

Tony Delmedico, Ph.D.
Licensed Marriage and Family Therapist

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Policies and Services Agreement

I am required by federal law to provide you with this information in written form, and to obtain your signature indicating your understanding and acceptance of the contents.

PSYCHOLOGICAL SERVICES

Psychotherapy varies depending on the therapist and the patient, and each situation's particular challenges. In working with various aspects of life, you may experience a range of feelings and emotions. Therapy has also been shown to have many benefits, including improved relationships, solutions to specific problems, and a significant reduction in feelings of distress. However, there are no guarantees of what will be experienced.

Our first few sessions will involve an evaluation of your needs and concerns. By the end of those sessions, I will be able to offer some first impressions of what our work will include, and how to proceed. You should evaluate this information, and decide on whether you feel comfortable working with me.

SESSIONS & FEES

Payment is due at the time of service. Checks, cash, debit and all major credit cards are accepted.

- 60-minute Individual Therapy sessions - \$140.
- 90-minute Couples Therapy sessions - \$200.

I will manage time boundaries, and appreciate your sensitivity in this matter.

Other services, such as consultation with other professionals, report writing, or services outside the therapy session will be billed at \$35 per 15-minute increment. Legal proceedings, including preparation time and transportation, are billed at \$250 per hour, even if I am called to testify by another party.

CONTACTING ME

Often, I am not immediately available by telephone, but you may leave a message on my confidential voicemail. Every effort will be made to return your call on the same day, with the exception of evenings, weekends and holidays. Email and/or texting can be used, but they are not completely secure and confidentiality cannot be guaranteed. I do not maintain continuous accessibility for emergencies. If you have an emergency and cannot wait for a return call, please contact your family physician or the nearest emergency room and ask for the psychiatrist on call. If I am unavailable for an extended period of 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 therapist. In most situations, I can only release information to others about your treatment if you provide written authorization on a form that meets HIPAA requirements. There are other situations that require only your advanced, written consent. Your signature on this agreement provides the consent for those situations, which are as follows:

- I occasionally find it helpful to consult with a supervisor, or other health and mental health professionals about our work. During a consultation, I make every effort to avoid revealing your

identity. The other health professionals are also 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.

- Disclosures required by health insurers or to collect overdue fees as discussed elsewhere in this agreement.
- If I believe that you present an imminent danger to your own health or safety, I may be obligated to seek hospitalization on your behalf, or to contact family members or others who can help provide protection.

In some situations, I am permitted or required to disclose information without your consent or written authorization:

- If you are involved in a court proceeding and a request is made for information concerning the professional services that I provided to you, such information is protected by psychologist-patient privilege law. I cannot provide any information without your written authorization or court order. If you are, or may become involved in, or are contemplating litigation, you should consult with your attorney to determine whether a court would be likely to order me to disclose information.
- If a government agency is requesting the information for health oversight activities, I may be required to provide it for them.
- If a client files a complaint or lawsuit against me, I may disclose relevant information regarding that patient in order to defend myself.

In some situations, I am legally obligated to take actions that may reveal some information your treatment:

- If I have cause to suspect that a child under 18 is abused or neglected, or if I have cause to suspect that a disabled or elderly adult is being abused or neglected, the law requires that I file a report with the County Director of Social Services, and may be required to provide additional information.
- If I believe that a client presents imminent danger to the health and safety of another, I am required to disclose information in order to take protective actions, including initiating hospitalization, warning the potential victim if identifiable, and/or calling the police.

If such a situation arises, an effort will be made to discuss it with you before taking any action. I will limit my disclosure to only what is necessary and required. The laws governing confidentiality can be complex, and it may be beneficial to obtain legal advice.

MINORS AND PARENTS

The law allows parents of clients under 18 years of age who are not emancipated to examine their child's treatment records. Because privacy in psychotherapy is often crucial to successful progress, particularly with teenagers, I usually request that parents agree to give up access to the teenager's records. If you agree, I will provide you only with general information about the progress of your child's treatment, and their attendance at scheduled sessions. I will also provide parents with a summary of their child's treatment when it is complete. Any other communication will require the child's authorization. However, if I feel that the child is in danger or is a danger to someone else, I will notify the parents of my concern. If possible, I will discuss the matter with the child first, and do my best to handle any objections they may have.

DELINQUENT ACCOUNTS

If you have an outstanding balance that has not been paid for more than 60 days, I retain the right to use legal means to collect the balance due. I will protect confidentiality by making every effort to disclose only the relevant information needed to secure payment.

INSURANCE AND REIMBURSEMENT

I am an “out of network” provider for all health care plans except for Blue Cross Blue Shield of North Carolina (BCBS). Many plans limit mental health coverage and reimbursement, and often dictate the length and types of treatment. This limits my ability to practice in an effective and ethical manner. You should review your plan details and/or call your plan administrator to see whether my services will be covered for reimbursement purposes. Also, plans frequently change. It is your responsibility to keep abreast of exactly what is covered and reimbursed by your insurance company.

With the exception of BCBS, I do not file insurance. Upon request, I can provide a detailed receipt which may aid in your reimbursement. If clarity is needed, I can call the company on your behalf, complete forms, and assist in helping you receive the benefits to which you are entitled.

If you seek reimbursement through your insurance company, they will require a clinical diagnosis, as well as other information relevant to the services that I provide to you. Also, I may be required to provide additional information such as treatment plans, summaries, or copies of your entire Clinical Record. I will make every effort to release only the minimum information about you that is necessary for the purpose requested. This information becomes part of the insurance company’s files, and is then beyond my control. By signing this Agreement, you agree that I can provide requested information to your carrier.

I am an “in network” provider for Blue Cross Blue Shield of North Carolina. I will collect your co-pay at the time of service, and bill BCBS directly for the balance due. There are a variety of plans, and plan details frequently change. It is your responsibility to keep abreast of exactly what BCBS covers, and to alert me to any changes in coverage.

Finally, you can opt to pay for services out-of-pocket, and not file with an insurance company at all. This will avoid the confidentiality issues described above, and provide an added measure of privacy with your employer and the insurance companies. It may also lessen the concern about future coverage and/or rate changes, as well as future life insurance coverage and rates.

Your signature below indicates that you have read and understood the information in this document and agree to its terms.

CANCELLATION POLICY

Please provide 24-hour advance notice of cancellation. Otherwise, there is a late cancellation fee of \$85. _____ (Please initial here.) Missed appointments are usually not reimbursable by third party payers.

Client Signature

Date

Client Signature

Date