BELL CENTER FOR ANXIETY AND DEPRESSION

Client Services and Consent Agreement

I, the undersigned, wish to receive psychotherapy services from the Bell Center for Anxiety and Depression (the "Practice") and Elspeth Bell, Ph.D. ("Dr. Bell") and/or the clinicians employed by the Practice, each referred to as a "Provider" or together referred to as a "the Providers". I understand that these psychotherapy services are offered subject to the following terms and conditions:

1. **Effective Date:** This Client Services and Consent Agreement (the "Agreement") shall be in effect beginning on the date of the last signature below.

2. **Nature of Services:** I understand that psychotherapy is a set of psychological interventions designed to help people resolve emotional, behavioral, and interpersonal problems and improve the quality of their lives. The Providers may use many different interventions to deal with the problems that I hope to address. Cognitive-behavioral psychotherapy calls for a very active effort on my part and in order for the therapy to be most successful, it will be important for me to work on the things talked about, both during my sessions and at home.

   Since therapy often involves discussing unpleasant aspects of my life, I may experience transient uncomfortable feelings like sadness, guilt, anger, frustration, loneliness, or helplessness. Psychotherapy has also been shown to have many benefits, such as better relationships, solutions to specific problems, and significant reductions in feelings of distress.

   During the first two (2) to four (4) sessions, the Provider will typically perform an initial evaluation of treatment needs. At the end of this evaluation, the Provider will offer his/her first impressions of what therapy will include, in addition to a treatment plan to follow if I decide to continue with therapy. I should evaluate this information along with my own opinions of whether I feel comfortable working with the Provider. Because therapy involves a large commitment of time, money, and energy, the Provider will strive to provide a good fit in matching me and my needs. If I have questions about the Provider's procedures, these will be discussed as they arise. If I request a second opinion, the Provider will provide a referral to another mental health professional.

3. **Services to be Provided:** I understand that the Provider will provide (a) certain psychotherapy services as requested by me or as deemed necessary by the Provider in accordance with the established standard of care for psychotherapy, and (b) certain professional services in connection with or as a supplement to these psychotherapy services. The fees for individual psychotherapy sessions are listed in Attachment A and the fees for professional services will be provided upon request.

   The hourly cost for professional services will be broken down for periods of less than one hour. Other professional services for which I may be billed include: report writing, conversing with me by telephone if the conversation lasts longer than a few minutes, consulting with other professionals with my permission, preparation of treatment summaries or similar records, and any other professional service I may request.

4. **Non-Participation in Medicare and Insurance Plans:** I understand that the Provider does NOT participate or contract with any insurance plans, including, but not limited to: Health Maintenance Organizations (HMOs), Point of Service Plans (POSs), Preferred Provider Organizations (PPOs), Preferred Provider Networks (PPNs), and any plans covering federal employees (GEHA, Federal Blue Cross, etc.) and that the Provider has also opted out of the traditional Medicare program, Medicare Advantage, and all other Medicare-contracted health plans and Railroad Medicare (collectively referred to here as "Medicare").

   I therefore acknowledge that (a) the Practice will bill me, and not Medicare or my insurance plan, directly for the psychotherapy service fees listed in Attachment A and any professional service fees; and (b) I, instead of Medicare or my insurance plan, will be fully and personally responsible for paying fees for psychotherapy

services listed in Attachment A and professional services. I understand that I may, at any point, elect to obtain psychological services from a provider who has not opted out of the Medicare program or who participates with my insurance plan, rather than receive psychological services from the Practice.

5. **Medicare Part B Beneficiaries:** If I am a Medicare Part B beneficiary, or if I will become a Medicare Part B beneficiary at any time within two (2) years after the date of this Agreement, I also agree to the terms listed in the Practice's Medicare Private Contract, and will sign the Practice's Medicare Private Contract in addition to this Agreement to confirm my acceptance of those terms.

