

## **Therapist Office Policy and Informed Consent Contract**

Psychotherapy is a very personal and life changing experience. Your own motivation for growth in therapy will largely determine how much you will benefit from it. In order to best enhance your chances of successful change and growth it is important that you understand your rights and obligations regarding the serious commitment of psychotherapy.

Psychotherapy can be a very healing experience yet it must proceed according to a set structure for the benefit of all parties - for you and your therapist.

Because policies differ from setting to setting and from psychotherapist to psychotherapist I've outlined my policies to give you an idea of how I handle these matters. These policies describe basic operating procedures of the business side of my psychotherapy practice. I've found that when these guidelines are adhered to it permits the focus of therapy to be on the important healing work.

Of course if you have concerns or reservations about any aspect of these policies we can discuss them in further detail so as to meet your specific needs when possible. If meeting these guidelines presents a hardship, you may be better served by finding a clinic or therapist with different policies that meet your requirements.

I am convinced that it is very beneficial for the patient and potential therapist to spend time in the beginning stage of therapy making sure there is a good fit for the therapeutic work to have its best chance of succeeding. Please take time to review and sign the office policies described below in order to acquaint yourself with my operating procedures and what is expected of you to allow the therapy to most effective.

## **1. FEES AND AVAILABILITY**

Currently my standard fee for individual, couple, or family 50-minute sessions ranges from \$95 to \$125. I do offer flexibility or a sliding scale upon demonstration of need. Payment is due at the time of treatment, payable by cash or check to Silvia MacAllister, LMFT. There will be a \$15 charge for checks returned for insufficient funds.

If your ability to pay is seriously compromised at this time you may be served by low-fee clinics in the area. These clinics are structured to serve persons of varied financial means. You can receive competent treatment at low-fee clinics especially if they are a training center for newer therapists. My experience and training permit me to work at an advanced level and my fee structure reflects this capacity.

Days and hours of availability for sessions are Monday through Friday 8:00 am to 7:00 pm

**I agree to make complete payment at the time of service.  
Please date and initial here to confirm agreement.** \_\_\_\_\_ / \_\_\_\_\_

## **2. INSURANCE**

I am on several insurance panels, which means these insurance companies consider me a "network provider", for the other insurances I am an "out-of-network provider".

If you expect to use insurance to obtain reimbursement for my therapy services, please check your current coverage carefully. Call the 1-800 number on your card and ask about your mental health benefits. Some carriers will only pay for therapy provided by a therapist pre-approved by them or will reimburse at a lower rate for non-approved providers. To ascertain your benefits, ask your insurance carrier the following questions:

1. Do I have mental health benefits?
2. What is my deductible?
3. How many sessions per calendar year does my plan cover?
4. Is Silvia MacAllister, LMFT on your list of approved providers?
5. If the answer to Question 4 is negative, you might want to ask: How much do you pay for an "out-of-network provider"?
6. Is there a limitation on how much you will pay per session?

Some insurance plans require advance authorization before they will reimburse for mental health services. Often they will only pre-approve a limited number of sessions, and it will be necessary to seek approval if additional sessions are needed. If you exceed the number of sessions allowed by your plan, or if they do not agree additional sessions are "medically necessary," you will be faced with either paying for more sessions out of pocket or discontinuing therapy. Insurance companies may not reimburse for missed appointments or additional fees incurred for other than direct therapy services.

Please remember that you, and not your insurance company or a third party payer, are responsible for full payment of the fee.

**I authorize Silvia MacAllister, LMFT, to bill my insurance for the therapy sessions.  
Please date and initial here to confirm authorization.** \_\_\_\_\_ / \_\_\_\_\_

### **3. HIPAA PRIVACY POLICY**

The Health Insurance Portability and Accountability Act or HIPAA took effect on April 14, 2003, and protects private health information from being disclosed without the patient's consent and sets standards for safe storage of such information. I am a fee-for-service provider and I do use electronic transmission (Internet) of billing information to obtain payment. Therefore, I do fall under the requirements of a HIPAA provider.

