand that hypnotherapy as a stand-alone service is not covered by my health insurance, nor is regression hypnotherapy covered.

ENDING THERAPY - I understand that I am free to discontinue treatment at any time; however, I realize that when I have reached my goals it is important for me to discuss this in session and plan for termination with my therapist. If I do plan to discontinue treatment I will advise my therapist.

MY SIGNATURES ON THE FOLLOWING SIGNATURE PAGE INDICATE THAT I HAVE 1) BEEN GIVEN THIS AGREEMENT AND 2) READ AND AGREE TO ITS TERMS.

DONNA BARTLETT, LCSW, LCAS, CMHt

PROVIDER-PATIENT TREATMENT AGREEMENT AND PRIVACY POLICY

Signature Page

THIS MUST BE SIGNED PRIOR TO YOUR FIRST SESSION

I have received a copy of the Donna Bartlett, LCSW, LCAS, CMHt Provider-Patient Treatment Agreement and a copy of the Donna Bartlett, LCSW, LCAS, CMHt Privacy Notice.
Name of Patient or Representative _____
Relationship _____ Date _____

THIS MUST BE SIGNED DURING YOUR FIRST SESSION

I have read, understand, and accept the following by initialing each item:

_____ I do not know of any reason why I should not undertake this therapy.

_____ that Donna Bartlett may disclose Protected Health Information as necessary to my insurance company if my insurance is to be filed. If this is not initialed, I understand that I must pay in full for services.
_____ that Donna Bartlett may use Protected Health Information within the practice for the purpose of Treatment/Consultation.
_____ that Donna Bartlett may share information as necessary with my primary care physician. If you do not wish information to be shared with your physician initial the "no" block below.
_____ NO, do not share information with my physician.

Please check the following if your therapist or staff:
_____ May NOT contact you or leave messages at your home telephone number.

I have read, understand, and I agree to participate fully and voluntarily and in agreement with all of the provisions of the Donna Bartlett, LCSW, LCAS, CMHt PROVIDER PATIENT TREATMENT AGREEMENT and Donna Bartlett, LCSW, LCAS, CMHt PRIVACY NOTICE

Name (Patient or Representative):_____

Relationship:_____ Date:_____