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PSYCHOTHERAPIST-CLIENT SERVICES AGREEMENT

This document contains important information about my professional services and business policies. When you sign this information, it represents an agreement between us. You may revoke this Agreement in writing at any time. This document also contains summary information about the Health Insurance Portability and Accountability Act (HIPAA), a federal law that provides privacy protection and patient rights about the use and disclosure of Protected Health Information (PHI). HIPAA requires that I provide you with a Notice of Privacy Practices for using and disclosing PHI for the purposes of treatment, payment, and health care operations. The required Notice is attached to this agreement. The law requires that I obtain your signature acknowledging that I have provided you with this information.

PSYCHOTHERAPY SERVICES

Psychotherapy is not an exact science; it can have both benefits and risks. For it to be most helpful to you it will require a very active effort on your part. There are no guarantees of outcomes. In our first meetings we will evaluate your therapy needs and devise a treatment plan. It is expected that you will take an active part in this process, and you will be expected to make your own decisions about whether this is the course you wish to follow.

SCHEDULING

Psychotherapy meetings are fifty minutes in duration unless otherwise arranged. I arrange all appointment times personally. Scheduling ahead allows you the best opportunity for appointment times that are convenient to you. As part of your therapy, we will discuss what an appropriate schedule of meetings is for you.

If you find it necessary to cancel an appointment, please do this one full business day in advance. Appointments which are not kept without notice are billed at full fee. Insurance companies do not reimburse appointments that you do not attend. You may notify me of your need to cancel or change an appointment by calling my office (616-443-1425). If you need to reschedule, please leave your name, and phone number for a return call. If you think you may be difficult to reach, please leave some suggestions of times when I might call you.

PHONE CALLS

Due to my work schedule, I am normally not immediately available by telephone as I do not receive calls while I am with clients. My telephone is answered by a private automated voice system. If your call is urgent, please state that. On workdays I make every effort to return calls on the same day I receive them. On holidays and weekends, I try to return calls promptly on the next workday. If you are unable to reach me immediately and feel that you cannot wait for me to return your call, contact your family physician, or go to the nearest emergency room and ask for the psychologist or psychiatrist on call.

COMMUNICATION

Email, text, and voicemail are common methods of communication. For privacy there are effective safeguards that can be used for the safe sharing of PHI such as passwords, software protection, email encryption, and others. However, there are always risks that the information may reach unintended recipients. For example, someone other than an intended recipient might see a phone text, overhear a voicemail, or see an email. Also, certain software is unable to receive secure levels of encryption allowing the possibility that an encrypted email might be seen by an unintended recipient. It is part of my practice to at times use email, text, and voicemail to plan appointments, and at times to use email to forward forms, receipts, questionnaires, and treatment exercises. HIPPA requires that I share there are risks in these communication methods. Your signature on this Agreement provides consent for these communications. If you prefer to not use email, text or voicemail communication let me know and I will arrange to communicate by phone and mail only.

CONFIDENTIALITY

The law protects the privacy of all communications between client and therapist. In most situations information about your treatment may only be released to others if you sign a specific written Authorization Form. There are some situations for which you may provide general permission in advance. Your signature on this Agreement provides consent for those disclosures as follows:

1. I may seek a colleague consult to help me in my work with you. I will not disclose your identity or any identifying information during a colleague consult, and I will note this consult in your clinical record (which under HIPAA guidelines is called your Protected Health Information or PHI).
2. If you threaten to harm yourself, I may be obligated to seek help hospitalization or support from family members or others whom you have designated.
3. I may disclose information to health insurers if you request that I submit claims for you.
4. I may disclose information about you to collect overdue fees.

There are some situations in which I am legally obligated to take actions to protect others from harm. While these situations may require that I reveal information about a client's treatment, I am expected to limit my disclosure to the information necessary to reduce the threat. These required disclosures include:

1 If I have reason to suspect the abuse or neglect of a child, a disabled adult, or a person who is under guardianship, the law requires that I file a report with the Family Independence Agency.
2 If I have reason to suspect the "criminal abuse" of an adult client, I must report it to the police.
3 If a client communicates a threat of physical violence against an identified third person, and the client has the apparent intent and ability to carry out that threat, I am required to disclose that threat to take protective action. Disclosure in this case may include notifying the potential victim, or the victim's parents in the case of a minor, contacting law enforcement, or seeking hospitalization of the client.
4 The laws governing required reporting and confidentiality are complex, and in some situations, it may be necessary to seek legal advice to determine what action may be needed.

While it is your right to have this written summary of exceptions to confidentiality, it is my intention to discuss with you any concerns you may have about it now or in the future course of our work together. If any of these situations should arise, I will make every effort to discuss the matter with you as fully as possible before taking action.

RECORDS

Under the provisions of HIPAA your Protected Health Information (PHI) is kept in two separate sets of records. They are as follows:

1 Your Clinical Record includes information about your reasons for seeking treatment, your diagnosis, your treatment plan, treatment reviews and summaries, progress notes for each visit, your medical and social history, your history of previous mental health treatment, records received from other providers, reports of colleague consultations, your billing records, reports or letters that have been sent to anyone about you including reports to your insurance carrier, your Psychotherapist-Client Services Agreement, any authorizations which you have signed, and a form accounting for any disclosures made about you either with your authorization or as otherwise required by law.