6. **Submission of Charges to Insurance Plans:** I understand that certain insurance plans may permit patients of the Practice to submit claims for services provided by the Provider. Before beginning treatment, it is my responsibility to check with my insurance company to ascertain which mental health services my insurance policy covers. Medicare and HMOs do NOT permit me to submit claims for services provided by the Provider, I agree not to submit a claim for any such services to Medicare or any HMO, and the Practice will not do so either.

   My insurer may require that treatment providers provide clinical information such as treatment plans or summaries, or copies of my entire clinical record. If so, the Provider will make every effort to release only the minimum information about me that is necessary for the purpose requested.

   The Practice will provide me with a comprehensive itemized and coded statement that I may submit in accordance with my insurance plan's rules. Some services may not be covered by insurance or may require pre-authorization, particularly non-standard sessions (longer than forty-five (45) minutes). I understand that I may not receive any reimbursement from my insurance and that I am responsible for the fees for all services rendered, regardless of my insurance coverage.

7. **TRICARE:** I understand that if I am insured through TRICARE (TRICARE Prime, TRICARE Prime Remote, TRICARE Standard, TRICARE Extra, TRICARE Reserve Select, TRICARE Retired Reserve, and US Family Health Plan), Dr. Bell is not a participating provider and does not privately contract with TRICARE beneficiaries.

8. **Payment for Services Rendered:** I understand that I will be expected to pay for each session at the time of service. I am required to provide credit card information prior to the first session and my credit card will be used to collect outstanding balances at each appointment unless other arrangements are made. If I do not provide credit card information, then I will be required to provide a deposit prior to the first session. If payment is made by check, there will be a twenty-five dollar ($25.00) additional charge for each returned check.

   I understand that if my account has not been paid for more than sixty (60) days and arrangements for payment have not been agreed upon, the Practice may hire a collection agency or go through small claims court, which will require the disclosure of otherwise confidential information (typically a patient's name, the nature of services provided, and the amount due). Costs of such legal action will be included in the claim. Additional measures may be necessary if the unpaid balance becomes excessive.

9. **Appointments and Cancellation Policy:** After the initial evaluation process of two (2) to four (4) sessions, psychotherapy sessions will usually be scheduled once a week for forty-five (45) to fifty (50) minutes in duration at an agreed upon time, although some sessions may be longer or more frequent in occurrence.

   I understand that if I need to cancel a session, it must be cancelled at least twenty-four (24) hours in advance. If I cancel a session with less than twenty-four (24) hours notice the Practice will charge me for the missed session. Additionally, the Practice will charge the full session fee if I arrive late for any sessions. It is important to note that most insurance carriers do not reimburse for missed sessions.

10. **Contacting Providers:**

By Telephone

I understand that the office staff is usually available to answer the main phone line between 8:30 a.m. and 5 p.m., but the Provider's work schedule may preclude him/her from answering immediately and I may leave a voicemail message. I should indicate in my voicemail times when I will be available for a return phone call and I should not disclose any sensitive or confidential health information in my voicemail. The Provider will make every effort to promptly return my call, but response times are likely to be longer on weekends and holidays. If I am unable to reach the Provider and feel that I cannot wait for him/her to return my call, I should contact my primary care provider or the nearest emergency room and ask for the therapist on call.

By E-mail

I understand that I may communicate with the Provider or the Practice via e-mail, but the Practice cannot guarantee the privacy, security, or confidentiality of e-mail communications. Because email communications will not be encrypted and will travel over the Internet, there is a risk that emails sent to or from the Practice or the Providers may be intercepted and read by unauthorized third parties. E-mail communications should be limited to non-urgent and non-sensitive issues, such as scheduling and basic logistics. I should contact the Providers by phone to discuss any health issues and I understand that e-mail is not an appropriate means of communication if I am in crisis. By signing this Agreement, I am stating that I understand the privacy risk in communicating via e-mail.

