York Psychology, P.L.L.C.
Janine S. York, Psy.D.
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Informed Consent
For Financial Responsibility & Practice Policy For Psychological Services
Guarantee of Payment

WELCOME!

INTRODUCTION

The following is intended to inform you of the conditions governing the psychological services you are requesting. We wish to thank you in advance for your patience regarding all this paperwork necessary in order to be in compliance with federal laws, state laws and regulations, and professional ethical standards. Also, we consider it important to clarify all financial matters beforehand to avoid misunderstanding.

PARTCIPATING INSURANCE PLANS

This practice participates in most insurance plans. The largest plans in which we participate are: CDPHP, VALUE OPTIONS, BCBS, FIDELIS, TRICARE, MEDICARE, and MEDICAID. For these plans this practice will bill your insurance carrier and you are responsible for your co-pay or deductible. However, please keep in mind the fact that no matter what payment information your carrier provides, this information is ADVISORY and not a guarantee of coverage or payment. You will only know your coverage for sure after your insurance claim is processed. Please be aware that not all services are covered by your insurance policy (e.g. school visits, phone calls, legal or court related services and sometimes educational testing or marital counseling). Most insurance plans place limits on the amount and type of services for which they will pay. If your insurance will not pay for the services provided, you will be told of this and asked to sign a form accepting financial responsibility.

FINANCIAL RESPONSIBILITY

For all those patients not covered by insurance plans accepted by York Psychology, P.L.L.C. you are expected to pay for each office visit at the time the service is rendered. By signing this form you indicate you understand and agree to pay the following charges for any direct or indirect professional service rendered on your behalf.

First Diagnostic Interview (90/min.)	$195
Subsequent Interview/Therapy Session (60/min.)	$170
Subsequent Interview/ Therapy Session (45/min.)	$160
Therapy Session (30/min.)	$150
Psychological Evaluation, per hour (includes scoring, analyzing, written reports)	$185
Any consultation or other service performed on behalf of the client, per hour	$185
Record review or preparation of any documents or forms, 15 minute increments	$ 45

Telephone Consultations longer than 5 minutes will be billed per quarter hour	$ 45

Our charges reflect the cost of maintaining a pleasant office environment, support staff, testing equipment, and continuing professional education which enables us to provide the most up-to-date, competent care possible. If you are unable to pay these fees please ask about our sliding fee scale.

STANDARD POLICIES

CANCELLATIONS & CHECK RETURNS

I understand and agree that appointments cancelled or broken without a 24-hour advance notice do not allow York Psychology, P.L.L.C. to offer my reserved time to another client. This in turn, exacts a financial toll on York Psychology, P.L.L.C.. As such, you will be charged a fee of **$35** for any appointments cancelled or broken without providing a 24-hour advance notice unless mutually agreed that the absence was unavoidable. Please note: if you have **3** late cancellations or no-shows in a period of **3 months** I have the right to non-voluntarily discharge you. You will be notified of the non-voluntary discharge by letter. You may appeal this decision with Dr. York or request to reapply for services at a later date.

For returned checks you will be charged the current bank fee. Returned checks must be picked up within three (3) business days and the full amount due must be paid in cash.

BILLING AND COLLECTIONS

I understand and agree that professional services are rendered and charged to me and not to an insurance company. I agree that it is my responsibility to understand my insurance plan and to keep York Psychology, P.L.L.C. informed of any changes. As a courtesy we will submit your claims to your insurance carrier and follow up on any disputed claims. If York Psychology, P.L.L.C. is a participating provider with my insurance plan, I understand and agree that co-payment and/or deductible amounts are due at the time of service and will pay them.

