

**Patient Agreement with Policies and Procedures  
And Informed Consent for Care  
Jan F. Sherbak, PsyD**

**Welcome**

Thank you for selecting my practice to serve your very special needs. I work along with several other independent mental health professionals in the “Solace” building. This name only represents shared expenses and administrative functions among the independently practicing professionals and does not suggest that we are in a group or practice with one another. While the members share a name and office space, I want you to know that I am completely independent in providing you with clinical services, and I am fully responsible for those services. My professional records are separately maintained, and no other professional can have access to them without your written permission.

I am committed to establishing with you the maximum level of trust and highest quality of care. The information in this letter is designed to share a little information about me with you and to share my policies and methods of practice so that I may best anticipate your needs. If you have any questions or suggestions as to how I may enrich my services to you, please let me know. The following information is provided to assist you in understanding policies and procedures of my office. I strive to provide you care which is both comfortable and of the highest quality.

Attached to this Patient Agreement Form is the newly required **Notification of Patient Rights** document now required with the passage of the federal “medical records privacy law” known as **HIPAA** (Health Insurance Portability and Accountability Act). I am required by law to give you a copy of this document and secure your signature indicating you have received a copy of it. Laws such as these are important, but also complex and in my **Notification of Patient Rights** document I have tried to inform you about your rights in plain, simple language. Please read the contract and do not hesitate to ask any questions you might have about these matters.

**Office Hours**

My office hours are by appointment, Tuesday, Wednesday and Thursday from 8 am until 8 pm. My phone number is (423)752-5207. Please use extension #10 for appointments or insurance information. My fax number is (423)752-5299. Messages can be left after office hours on my confidential voice mail at extension #15. Should there be an urgent after hours need to contact me, please call (423) 802-6894 for the therapist on call; your call will be returned as soon as possible. All other calls will be returned during regular business hours. For life-threatening emergencies, please call 911 or go to your nearest hospital emergency room.

**Appointments**

Appointments may be made by the patient or by the referring physician as indicated. If you find it necessary to cancel your appointment, a 24-hour notice is required to avoid being charged the No Show Fee of \$50.00, for your scheduled appointment. You may cancel an appointment by speaking with my staff or by leaving a message on my voice mail.

**Financial**

Payment is expected at the time of service for all care provided. Since an atmosphere of mutual trust and understanding between the patient and the office is desirable, please feel free to discuss fees and methods of payment with me or my staff. Various methods of payment include personal check, cash, selected credit cards, and contracted third party payment.

It is my policy to collect all debts, including returned checks. There is a \$30.00 service charge for all returned checks. I reserve the right to use a collection agency to collect outstanding debts as well as the right to terminate my services or pursue collection legally. A **35%** collection fee will be added if turned over to a collection agency. You will be responsible for any additional legal or other fees for the collections of the balance. Confidentiality for services rendered cannot be guaranteed if your account is submitted to a collection agency, attorney, court, etc.

Court testimony is not covered by insurance and payment for any legal proceedings must be paid in advance. Cost for court testimony in Hamilton County and for depositions at my office is \$300.00 for the first hour and \$200.00 per hour thereafter. Additional travel fees will be added for travel to other destinations. All correspondence or conversations with attorneys are billed at \$200.00 per hour. All court ordered therapy is the financial responsibility of the person ordered to attend and/or the guardian of the minor child. In many court ordered cases, insurance might not be able to be utilized for therapy sessions.

**Insurance**

Insurance assignments will be accepted with deductibles and co-insurance payments due at time of visit. Information required by insurance carriers to reimburse patients for charges paid will be provided to patients treated on an outpatient basis. Although this office cannot assume responsibility for collection or negotiating settlements with your insurance company, I will be happy to supply you with any information appropriate to obtain maximum benefits from your insurance carrier. I do not file to secondary insurance companies – you will be responsible for this but I will be glad to assist you in any way possible.

I must emphasize that as a health care provider, my relationship is with you, and not your insurance company. If you have contracted health care, your payment policy may vary depending upon the contract agreement, and any questions or disputes you may have regarding your particular payment policy should be directed toward your insurance company. It is your responsibility to obtain a referral from your primary care physician, if required, and contact your insurance prior to your visit to receive information about pre-authorization. Insurance companies will not backdate authorizations therefore, if this step is omitted or forgotten, you are held liable.