#### **3.1 SAFEGUARDING YOUR PROTECTED HEALTH INFORMATION (PHI)**

I am legally required to protect the privacy of your PHI, which includes information that can be used to identify you that I've created or received about your past, present, or future health or condition, the provision of health care to you, or the payment of this health care. I must provide you with this Notice about my privacy practices, and such Notice must explain how, when, and why I will "use" and "disclose" your PHI. A "use" of PHI occurs when I share, examine, utilize, apply, or analyze such information within my practice; PHI is "disclosed" when it is released, transferred, has been given to, or is otherwise divulged to a third party outside of my practice. With some exceptions, I may not use or disclose any more of your PHI than is necessary to accomplish the purpose for which the use or disclosure is made. And, I am legally required to follow the privacy practices described in this Notice.

However, I reserve the right to change the terms of this Notice and my privacy policies at any time. Any changes will apply to PHI on file with me already. Before I make any important changes to my policies, I will promptly change this Notice and post a new copy of it in my office and on my website at <http://www.silviamacallister.com>. You can also request a copy of this Notice from me, or you can view a copy of it in my office or at my website, which is located at <http://www.silviamacallister.com>.

#### **3.2 USE AND DISCLOSE OF YOUR PHI**

I will use and disclose your PHI for many different reasons. For some of these uses or disclosures, I will need your prior written authorization; for others, however, I do not. Listed below are the different categories of my uses and disclosures along with some examples of each category.

A. Uses and Disclosures Relating to Treatment, Payment, or Health Care Operations Do Not Require Your Prior Written Consent. I can use and disclose your PHI without your consent for the following reasons:

1. For Treatment. I can use your PHI within my practice to provide you with mental health treatment, including discussing or sharing your PHI with my trainees and interns. I can disclose your PHI to physicians, psychiatrists, psychologists, and other licensed health care providers who provide you with health care services or are involved in your care. For example, if a psychiatrist is treating you, I can disclose your PHI to your psychiatrist to coordinate your care.
2. To Obtain Payment for Treatment. I can use and disclose your PHI to bill and collect payment for the treatment and services provided by me to you. For example, I might send your PHI to your insurance company or health plan to get paid for the health care services that I have provided to you. I may also provide your PHI to my business associates, such as billing companies, claims processing companies, and others that process my health care claims.
3. For Health Care Operations. I can use and disclose your PHI to operate my practice. For example, I might use your PHI to evaluate the quality of health care services that you received or to evaluate the performance of the health care professionals who provided such services to you. I may also provide your PHI to my accountant, attorney, consultants, or others to further my health care operations.

4. Patient Incapacitation or Emergency. I may also disclose your PHI to others without your consent if you are incapacitated or if an emergency exists. For example, your consent isn't required if you need emergency treatment, as long as I try to get your consent after treatment is rendered, or if I try to get your consent but you are unable to communicate with me (for example, if you are unconscious or in severe pain) and I think that you would consent to such treatment if you were able to do so.

B. Certain Other Uses and Disclosures Also Do Not Require Your Consent or Authorization. I can use and disclose your PHI without your consent or authorization for the following reasons:

1. When federal, state, or local laws require disclosure. For example, I may have to make a disclosure to applicable governmental officials when a law requires me to report information to government agencies and law enforcement personnel about victims of abuse or neglect.

2. When judicial or administrative proceedings require disclosure. For example, if you are involved in a lawsuit or a claim for workers' compensation benefits, I may have to use or disclose your PHI in response to a court or administrative order. I may also have to use or disclose your PHI in response to a subpoena.

3. When law enforcement requires disclosure. For example, I may have to use or disclose your PHI in response to a search warrant.

4. When public health activities require disclosure. For example, I may have to use or disclose your PHI to report to a government official an adverse reaction that you have to a medication.

5. When health oversight activities require disclosure. For example, I may have to provide information to assist the government in conducting an investigation or inspection of a health care provider or organization.

6. To avert a serious threat to health or safety. For example, I may have to use or disclose your PHI to avert a serious threat to the health or safety of others. However, any such disclosures will only be made to someone able to prevent the threatened harm from occurring.

7. For specialized government functions. If you are in the military, I may have to use or disclose your PHI for national security purposes, including protecting the President of the United States or conducting intelligence operations.

8. To remind you about appointments and to inform you of health-related benefits or services. For example, I may have to use or disclose your PHI to remind you about your appointments, or to give you information about treatment alternatives, other health care services, or other health care benefits that I offer that may be of interest to you.