11. **Minors:** I understand that if I am under eighteen (18) years of age and not emancipated from my parents or guardian, that the law may allow my parents or guardian to examine my treatment records. Because of the importance of privacy in psychotherapy, the Practice may ask my parents or guardian to respect my privacy and allow for us to keep elements of our interactions in confidence so long as there is not any related danger to me. I understand that the Practice may share general information about the progress of my treatment and my attendance at scheduled sessions. If possible, the Providers will speak with me in advance of providing any information to my parents or guardian.

12. **Termination of this Agreement:** I understand that I may choose to terminate this Agreement at any time by sending the Practice written notice (a) stating that I wish to cease using the Providers for psychological services and (b) requesting that a copy of my medical record be sent to either another provider or directly to me. The Practice may also terminate this Agreement and the Providers' psychologist-patient relationship with me at any time upon thirty (30) days written notice; in such case, the Practice will assist me in finding another provider to take over my care at the end of the thirty (30) day notice period.

13. **Coverage:** The Providers will provide psychological services to me under this Agreement, but I understand and agree that in the event the Providers are temporarily unavailable, I will not be seen by the Providers and will instead be referred to a substitute provider. I understand that the services of the substitute provider are not covered under the terms of this Agreement and that the substitute provider will bill me directly for any services rendered in the Providers' absence.

14. **Ethical Duties of Providers:** The Providers will provide all psychological services in accordance with the ethical obligations imposed upon them by the Maryland Board of Examiners of Psychologists' Code of Ethics and Professional Conduct, including but not limited to: acting in the interests of client welfare; protecting the confidentiality of patient records as detailed in the Practice's Notice of Privacy Practices; and explaining the legal and ethical limits of the Provider's confidentiality obligations under law to inform authorities of abuse and neglect of children and vulnerable adults. In the event of the death, incapacity, or discontinuation of practice of the Provider, your clinical records will be handled in accordance with Maryland laws and regulations regarding the retention and disposal of medical records and Protected Health Information.

By signing this document, it is an agreement between me and the Practice. I may revoke this agreement in writing at any time. I understand that the revocation cannot be retroactive, nor can it prevent the Practice from meeting obligations imposed by my health insurer in order to process or substantiate claims made under my policy or from taking steps to collect if I have not satisfied any financial obligations incurred in the course of services.

Patient Name: _____

Patient Signature: _____

Date: _____

Provider Name: _____

Provider Signature: _____

Date: _____

PLEASE RETAIN THIS DOCUMENT FOR YOUR PERSONAL RECORDS

<u>Attachment A</u> - Professional Fees

The fee schedule for psychotherapy sessions is as follows:

CPT Code*	Session Length	Fee – Dr. Bell	Fee – Associates
90832	30 minutes	$130	$105
90834	45 minutes (standard session)	$190	$150
90837	60 minutes	$230	$185
90837	75 minutes	$285	$225
90837	105 minutes	$380	$300
90846/ 90847	Family Therapy (with or without patient present)	See individual therapy fees	See individual therapy fees
90853	Group Psychotherapy (any length)	Varies by group	Varies by group
90791	Diagnostic Evaluation	See individual therapy fees	See individual therapy fees

* - Current Procedural Terminology Codes are used by the medical community and insurance companies to categorize services provided. Not all CPT codes are listed in this table. Please ask for the CPT code and associated fee with any other services that you may receive.

Longer sessions will be charged proportionately based on the forty-five (45) minute (1 Session) fee.

Recommended questions to ask the insurance company:

- Do I have out-of-network coverage?
- Do you require a referral for services?
- Do you reimburse for services related to my diagnosis?
- What is the reimbursement rate for a standard session?
- What is the reimbursement rate for family therapy (or other service)?
- Do you reimburse for sessions longer than forty-five (45) minutes?
- Do you reimburse for two (2) or more sessions in a day?
- What services would require pre-authorization?
- Is there a limit to the number of sessions I can have in a calendar year?