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PROFESSIONAL DISCLOSURE STATEMENT
ACKNOWLEDGMENT OF INFORMED CONSENT TO TREATMENT
THERAPIST-PATIENT SERVICES AGREEMENT
NOTICE OF PRIVACY PRACTICES

WELCOME!

Welcome to my practice. This suite consists of a group of independent, private clinicians who function autonomously within their own private practices. The following information and agreement is with me, Jennifer E. Phillips, Ph.D. and independent of the other clinicians at this office. I am glad you are here and am committed to providing you with quality care. This document contains important information about my professional services and business policies. Please read it carefully and jot down any questions you may have so we can discuss them. Please keep this form for your records.

PROFESSIONAL DISCLOSURE

I have been a licensed psychologist with the State of Ohio since 2012. I graduated with my Ph.D. in Clinical Health Psychology from the University of Pittsburgh in 2011. I have worked in both hospital and outpatient settings, primarily with adult clients.

THE THERAPEUTIC RELATIONSHIP

The therapy relationship between client and psychologist is one of mutual responsibility. Therapy is a process in which both work together to define/explore the client's goals and work toward achieving such goals. **However, the ultimate responsibility is with you, the client, to decide what the therapy goals will be.** The therapeutic relationship is a professional one, in which it is imperative that that I not have any other personal or business relationship with you. While professionalism will be maintained at all times, the client/psychologist relationship is also warm and personable and involves mutual confidence, respect and trust.

THERAPY SERVICES

The therapy process involves several stages, including Assessment, Goal Setting, Working, Maintenance, and Conclusion/Termination. An assessment is conducted to help define the problem. The client and psychologist then work together to define realistic, measurable, and mutually agreed upon psychotherapy goals. Next, the psychologist and client work together to achieve the goals established in the preceding stage. During the maintenance phase, the client incorporates changes into their life, and the client and psychologist work on identifying and managing identified barriers or obstacles to maintaining these changes. The frequency of sessions may be reduced during maintenance. The conclusion/termination stages are when the defined goals have been satisfactorily achieved and/or the client is able to function independently in the goal areas. Each of these stages may need to be revisited from time to time as the process unfolds. After some time in the working stage, the client may decide to revise a goal and work on a new issue.

RISKS AND BENEFITS OF THERAPY

While therapy may often be beneficial, there are some risks of which one should be aware. Therapy opens up levels of awareness which could cause some pain and anxiety. Personal changes often mean changes in relationships. Clients should be aware that those to whom they closely relate sometimes do not respond positively to therapy related changes, and it may be necessary to deal with relational adjustments, should they unfold. Therapy requires much effort, struggle and sometimes pain but marks a season of growth, progress and healing in a person, couple or family's lifestyle.

CONFIDENTIALITY ISSUES

Your communications in therapy are completely confidential, as required by professional standards and HIPAA. However, there are some exceptions to make note of: communications to a qualified law/medical personnel if a client threatens serious, mental/emotional/physical harm to self; if a client reports abusing an elderly, handicapped or disabled person or child/teen; if a psychological issue related to a child's therapy arises in a custody battle; if a client uses therapy to evade arrest for a crime; if a client discloses therapy information related to the client's condition as a party of a claim or defense regarding such; in a court-ordered examination; to a governmental agency or official legislative inquiry as required by law; to insurance personnel as necessary to obtain more sessions or process of any insurance/EAP/HMO/PPO claims for psychotherapy services rendered; in a civil or criminal action as allowed by law or ordered by a judge; when proceedings are brought by a client against a therapist; when a client waives confidentiality of therapy records in writing, when a professional collection agency is used in collecting fees for services rendered; and/or to a client's representative if the client is deceased.

Select information may also be shared with administrative staff affiliated with me in order to verify benefit information, quality assurance and/or to obtain payment for services rendered. All staff are bound by the confidentiality rules. All practitioners are independent providers and share only office space expenses, so this would only affect administrative/billing staff. The staff has been given training regarding privacy issues and will not disclose any information outside the psychology practice without permission of the psychologist/client. A contract has been made with my billing services in which they commit to maintain confidentiality of client information, except as specifically allowed by the contract. If you wish, I can provide you with the names of these organizations.

