MURPHY • URBAN
& ASSOCIATES
PSYCHOLOGICAL SERVICES

PSYCHOTHERAPIST - PATIENT SERVICES AGREEMENT

Welcome to Murphy Urban & Associates Psychological Services. Our practice has served the Wabash Valley community since 1979 and provides a full range of outpatient psychological services including psychological assessments and evaluations; individual, family, couples, and group therapy; and consultation to courts, businesses, schools, and social service agencies. Our staff includes six credentialed clinical psychologists including: Michael J. Urban, Psy.D., Laura L. Fredendall, Psy.D., Kathryn A. Springer, Psy.D., Jeffrey M. Huttinger, Psy.D., Thomas E. Rea, Psy.D., Joseph Biggs, Ph.D., Troy Hardwick, LMHC, LCAC, and Dawn Castner-Rector, Ph.D. Office staff is available between the hours of 9:00 a.m. and 5:00 p.m. Monday through Friday. Appointment hours vary with the clinician. However, evening hours are typically Monday and Wednesday.

SCHEDULING APPOINTMENTS AND FEES

Psychotherapy sessions last 45 minutes and are scheduled at regular intervals. The frequency of therapy sessions is decided on an individual basis and will be discussed with you by your therapist. Every effort is made to schedule appointments at your convenience; however, please understand that clients who come on a regular basis make requests for late afternoon or evening appointments. Therefore, these times are at a premium and may not be immediately available to you.

Currently, the fee for these sessions is $115.00. Because of the added administrative costs that accompany the first session (Diagnostic Interview), the fee for the first session is $150.00. **Our policy is that full payment for each session (if you have not met your deductible) OR your copay for each session is expected at the time of service unless other financial arrangements have been made.** Payment schedules for other professional services will be agreed to as they are requested.

In addition to regular appointments, there are also charges for other professional services you might need: Testing, preparation of reports, consulting with other professionals at your request, etc. If you become involved in legal proceedings that require the participation of your therapist, you will be expected to pay for all of the therapist's professional time, including preparation and transportation costs. Be advised that insurance companies do not reimburse for such service.

CANCELLATIONS

Your therapy appointment is time set aside for your treatment only. Therefore, your cooperation is strongly requested in promptly keeping scheduled appointments. If a cancellation becomes necessary, a minimum of 24 hours advance notice is requested so that another patient might utilize that time. We understand that unexpected circumstances do arise, and every effort will be made to reschedule your appointment as quickly as possible.

CONTACTING YOUR THERAPIST

In case of an emergency, please inform our office personnel of the urgency of your situation so your therapist can be contacted as quickly as possible. Should an emergency arise after hours, contact our office (812) 235-6121 and our 24-hour live answering service will put you in touch with your therapist or the therapist on call. In extreme situations where medical care is necessary, go to a hospital emergency room and inform the staff that you are a patient in our practice so that we may respond appropriately.

HEALTH INSURANCE

Many health insurance policies cover outpatient mental health care. As a service to our clientele **provided free of charge,** our office will assist you in filing your health insurance directly if you so desire. However, **<u>you</u>** – not the insurance company—**<u>are responsible for full payment of our fees.</u>**

It will be necessary for you to sign appropriate forms that authorize us to provide this service and to ensure that you fully understand the responsibilities of the patient, our office, and the insurance company. Public insurance programs such as Medicaid and Medicare, as well as some managed care programs, have specific regulations and procedures. Please discuss all insurance questions with our office manager.

CONFIDENTIALITY

Indiana law protects the privacy of matters discussed within the therapeutic relationship between client and psychologist. Additionally, the Health Insurance Portability and Accountability Act (HIPAA), a federal law enacted in 2003, provides new privacy protections and new patient rights with regard to the use and disclosure of your Protected Health Information (PHI). This information is used for the purpose of treatment, payment, and health care operations. Please be assured that our personnel hold the highest possible ethical and legal standards regarding privacy and confidentiality. We make every effort to safeguard information concerning your care. If you desire information obtained, released, or exchanged with any other health-care professional or individual, your written permission will be necessary and appropriate release of information forms will be completed. Please note, however, that it is necessary for us to release certain basic information regarding your care when you ask us to submit billing to your insurance company. At a minimum, your name, dates of service, and medical diagnosis are required in order for the company to process your claim. These arrangements can be discussed with you by our office personnel as well as by your therapist. We encourage you to ask any questions you may have so that you fully understand this process. It is our goal to provide you with the highest quality of mental health care services possible. We welcome and appreciate your questions, concerns, or complaints regarding any aspect of your relationship with our office, as it is our desire to provide you with a positive experience and successful outcome in your treatment.