C. Certain Uses and Disclosures Require You to Have the Opportunity to Object.

1. Disclosures to Family, Friends, or Others. I may provide your PHI to a family member, friend, or other person that you indicate is involved in your care or the payment for your health care, unless you object in whole or in part. The opportunity to consent may be obtained retroactively in emergency situations.

D. Other Uses and Disclosures Require Your Prior Written Authorization. In any other situation not described in sections III A, B, and C above, I will need your written authorization before using or disclosing any of your PHI. If you choose to sign an authorization to disclose your PHI, you can later revoke such authorization in writing to stop any future uses and disclosures (to the extent that I haven't taken any action in reliance on such authorization) of your PHI by me.

### 3.3 YOUR RIGHTS REGARDING YOUR PHI

You have the following rights with respect to your PHI:

A. The Right to Request Restrictions on My Uses and Disclosures. You have the right to request restrictions or limitations on my uses or disclosures of your PHI to carry out my treatment, payment, or health care operations. You also have the right to request that I restrict or limit disclosures of your PHI to family members or friends or others involved in your care or who are financially responsible for your care. Please submit such requests to me in writing. I will consider your requests, but I am not legally required to accept them. If I do accept your requests, I will put them in writing and I will abide by them, except in emergency situations. However, be advised, that you may not limit the uses and disclosures that I am legally required to make.

B. The Right to Choose How I Send PHI to You. You have the right to request that I send confidential information to you to at an alternate address (for example, sending information to your work address rather than your home address) or by alternate means (for example, e-mail instead of regular mail). I must agree to your request so long as it is reasonable and you specify how or where you wish to be contacted, and, when appropriate, you provide me with information as to how payment for such alternate communications will be handled. I may not require an explanation from you as to the basis of your request as a condition of providing communications on a confidential basis.

C. The Right to Inspect and Receive a Copy of Your PHI. In most cases, you have the right to inspect and receive a copy of the PHI that I have on you, but you must make the request to inspect and receive a copy of such information in writing. If I don't have your PHI but I know who does, I will tell you how to get it. I will respond to your request within 30 days of receiving your written request. In certain situations, I may deny your request. If I do, I will tell you, in writing, my reasons for the denial and explain your right to have my denial reviewed.

If you request copies of your PHI, I will charge you not more than \$.25 for each page. Instead of providing the PHI you requested, I may provide you with a summary or explanation of the PHI as long as you agree to that and to the cost in advance.

D. The Right to Receive a List of the Disclosures I Have Made. You have the right to receive a list of instances, i.e., an Accounting of Disclosures, in which I have disclosed your PHI. The list will not include disclosures made for my treatment, payment, or health care operations; disclosures made to you; disclosures you authorized; disclosures incident to a use or disclosure permitted or required by the federal privacy rule; disclosures made for national security or intelligence; disclosures made to correctional institutions or law enforcement personnel; or, disclosures made before April 14, 2003. I will respond to your request for an Accounting of Disclosures within 60 days of receiving such request. The list I will give you will include disclosures made in the last six years unless you request a shorter time. The list will include the date the disclosure was made, to whom the PHI was disclosed (including their address, if known), a description of the information disclosed, and the reason for the disclosure. I will provide the list to you at no charge, but if you make more than one request in the same year, I may charge you a reasonable, cost-based fee for each additional request.

E. The Right to Amend Your PHI. If you believe that there is a mistake in your PHI or that a piece of important information is missing, you have the right to request that I correct the existing information or add the missing information. You must provide the request and your reason for the request in writing. I will respond within 60 days of receiving your request to correct or update your PHI. I may deny your request in writing if the PHI is (i) correct and complete, (ii) not created by me, (iii) not allowed to be disclosed, or (iv) not part of my records. My written denial will state the reasons for the denial and explain your right to file a written statement of disagreement with the denial. If you don't file one, you have the right to request that your request and my denial be attached to all future disclosures of your PHI. If I approve your request, I will make the change to your PHI, tell you that I have done it, and tell others that need to know about the change to your PHI.

F. The Right to Receive a Paper Copy of this Notice. You have the right to receive a paper copy of this notice even if you have agreed to receive it via e-mail.