In order to process claims, insurance companies must have such information as diagnosis, dates of service, fees charged and in some cases I am required to provide additional clinical information such as treatment plans or summaries, or sometimes (rarely) copies of client's case file. In such situations I will make every effort to release only minimum information necessary for the purpose requested. This information will become a part of the insurance company files and will probably be stored in a computer. Though all insurance companies claim to keep such information very confidential, I have no control over what they do once it is in their hands. Some insurances may share information with a national computer data bank. I will inform you of any confidential therapy information sent, upon request. By signing this agreement, you agree that I can provide requested information to your insurance carrier.

CLIENT RIGHTS

The client has the right to: Request an explanation of the rationale of my treatment or intervention and/or to refuse any treatment; to know the psychologist's views and values regarding relevant life issues and/or general treatment paradigm; to end therapy or seek referral at any time during therapy; to know the psychologist's credentials and experience level; to request significant others to be present in the therapy session; to rescind authorization to release confidential therapy information; to know the length of sessions and/or general treatment protocol for a particular problem; to be informed of fees involved for therapy or testing.

HIPAA federal privacy rights include: confidential communication; to request restriction on use and disclosure of confidential treatment information (however I am not required to necessarily agree to such), as well as right to request alternative means and/or location for receipt of confidential communication; to review or obtain a copy of mental health records via letter request; to amend or correct mental health information via letter request, using HIPAA procedure; to be informed of how and to whom treatment information is being disclosed; to obtain a copy of this notice of general privacy policy; and/or to ask questions and/or express feedback/concerns regarding psychology privacy; information practices to Dr. Jennifer Phillips. Therapy services will not be compromised when a client expresses concerns regarding privacy practices. Privacy policies may be amended or modified as federal law mandates and I will provide you with any notice of such at the time of your appointment. A current copy of privacy practices will be made available in the office.

OFFICE PROCEDURES

I normally conduct an intake evaluation that will take between 1 and 2 sessions and will last approximately 55 minutes; the assessment fee is $150.00. During this time, we will both decide whether I am the right "fit" for you and your treatment needs. If we elect to work together, we will schedule sessions once every week or every other week, although sessions may occur less frequently depending upon the treatment plan.

Therapy sessions typically last 45-50 minutes and the fee is $125.00 per session; a 60 minute session fee is $135.00. If you are unable to keep an appointment, please **GIVE 24 HOUR COURTESY NOTICE. APPOINTMENTS CANCELLED LATER THAN THIS WILL BE CHARGED A $50.00 NO-SHOW FEE.**

Longer sessions, phone consultation beyond 10 minutes (i.e. tele-therapy, crisis calls, consultation with family), letter writing, consultation or travel will be billed according to the $135.00 hourly rate.

If you are requesting copies of records for yourself or to be sent to other professionals, you will be billed a copying fee of 50 cents per page plus postage.

X_____ (Client initials)

PATIENT PAYMENTS

Co-pays or coinsurance is to be paid for at the time of service. I accept cash, personal checks, and credit card payments via the online Affinipay link on my website (www.drjenniferphillips.com). Payment of fees is due at time of therapy services. If your account has not been paid for more than 60 days and arrangements have not been agreed upon, I have the option of using legal means to secure the payment. This may involve collection services. If you are having financial problems, please do not delay in discussing this with me, so that we can avoid any of the above-mentioned problems.

X_____ (Client initials)

INSURANCE BENEFITS & VERIFICATION

It is very important that you find out exactly what mental health services your insurance policy covers. Please be advised that verification of benefits is not a guarantee of claim payment and a final coverage determination cannot be made until your insurance company receives a claim of examination. This disclaimer is provided to advise you that if your insurance company deems your claim not medically necessary or does not pay the entire amount of the claim, you will be solely responsible for payment of any remaining balance on the claim identified as "patient responsibility" or "patient portion". Estimated charges could differ based upon the actual visit or tests administered by Dr. Phillips. In the event that the estimated charges differ from the actual charges, a statement for those charges will be billed to you.

It is important to remember that you have the right to pay for my services yourself to avoid using insurance, unless prohibited by contract.

If I am not a provider for your insurance plan, you will need to pay for my services in full at the beginning of each session.