Normally you may examine and receive a copy of your Clinical Record if you request it in writing. The exception to this would be disclosures which would endanger you or others, portions of the record that make references to another person such that disclosure is likely to cause substantial harm to that other person, information which has been provided to me confidentially by others.

Because your PHI is a professional record, it may contain information which is not clear to the untrained reader. For this reason, if you do request a review of your record, I would request that you initially review it in my presence or have it forwarded to another mental health professional who can review it with you. In the case of lengthy records, I am allowed to charge a copying fee of one dollar per page. The exceptions to this policy are contained in the attached Notice Form. If I refuse your request for access to your Clinical Records, you have the right of review, which I will discuss with you upon request.

2 Psychotherapy Notes may include the contents of our conversations, my analysis of those conversations, informal notes that I make to myself during our meetings, reminders to myself of matters that I wish to pursue with you at a later date, or personal information about you that is not clinical information, for example an announcement about you that appears in the newspaper. These notes may also contain sensitive information that you reveal to me that is not required to be in your Clinical Record. These Psychotherapy Notes are kept separate from your Clinical Record. Psychotherapy Notes are not available to you and normally are not sent to anyone else, including your insurance companies. In the unusual event that I am ordered by law to disclose Psychotherapy Notes your written, signed authorization would be required. Insurance companies may not require your authorization as a condition of coverage, nor may they penalize you in any way if you refuse to provide authorization.

CLIENT RIGHTS

HIPAA provides you with rights regarding your Clinical Record and disclosures of your PHI. You may request that I amend your record; you may request that I restrict the information from your Clinical Record that is disclosed to others; you may request an accounting of disclosures of PHI that you have not authorized by means of the signed Authorization Form, you may request that I add a written complaint by you about my policies and procedures to your record, and you may request a paper copy of this agreement, the attached Notice form, and a copy of my privacy policies and procedures.

MINORS

Clients under eighteen years of age and their parents should be aware that the law allows parents to examine their child's treatment records. They should also be aware that clients fourteen and over can consent to treatment and control access to information about their treatment, although that treatment cannot extend beyond twelve sessions or four months. While privacy is very important, parental involvement is also an important part of successful treatment. For this reason, I normally ask minors to agree that we will share general information about meetings attended and progress in treatment, and I ask parents to agree that their child may keep the specific content of meetings private. If I believe that the child is in danger or a danger to someone else, I will notify the parents of my

concern, and if it is possible and reasonable to do so, I will discuss this with the minor child prior to the disclosure.

BILLING AND PAYMENTS

You will be expected to pay for each session at the time of service unless we have agreed otherwise. My 50-minute session fee is $170. In addition to regular appointments, I charge this amount for other professional services that you may need. Other services may include report writing, testing and evaluation, consulting with other professionals with your authorization, preparation of records and treatment summaries, and time spent performing any other service you may request of me. Prior to providing these additional services I will discuss the cost for them with you.

All legal work is billed at $250 per hour. This includes consultation with attorneys and probation officers, letter writing for the court or for legal representation, the copying or preparation of client records as well as depositions or court testimony and travel.

If your account has not been paid for more than sixty days and no arrangement for payment has been agreed upon, I have the option of using legal means to secure payment. In this case only the minimum information necessary (client name, nature of services provided, dates of service, and amount due) will be disclosed.

INSURANCE

If you have a health insurance policy, it may provide coverage for mental health treatment. I will fill out forms and provide you with assistance in helping you receive benefits to which you are entitled; however, your health insurance policy is an agreement between you and your insurance company. Similarly, the contract for my services is with you and not with your insurance company.

You should also be aware that your contract with your health insurance company requires that I provide information relevant to the services I provide to you. This information routinely includes a diagnosis, the dates of service, and the type of service which I have provided to you. In rare circumstances they may request further information from your Clinical Record or a disclosure of the full record. I will make every effort to release only the minimum information about you that is necessary for submitting and following up a claim. You have a right to know what information I release to the insurance company, and by signing this Agreement you give me permission to provide information to your carrier.

YOUR SIGNATURE BELOW INDICATES THAT YOU HAVE RECEIVED THE HIPAA NOTICE ENTITLED: NOTICE OF PRIVACY PRACTICES TO PROTECT THE PRIVACY OF YOUR PATIENT'S HEALTH INFORMATION.

Signature Date

YOUR SIGNATURE BELOW INDICATES THAT YOU HAVE READ THE PSYCHOTHERAPIST-CLIENT SERVICES AGREEMENT FOR JEFF DWARSHUIS LMSW, ACSW AND CONSENT TO ITS TERMS.

Signature Date

YOUR SIGNATURE BELOW INDICATES THAT YOU GIVE YOUR PERMISSION TO HAVE INSURANCE CLAIMS SUBMITTED FOR SERVICES RENDERED TO YOU FOR THE PURPOSE OF SEEKING REIMBURSEMENT.

Signature Date