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GENERAL PATIENT INFORMATION

Patient Name ____________________________ Birthdate _____________ Age ________

Address ________________________________ Home Phone # ________________________

City/State/Zip ____________________________ Work Phone # ________________________

Social Security # _________________________ Cell # _______________________________

Gender: Male Female Email:_______________________________

Marital Status: Single Married Separated Divorced Widowed

Level of Education: Less than High School High School College Graduate School

Place of Employment ________________________________ Position ________________

ACCOUNT INFORMATION

Referred by _______________________ Person responsible for account ____________________
Do you plan to use health insurance benefits for your visit? (Please Mark) Yes No

FAMILY INFORMATION

List members of your family and all others residing in your home:

Name	Birthdate	Relationship	Occupation or Grade

MEDICAL INFORMATION

Patient's primary physician ___________________________ Date last examined _____________

Physician's address ________________________________ Phone # _____________________

List any major health problems for which you currently receive treatment __________________

____

Current medications and dosages ____

Allergies ____

Have you ever received psychiatric or psychological services or counseling of any kind before? _____________
If yes, please note where and when ____________________________________

CURRENT SITUATION

Please check any of the following problems that pertain to you at the current time.

___Alcohol Use
___Ambition
___Anger
___Appetite
___Being a parent
___Bowel trouble
___Career choice
___Children
___Concentration
___Depression
___Divorce
___Drug Use
___Education
___Energy
___Fears
___Finances
___Friends
___Headaches
___Health Problems
___Inferiority feelings
___Insomnia
___Legal matters
___Loneliness
___Making decisions
___Marriage
___Memory
___My thoughts
___Nervousness
___Nightmares
___Relaxation
___Self-Control
___Separation
___Sexual problems
___Shyness
___Sleep
___Stomach trouble
___Stress
___Suicidal thoughts
___Temper
___Tiredness
___Unhappiness
___Work

Please state your reasons for seeking our services.

____

____

____

____

Signature ____________________________________ **Date** ___________________

Typed Name Will Serve as Valid Signature

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ADULT CONSENT FOR PSYCHOLOGICAL TREATMENT

I, ___________________________, give my consent for psychological treatment including but not limited to, clinical interview, psychological testing, and therapy as deemed necessary by the staff of Murphy Urban & Associates Psychological Services. I understand that I am consenting and agreeing only to those mental health services that the provider is qualified to provide within:

a) the scope of the provider's license, certification, and training; or
b) the scope of the license, certification, and training of those mental health providers directly supervising the services received by me.

Furthermore, I understand that I am an active participant in my treatment and will be expected to have input regarding my treatment goals. I also understand that I can decline particular forms of treatment at any time that I am not comfortable.

I am aware that the information obtained during the course of my treatment is confidential and may not be released without my authorization. I further understand there may be limits to this confidentiality and the psychologist will explain these limits to me.

Finally, I understand that I am financially responsible for the services rendered to me and will make payment for such services at the time they are provided unless specific arrangements are made with the office manager.

Signature___________________________________ **Date** ___________________

Typed Name Will Serve as Valid Signature

Witness ____________________________________ Date ___________________

Typed Name Will Serve as Valid Signature

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CHILD CONSENT FOR PSYCHOLOGICAL TREATMENT

I hereby give my consent for psychological treatment but not limited to, clinical interview, psychological testing, and therapy as deemed necessary by the staff of Murphy Urban & Associates Psychological Services for my minor child, ___________________.

I understand that I am encouraged to seek information from my child's therapist regarding procedures, techniques, and the general progress of treatment for my child, and my inquiries will be responded to promptly.

I further understand that information regarding my child's treatment will not be released without my written consent. Finally, I understand that I am consenting to and agreeing only to those mental health services the provider is qualified to provide within:

a) the scope of the provider's license, certification, and training; or
b) the scope of the license, certification, and training of those mental health providers directly supervising the services received by my minor child.