X_____ (Client initials)

MISSED APPOINTMENTS & LATE CANCELLATIONS

You are responsible for any necessary appointment cancellations within 24 hours of the appointment; failure to do so will **result in a $50.00 late cancellation/no-show fee.** This fee is not billable or paid by insurance. It is the responsibility of the patient and must be paid for at or before your next appointment.

X_____(Client initials)

CONTACTING ME: 513-793-6226 ext. 2

At the current time, in addition to private practice, I teach courses at a local University and conduct research/consultation for a local medical center. Due to my work schedule, I am often not immediately available via telephone. When I am unavailable, my telephone is answered by my confidential voicemail system. I am the only person with access to this voicemail. Unless I am out of the office for vacation or illness, I monitor this throughout the day and will make every effort to return your call that day.

LEGAL SERVICES

Please be advised that should any portion of yours or your family's therapy or Dr. Phillips's services entails or results in a legal matter, such as consultations, preparation of reports, travel time to court or court testimony, etc., legal services are billed at an hourly rate of $150.00 which the patient or guarantor on the account is solely responsible. Reports and/or letters will not be released to the person(s) it is intended for, or addressed to, prior to the charges for such services being paid in full. If the charges are being split between two parents for instance (assuming this is directly related to a child of divorced parents), then both parties must have paid their portion in full prior to Dr. Phillips releasing the report/letter. Phone consultations must be paid for in advance and are billed at a standard session rate.

X_____ (Client initials)

Be advised if couple or marital therapy is conducted and divorce eventuates, Dr. Phillips will not be subpoenaed to testify in any custody or court matters whatsoever, at any time.

X_____ (Client initials)

TESTING & NON-LEGAL REPORTS OR LETTERS

If Dr. Phillips feels it necessary to administer tests for you or a child for diagnostic purposes, often the testing is covered by insurance, but not always, in which case the guarantor on the account will be responsible financially. Again, the results will not be discussed or released until the charges for such tests are paid in full. If insurance does not cover testing, these charges will be billed at a rate of $125.00 at 45 minute intervals (same amount of time for each therapy session). The number of testing sessions will be determined by the tests which are to be administered, usually 2-4 sessions total. Dr. Phillips will discuss this with you prior to any tests being administered and the charges associated with the services.

X_____ (Client initials)

EMERGENCY PROCEDURE

If you have an emergency, please call 911 and/or Hamilton County Crisis Intervention (Psychiatric Emergency Services: (513) 584-8577) and/or go to the nearest hospital emergency room.

IN THE EVENT OF INCAPACITY OR DEATH

In the event that I, Jennifer E. Phillips, Ph.D. become incapacitated or die, it will become necessary for another therapist to take possession of your file and records. By signing this informed consent to treatment form you are giving your consent to allow another licensed mental health professional selected by me to take possession of your records and provide you with copies upon request.

AUTHORIZATION FOR TREATMENT AND RELEASE OF RECORDS

Your signature indicates you have read this document, understand it, and consent to the provisions therein. Your consent allows Dr. Phillips to provide psychotherapy treatment and to confer with and or supply a treatment plan (including diagnosis and dates of services) and/or other requested information to your insurance company/HMO/PPO/EAP as necessary to obtain treatment session certification, verification, and/or remittance. Your signature also indicates you have received a copy of this HIPAA notice form.

If your minor child/children is/are in therapy with Dr. Phillips, your signature indicates you have conservatorship of your child/children and have the legal right to determine their treatment and release of their records. You also accept financial responsibility for their psychotherapy services.

_____ _____

Client/Guarantor Signature Signature Date

_____ _____

Clinician Signature Signature Date

_____

☐ I consent to having Dr. Phillips contact my Primary Care Physician for coordination of care.

PCP name: _____

PCP address: _____

PCP phone/fax: _____

☐ I DO NOT consent to having Dr. Phillips contact my Primary Care Physician for coordination of care.

☐ I do not have a Primary Care Physician at this time.

_____ _____
Client/Guarantor Signature Signature Date

_____ _____
Clinician Signature Signature Date

You must go to your prescribing doctor for medication checks consistently as the doctor recommends, take medicines consistently, and/or communicate any medication concerns to your prescribing physician.

X_____ (Client initials)