Hope Panara, MA, LPA
Licensed Psychological Associate

901 Paverstone Dr. Suite 12
Raleigh, NC 27615

Phone: 919-623-3989
Hpanara@mac.com

Policies and Services Agreement

Welcome to my practice. 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. I will be happy to discuss any questions you may have.

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.

- First diagnostic interview is 90 minutes and is $145.
- 55-minute sessions are $110, but when needed a sliding scale is availabe.
- Group therapy 60-90 minutes is $35
- Telephone consultations greater than 15 minutes are $35 per quarter hour.

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

Other services, such as consultation with other professionals, report writing, school visits, or services outside the therapy session will be billed at $30 per 15-minute increment. Legal proceedings, including preparation time and transportation, are billed at $225 per hour, even if I am called to testify by another party.

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

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 and within normal business hours. Email can be used, but they are not completely secure and confidentiality cannot be guaranteed. If you chose to communicate by email, please be aware that all emails are retained in the logs of internet service providers.
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 consult with a supervisor and 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 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 heath 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. Privacy in psychotherapy is often crucial to successful progress, particularly with adolescents. As such, I 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. By signing this agreement, you are waiving your right to access your child's treatment records except for treatment summaries provided upon request. Further, treatment with adolescents is to facilitate adjustment and I specifically ask that you do not request that I testify in court or by affidavit. If I am required to testify, I have not provided a forensic custody evaluation and I do not give opinions about either parents' custody rights or visitation.

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.

PAYMENT POLICY

My practice is not on any insurance panels and I am considered an "out of network" provider. Subsequently, you are expected to pay for each visit at the time of service. My services are covered under Mental Health insurance provisions. Since plans are so varied, please check your policy to make sure you understand benefits and limitations.

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.

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.

READ CAREFULLY AND COMPLETE
Your signature below indicates that you have read, understand and accept the information in this Policies and Services Agreement and agree to its terms.

* I understand that I am financially responsible for services rendered and that my account is due in full at each session.

* I understand that it is my responsibility to secure authorization from my insurance company, PPO or Managed Care Provider before any visits occur. I also understand that a therapist must release minimally necessary PHI to insurance companies should they request it.

* I understand and accept the confidentiality policy.

* I agree that the clinician's role is limited to providing treatment and that I will not involve her in any legal dispute, especially one involving custody or visitation agreements.

_____ _____
Client Signature Date

_____ _____
Client Signature Date