If your insurance plan has changed, it is your responsibility to notify the office prior to your appointment. In instances where your plan requires pre-authorization or a referral from your primary care physician, it is your responsibility to notify the physician's office. If you do not give the proper notification prior to the visit, and insurance denies the claim, the bill is your obligation. (This includes TennCare

participants.) I can not resubmit claims for dates incurred before notification of an insurance change due to guidelines for timely filing. Some insurance carriers will disallow certain codes such as family therapy and may only cover individual therapy. Do not ask my office to change billing coding in order for a service to be covered by the insurance carrier. This is considered insurance fraud.

While the filing of insurance claims is a courtesy that I extend to my patients, all charges are your responsibility from the date services are rendered. I realize that temporary financial problems may affect timely payment of your account, and I encourage you to contact me promptly for assistance in the case of such events.

## **CONFIDENTIALITY INFORMATION**

### **Confidentiality**

The communications between me and my patients are confidential. By law, information about the patient may not be disclosed. However, there are four exceptions to this policy:

1. The patient may sign a release of information form allowing me permission to communicate with the party specified in the release. For example, a company might require that a troubled employee seek treatment in order to keep his/her job. In that case, the patient may want to sign a release allowing me to verify to the employer that the employee is in treatment.
2. If a patient has expressed the intent to harm himself or another person, I may breach confidentiality in order to protect the patient or others from harm.
3. By law, all cases of child abuse must be reported to the authorities. This supersedes laws governing confidentiality.
4. If a court of law subpoenas medical records, I must comply with this request.

### **Confidentiality and Control of Information Regarding Treatment of Minor Child**

The communications between a patient and a therapist are confidential, and this special relationship is protected by the law. In the case of a child (minors under 16), the information about the service provided by therapist is controlled by the patient or guardian. There are some specific limits to confidentiality, and those exceptions are listed below.

1. By law I am required to report cases of suspected child abuse to the Department of Human Services, the Department of Family and Children's Services or another authority such as Juvenile Court.
2. In the case of emergency or when there is imminent danger to the minor child or other person, the therapist may breach the requirements of confidentiality.
3. Until the courts have terminated parental authority, both parents have access to records and information regarding the minor child. This pertains to custodial guardians. In the case of other family members (step-parents, grandparents, aunts, uncles, etc.) there must be a release signed.

4. Release of confidential information to a third party (school, court, other professionals, etc.) is controlled by the parent/guardian.
5. When a child is referred by a school, agency, physician, or other professional, communication regarding treatment will be maintained with that agency or person unless the parent/guardian specifies to the contrary.
6. The control and release of confidential information is protected through the relationship of trust between the therapist and patient. As a trustee of the child, the therapist is required to release only information that he/she believes is in the best interest of the child. Thus, there may be information that the therapist does not release to the parents/guardian or to third parties.

In summary, the confidentiality and control of information regarding evaluation and treatment of minor children is complex. The laws and policies are designed to benefit all concerned – the child, the family, and society at large. It is important for everyone to understand the limits of confidentiality and how these policies may apply to your unique situation. At the discretion of the therapist a summary of treatment may be sent instead of the entire record. You are encouraged to talk to me about matters of confidentiality and other issues of treatment.

### **Confidentiality and Your Insurance Carrier**

If your insurance carrier is an HMO or is contracted with a managed care organization I may be required to do treatment plans in order to get your services approved. These treatment plans usually ask in depth questions about your treatment. If I do not complete the treatment plans most insurance companies will not cover the services. Once this information is release to the insurance carrier there is a possibility that the information may be released to other entities by them. Once this happens, confidentiality of your treatment is no longer contained within my office, and I can not be held responsible.

### **Your Informed Consent to Care**

I have provided this information to you in the hope of fully informing you about the policies of this office and some of the parameters of care you will receive here, such as the importance of confidentiality. Psychiatric and psychological care, like other things in life, offers no absolute guarantee of success and there are limitations to any form of care offered a patient. Since such limitations are always a function of the particular problems in question, I invite you to discuss your treatment plan with me.