SEPARATION/DIVORCE POLICY

For separated or divorced families, the person who initiates the service or who comes or brings a child for the service is financially responsible. We will not bill another person or the other parent unless that individual informs us in advance and in writing of his/her willingness to pay for the services. Should another party be willing to assume financial responsibility for our services they may download the FINANCIAL RESPONSIBILITY form and return it by email, fax, or mail. Whenever possible our goal is to promote a better relationship between children and their parents. Privacy is especially important in securing and maintaining the trust necessary to successful treatment. We will not necessarily share with you what your child has disclosed unless safety is an issue. We will, though try to discuss general concerns, the progress being made and what needs to be done. Unless the divorce settlement agreement prohibits it or we believe the child's safety requires it, the other parent is entitled to participate in whatever way is considered beneficial and also is entitled to the same information (with the limitations

just discussed). In addition, both parents must agree to treatment by signing the consent to treatment or submitting a letter signed by the other parent unless a custody agreement is provided stating the non-custodial parent has no rights. If both parents do not agree that treatment is necessary, it can be very disruptive to your child's treatment.

ACKNOWLEDGEMENT OF RESPONSIBILITY

In consideration of the services rendered, I promise to pay York Psychology, P.L.L.C. all the charges minus authorized discounts and to make full payment at the time of service. In lieu of this, I will guarantee full payment with a credit card. In the event that the undersigned client is a subscriber to an insurance plan in which York Psychology, P.L.L.C. is a participating provider and is entitled to benefits, I hereby assign any insurance benefits to Janine S. York, Psy.D./York Psychology, P.L.L.C. I understand and agree that York Psychology, P.L.L.C. is not responsible for actions taken by my insurance company. If York Psychology, P.L.L.C. is an in-network provider for my insurance plan I understand and agree that I will be responsible for payment for any charges or services that are not covered by my insurance company within a 60 day period. If any problems occur with the insurance reimbursement York Psychology, P.L.L.C. will try to help resolve any issues, but ultimately I am responsible for my account.

If York Psychology, P.L.L.C. is an out of network provider with my insurance plan I understand and agree that I am the responsible party for settling my account directly with York Psychology, P.L.L.C. I understand York Psychology, P.L.L.C. accepts cash, checks and credit cards. I authorize York Psychology, P.L.L.C.to charge any visits for which I do not pay directly by cash or check to my credit card.

I understand and agree that York Psychology, P.L.L.C. may refer accounts past due to a collection agency, or to an attorney chosen by York Psychology, P.L.L.C., with information released as necessary for collection purposes. I specifically authorize York Psychology, P.L.L.C. to release information to the collection agency, and/or attorney as necessary for billing purposes. I understand that if I do not settle my account within thirty (30) days, and if my account is assigned to an attorney or collection agency, this may adversely affect my credit. I hold York Psychology, P.L.L.C. harmless for any adverse consequences that may occur as a result of the assignment of my account to a collection agency or attorney.

CONFIDENTIALLITY AND CONSENT INFORMATION

RELEASE OF INFORMATION

I understand and agree that York Psychology, P.L.L.C. may communicate by phone and in writing with my insurer if York Psychology, P.L.L.C. is a participating provider for the purpose of conducting utilization reviews. I understand and agree that utilization reviews may require the written or telephonic release of confidential information such as progress notes, treatment reports and psychological reports.

When asked, I direct York Psychology, P.L.L.C. to exchange information regarding my case, including release of a psychological report, to agencies, doctors, therapists or to anyone whom I authorize in writing.

By authorizing a release of information, I understand that I am waiving the confidential nature of the client-psychologist relationship. I also authorize the release of information as necessary for the purpose of York Psychology, P.L.L.C. obtaining consultation regarding my evaluation and/or treatment. If York Psychology, P.L.L.C. is an in network provider for my insurance plan I authorize the release of any and all information requested by my insurance carrier for the purpose of processing my insurance claim and obtaining payment for services. If York Psychology, P.L.L.C. is an out of network provider for my insurance plan I authorize the release of any and all information requested by my insurance carrier for the purpose of processing my insurance claim and obtaining payment for services directly to me. In authorizing the release of information to any insurance company or other third party, I understand that the information may become part of the third party's records and that York Psychology, P.L.L.C. can no longer control any subsequent release of that information. It is important to note here that **THE ONLY WAY YOU CAN ABSOLUTELY ASSURE THE CONFIDENTIALITY OF YOUR TREATMENT IS TO PAY FOR THE SERVICES YOURSELF.** As long as a third party is involved, your confidentiality will be compromised to some degree.