Finally, I understand that I am financially responsible for the services rendered to my minor child and will make payment for such services at the time they are provided unless specific arrangements are made with the office manager.

Signature____________________________________ **Date** ___________________
Typed Name Will Serve as Valid Signature

Witness _____________________________________ Date ___________________

Typed Name Will Serve as Valid Signature

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INFORMED CONSENT FOR TELEPSYCHOLOGY

This Informed Consent for Telepsychology contains important information regarding psychotherapy using the phone or the Internet. Please read this carefully and let us know if you have any questions. When you sign this document, it will represent an agreement between Murphy, Urban & Associates and you.

Benefits and Risks of Telepsychology

Telepsychology refers to providing psychotherapy services remotely using telecommunications technologies, such as video conferencing or telephone. Telepsychology, however, requires technical competence on both our parts to be helpful. Although there are benefits of telepsychology, there are some differences between in-person psychotherapy and telepsychology, as well as some risks. For example:

- Risks to confidentiality. Because telepsychology sessions take place outside of the therapist's private office, there is potential for other people to overhear sessions if you are not in a private place during the session. On our end we will take reasonable steps to ensure your privacy. But it is important for you to make sure you find a private place for our session where you will not be interrupted and there is a reduced chance that other people will hear our conversation.
- Issues related to technology. There are many ways that technology issues might impact telepsychology. For example, technology may stop working during a session, other people might be able to get access to our private conversation, or stored data could be accessed by unauthorized people or companies.
- Efficacy. Most research shows that telepsychology is about as effective as in-person psychotherapy. However, some therapists believe that something is lost by not being in the same room. For example, there is debate about a therapist's ability to fully understand non-verbal information when working remotely.

Electronic Communications

We will decide together which kind of telepsychology service to use. You are solely responsible for any cost to you to obtain any necessary equipment, accessories, or software to take part in telepsychology.

Fees

The same fee rates will apply for telepsychology as apply for in-person psychotherapy. However, insurance or other managed care providers may not cover sessions that are conducted via telecommunication. If your insurance, HMO, third-party payor, or other managed care provider does not cover electronic psychotherapy sessions, you will be solely responsible for the entire fee of the session. Please contact your insurance company prior to our engaging in telepsychology sessions in order to determine whether these sessions will be covered.

Records

The telepsychology sessions shall not be recorded in any way unless agreed to in writing by mutual consent. I will maintain a record of our session in the same way I maintain records of in-person sessions in accordance with my policies.

Informed Consent

This agreement is intended as a supplement to our general informed consent and does not amend any of the terms of that agreement. Your signature below indicates agreement with its terms and conditions.

Email:____ Cell Phone:______________________________

__________________________ Typed Name Will Serve as Valid Signature __________________________

Client Date

__________________________ __________________________

Witness Date

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NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability & Accountability 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
- Obtain payment from third-party payers
- Conduct normal healthcare treatment and assessments

I understand that Murphy Urban & Associates 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 Private Practices.

I understand that I may request in writing that Murphy Urban & Associates restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand that Murphy Urban & Associates is not required to agree to my requested restrictions, but if Murphy Urban & Associates does agree, then the organization is bound to abide by such restrictions.

ASSIGNMENT OF BENEFITS

I hereby assign all medical benefits regarding services received in this office to include major medical benefits to which I am entitled, including Medicare, private insurance, and any other health plan to MU Associates, LLC.

This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance. In the event this account is assigned to collection, I agree to pay all costs of collection, including reasonable attorney fees. Please complete insurance information below:

Name of policy holder: ______________________________ Member ID: ____________________________
Insurance Carrier:__________________________________ Group #: ______________________________
Patient's relationship to the policy holder: Self Spouse Child Other
Effective Date: ___________________________

I have reviewed the:

- Psychotherapist-Patient Services Agreement
- Notice of Psychologist's Policies and Practices to Protect the Privacy of Your Health Information
- Assignment of Benefits

Patient Name: ____

Signature of Responsible Party: ____

Date: ____

Witness: ____

Typed Name Will Serve as Valid Signature

Office Use Only:
I attempted to obtain the patient's signature in acknowledgement, but was unable to do so as documented below:
Date:______________ Initials:_____________ Reason:_________________