**3.4 HOW TO COMPLAIN ABOUT OUR PRIVACY PRACTICES**

If you think that I may have violated your privacy rights, or you disagree with a decision I made about access to your PHI, you may file a complaint with the person listed in Section 3.5 below. You also may send a written complaint to the Secretary of the Department of Health and Human Services at 200 Independence Avenue S.W., Washington, D.C. 20201. I will take no retaliatory action against you if you file a complaint about my privacy practices.

**3.5 PERSON TO CONTACT FOR INFORMATION ABOUT THIS NOTICE OR TO COMPLAIN ABOUT MY PRIVACY PRACTICES**

If you have any questions about this notice or any complaints about my privacy practices, or would like to know how to file a complaint with the Secretary of the Department of Health and Human Services, please contact me at:

Silvia MacAllister  
1801 Bush Street, Suite 115  
San Francisco, CA, 94109  
Phone: 415 646 0646  
Email: [contact\\_me@silviamacallister.com](mailto:contact_me@silviamacallister.com)

I have read and understood the privacy policy and authorize Silvia MacAllister, LMFT to keep all the records necessary for my treatment and provide the necessary diagnostic/treatment information, as well as any information related to my therapy that my insurance company and/or managed care organization may require.

**Please date and initial here to confirm authorization.** \_\_\_\_\_/\_\_\_\_\_

**4. CANCELLATION**

When you make an appointment, I reserve that time specifically for you. If you do not show or cancel late, I lose revenue, but just as importantly, I lose time. Therefore, you are requested to notify me as soon as possible, but no later than **24** hours in advance, if you need to cancel or reschedule a session. Without such notification, you will be charged the full fee for the session.

Please call my voice mail at (415) 646 0646 and leave a message to cancel or reschedule. My voice mail has a time and date marker that indicates when your call was received. If you cancel or miss a session, I call back to see what happened and to see if we can reschedule.

I have read and understood the cancellation policy.

**Please date and initial here.** \_\_\_\_\_/\_\_\_\_\_

**5. CONTACTING ME**

Between therapy appointments, or in case of emergency, you can leave a message by calling (415) 646 0646. Once you leave a message on my voice mail, I am notified that a message is waiting. I try to return calls as soon as possible, but that may not be for several hours. On weekends and holidays, the time to return your call may be even longer. If I don't return your call within 24 hours, please call back. Be sure to speak slowly and clearly when leaving your name and phone number, and don't forget to include the area code. If I am going to be away for an extended period of time (such as vacations or professional conferences), I will leave the name and telephone number of a trusted colleague on my outgoing message who may be able to help you in the meantime. If at any time you are experiencing an emergency and you cannot contact me within a short time, please go to the nearest hospital emergency room for assistance or call 911.

I can be contacted by email at [contact\\_me@silviamacallister.com](mailto:contact_me@silviamacallister.com) (contact\_me at silviamacallister dot com), but I cannot guarantee I will respond to non-patients. I do my best to answer questions from others if the question can be answered briefly and if I can fit this into my schedule.

**6. TREATMENT OF MINORS AS INDIVIDUAL PATIENTS**

When a patient who is a minor is in individual therapy, the parent or guardian has the right to ask for information about the minor's therapy, and the therapist, acting in the best interest of the minor patient, has the right to limit the amount of information disclosed.

If the minor patient is a participant in any legal proceedings raising the protection of all client/therapist communications as "privilege," then no disclosure will be made of any of the content of the therapy except by written waive of privilege, given in writing by the parent, guardian or other lawful representative acting on behalf of the minor patient.

**7. EFFECTIVE DATE AND CHANGES TO OFFICE POLICY**

This office policy will go into effect on April 14, 2003.  
I reserve the right to change the terms of this policy and to make the new policy provisions effective for all clients. I will provide you with a revised notice by posting updates on my website <http://www.silviamacallister.com/>

**8. PERMISSION TO TREAT**

I acknowledge that it is my choice to participate in psychotherapy (or have my child participate). I will take responsibility for my psychotherapy and will come prepared and ready for each session. I will discuss termination prior to ending treatment.

Before you sign below, please ask any questions you may have of this document. Thank you for your courage to come and for your strength in discovering more about yourself.

**Your signature acknowledges agreement and understanding:**

\_\_\_\_\_  
signature of client

\_\_\_\_\_  
date

\_\_\_\_\_  
signature of therapist

\_\_\_\_\_  
date