Should you desire written records of your treatment, you must sign an authorization and a summary of treatment will be provided.

CONSENT FOR PSYCHOLOGICAL SERVICES

I hereby voluntarily apply for and give my consent to psychological services provided by York Psychology, P.L.L.C. This consent applies to myself, my child, and/or family. Because I have the right to refuse services at any time, I understand and agree that my continued participation implies voluntary informed consent.

LIMITATIONS OF SERVICES

I understand that York Psychology, P.L.L.C. provides outpatient psychological, consultation and educational services only. This practice is not geared to the provision of emergency services. While the practice maintains a confidential voice mail service, and Dr. York has after-hours emergency phone service, this is not a guarantee of the availability of emergency coverage. Should you require emergency after hours care, call 911 or call St. Mary's crisis hot line (518) 842-9111.

ASSUMPTION OF RISKS

I understand that the potential benefits of undergoing psychological or other consultative professional services may include improvement in psychological functioning of myself or child and/or an increased understanding of myself and/or my child or help in resolving conflicts. I understand that the potential risks may include possible disagreement with the opinions offered

to me, and possible emotional distress concerning my situation. I understand that alternative procedures include services by another psychologist, psychiatrist, or mental health professional.

I understand that while the evaluation and/or treatment will be based upon known psychological principles and research, the practice of psychology is not an exact science. I acknowledge that no guarantees have been made to me concerning the results of evaluation or treatment provided by York Psychology, P.L.L.C.

LIMITS OF CONFIDENTIALITY

I understand and agree that my disclosures and communications are considered privileged and confidential, except to the extent that I authorize a release of information. I understand that New York state law requires a psychologist to disclose the following without consent or authorization: (1) Known or reasonably suspect abuse or harmful neglect of children, the elderly, or disabled or incompetent individuals; (2) Immediate threats of physical violence against a readily identifiable victim; (3) An immediate threat of self-inflicted damage. (4) Also, where a patient or client, by alleging mental or emotional damages in litigation, puts his or her state at issue or files a malpractice claim, records may be released without consent or authorization. Where a patient is examined pursuant to a court order, confidentiality may not apply. Under such circumstances, I acknowledge that I hold York Psychology, P.L.L.C. harmless for releasing information under any of the above conditions.

STATEMENT OF UNDERSTANDING

I certify that I have read this form or that it has been read and explained to me in terms that I understand. My questions have been answered to my satisfaction and all statements of which I do not approve have been stricken by mutual agreement. I accept the policies described. I understand that I may revoke this consent at any time except to the extent that action has been taken in reliance upon it. I understand that my consent for release of information will be considered valid for twelve (12) months after my discharge. I acknowledge that I voluntarily consent to the preceding conditions. By signing this form, I understand and agree with the terms and conditions of this form.

_____ _____

Name of Client Date of Birth

_____ _____

Signature of Adult Client or Parent/Guardian of Client Date

GUARANTEE OF PAYMENT

This practice cannot provide loan or credit services. Therefore, we require payment at the time

of service and/or a credit card guarantee of payment. I authorize York Psychology, P.L.L.C. to charge any visit for which I do not pay directly by cash or check to my credit card listed below. I understand and agree that if York Psychology, P.L.L.C. is a participating provider in my insurance plan they may charge my credit card or debit card in the event (1) my insurance carrier fails to pay within 30 days of filing (as required by law), and (2) I have been notified by letter or phone, and, (3) I have been allowed to pay my bill within 10 days, and (4) I have failed to pay within those 10 days. This guarantee of payment is valid for twelve consecutive months after my last visit unless I cancel this authorization through written notice to York Psychology, P.L.L.C.

_____ _____

Cardholder's Name (Please Print) Date

_____ _____ _____

Credit Card Number Security # Card Expiration Date

__VISA ___ M/C ___AMX ___ DISCOVER

_____

Cardholder's Signature

_____

Cardholder's Full Address (No P.O. Boxes)

_____ Please initial here if you wish for our office to charge this card at the time of your visit.

Thank you

HIPAA NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW PSYCHOLOGICAL/HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This notice is effective April 14, 2003 and remains valid until changed and you are notified of the changes and agree to them. This notice describes how this practice may use and disclose the psychological information that is gathered as a result of our evaluation and treatment of you and/or your child. We recognize this information is personal and we will comply with State and Federal regulations regarding this protected health information.

USES AND DISCLOSURES FOR TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS:

- York Psychology, P.L.L.C. may use or disclose psychological information that is collected and referred to as *Protected Health Information* (PHI), for treatment, payment and health care operation purposes. To help clarify these terms, here are some definitions:

    - **PHI** refers to psychological information that we create and obtain during the course of providing our services to you. Such information may include documenting your symptoms, your personal history, test results, diagnosis, and/or treatments, used to apply for future care and treatment.

    - "Payment" means obtaining reimbursement for your mental health care. This includes all billing matters, such as the need to disclose your PHI to your health insurer to obtain payment for your mental health care or to determine eligibility or coverage.

    - "Health care operations" are activities that relate to the performance and operation of York Psychology, P.L.L.C. This includes such things as accessing quality of care management and care coordination.

    - "Uses" applies to activities within York Psychology, P.L.L.C. such as maintenance of records. Disclosure applies to activities outside this clinical practice such as releasing, transferring or providing access to information about you to other parties. For example, sometimes it is necessary to consult with another specialist and share information with that specialist in order to obtain that specialist's consultative input.

<u>YOUR HEALTH INFORMATION RIGHTS:</u>

All mental health records, as well as billing records are securely maintained on the physical property of this office. This information will only be disclosed with an appropriate

authorization. An authorization is a written permission provided by the client, parent or guardian that gives permission to share PHI about you or your child with a specified person or agency. You have the right to:

- Request a restriction on uses or disclosures of your protected health information by delivering such a request in writing to our office. However, we are not required to agree with your request for a restriction.

- Obtain a paper copy of this notice of Privacy Practice for Protected Health Information by making a request at our office. You have the right to inspect or obtain a copy (or both) of your mental health PHI and billing records for as long as a PHI record is maintained. You may exercise this right by delivering your request in writing to our office. If you want a copy of your record we will charge you $1.00 per page up to 25 pages; thereafter you will be charged $0.25 per page.

- Request that your mental health care record be amended to correct incomplete or incorrect information. You may do this by delivering a written request to our office using the form we provide to you upon request. York Psychology, P.L.L.C. may deny your request. You have a right to file a statement of disagreement if your amendment is denied, and require that the request for amendment and any denial be attached to all future disclosures of your PHI.

- Receive an accounting of all disclosures of your PHI. This will include disclosures made at your request.

- Request and receive confidential communications of your PHI by any alternative means and at any alternative locations.

- Revoke any authorizations that you may have made previously regarding use or disclosure of PHI, except to the extent that the information has already been released based upon prior authorization, or that action has already been taken. You may rescind an authorization by delivering a written revocation to our office.

If you want to exercise any of the above rights, please contact York Psychology, P.L.L.C. at (518) 673-8060.

NON-RESRICTED PHI USES AND DISCLOSURES:

There exist a number of contingencies wherein this practice may disclose certain limited PHI without prior consent. Examples of these are as follows:

BUSINESS PRACTICES

- This practice has Business Associates with whom we may share limited PHI. For example, information about payments may be shared with our accountant. Also, we may need to hire computer technicians and software vendors. In performing their duties, they may have access to your name and perhaps limited PHI data.

FAMILY

- When there is a need to communicate with family members, using our best judgment, this practice may disclose to a family member, other relatives, close personal friends, or any other person you identify, PHI relevant to that person's involvement in your in your care, or for payment for such care, provided you do not object, or in case of emergency.

DISASTER RELIEF

- We may use and disclose your protected health information to assist in disaster relief efforts.

NOTIFICATION OF APPOINTMENTS

- We may contact you to provide you with appointment reminders.

WORKER'S COMPENSATION

- If you are seeking or receiving compensation through Worker's Compensation, we may disclose your PHI to the extent necessary to comply with the laws relating to Worker's Compensation.

ABUSE AND NEGLECT

- As required by law, we may disclose your PHI to public health authorities to report abuse or neglect.

JUDICIAL/AMINISTRATIVE PROCEEDINGS

- If treatment or evaluation is being provided for legal purposes pursuant to a court order, you give up your right to confidentiality and all PHI will be subject to disclosure without your consent. This includes certain narrowly-defined disclosures to law enforcement agencies, to a health oversight agency (such as HHS or a state department of health), to a coroner or medical examiner, for public health purposes relating to disease or FDA-regulated products, or for specialized government functions such as fitness for military duties, eligibility for VA benefits, national security and intelligence.

OTHER USE AND DISCLOSURES

- Other uses and disclosures, in addition to those identified in this Notice, will be made only as authorized by law **or with written authorization**. You may revoke that

authorization at any time. Some examples are: PHI in a way that is not described in this Notice, including psychotherapy notes.

COMPLAINTS

If you have any questions, concerns or want to report a problem regarding the handling of your PHI, you may contact Janine S. York, Psy.D. in person or writing.

In addition, if you believe your privacy rights have been violated, you may file a written complaint at your office by delivering the written complaint to the following person: Janine S. York, Psy.D. (518) 673-8060.

You may also submit a complaint to the U.S. Dept. of Health and Human Services and/or The National Alliance on Mental Illness at (518) 462-2000.

PSYCHOLOGIST'S DUTIES

The Psychologists of York Psychology, P.L.L.C. are required to:

- Maintain the privacy of your mental health information as required by law.
- Provide you with a notice of the practice's legal duties and privacy practices with respect to PHI.
- Abide by the terms of the Notice.
- Notify you if we cannot accommodate a requested restriction or request.
- Janine S. York, Psy.D. or York Psychology, P.L.L.C. reserves the right to change the privacy policies and practices described in this notice. Unless notified, however, this practice is required to abide by the terms currently in effect.

By signing below, I acknowledge that I have read this Notice of Privacy and I am aware I may request and be given a copy.

Signature: _____ Date: _____

ADDENDUM TO

CLIENT INFORMED CONSENT

August 2016

Notice to all of our clients:

- Appointments made in advance will ensure that you remain an active client.
- If you feel you do not need continuing services please contact our office and speak to your doctor about being discharged.
- If you have not been seen within a three (3) month time and no contact with us has been made you will be automatically discharged from our facility.

Steps we take if you do not schedule an appointment within a month of your last appointment or you late cancel or no-show for a scheduled appointment without talking to your doctor (all steps taken are documented in client chart):

- Either administrative staff or your doctor attempts to call you and leaves a voicemail regarding missed appointment as well as need to reschedule
- After a week to two weeks if we have not heard from you someone will call again
- If we do not hear from you after a month or more, you will receive a letter regarding the need to contact the office to discuss missed appointment and reschedule. It will include a date two weeks from the date of letter when you will be discharged from York Psychology if we do not hear from you to reschedule.
- We will provide a referral to a mental health crisis line or another provider – whichever your doctor deems appropriate.
- We do all this as a courtesy for our clients. However, it is ultimately your responsibility to maintain contact with your doctor in order to remain an active client.

- Please note that achieving treatment goals does not occur if you do not attend scheduled sessions and we cannot keep you as an active client in those cases.

If in the future, you decide you need services please know we cannot guarantee an immediate appointment as it will depend on the doctor's availability at that time.

Print Name: I, _____, have read and reviewed this policy and any questions have been answered by administrative staff or my doctor.

Signature: _____ Date:_____