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WELCOME TO MY PRACTICE

Thank you for choosing me as your behavioral health care provider. This welcome letter outlines my policies and procedures. When you sign this document, it will represent a legal agreement between us. If we are contracting for forensic services, you will be asked to read and sign a separate form, in addition to this one. ***Please keep a copy of this letter for your reference***.

A. PROFESSIONAL FEES: PSYCHOTHERAPY

Fee-for-service: If you are a fee-for-service client, my basic hourly fee (45-50 minutes) is $170 (with some exceptions, see below). In addition to therapy appointments, I charge this amount for other professional services you may need, though I will break down the hourly cost if I work for periods of less than one hour. Other services include report writing, telephone conversations lasting longer than 5 minutes, attendance at meetings with other professionals you have authorized, preparation of records or treatment summaries, and the time spent performing any other service you may request of me.

- In some cases, I am willing to see clients for a discounted fee (sliding scale). We will discuss this possibility beforehand.
- If an unusual financial hardship arises during the course of therapy, I may be willing to negotiate a fee adjustment or payment installment plan.

Insurances I accept: I am a participating provider with the following insurances: Aetna, CareFirst (many), CIGNA, ValueOptions, and the Magellan EAP plan**.** There's a wonderful saying: "if you've seen one insurance policy, you've seen one insurance policy." Check **your** policy carefully.

If I am a participating provider for your insurance, my hourly fee for therapy and other clinical services is whatever your insurance carrier allows. In that case, your "missed appointment" or "late cancellation" fee is the amount that your carrier would pay had you kept the appointment. All other services, as noted above, are at my regular hourly rate.

Co-payments: Most Insurance carriers require a co-pay for each session. Unless we know your co-pay beforehand (check your insurance card), I charge a $20 co-pay. If we learn (from the insurance company's payment form) that it should be less, I'll refund the difference. If it's more, you will be expected to pay the difference and then pay the required rate at each session.

Please pay your co-pay by cash or check at the start of each session.

B. HOW LONG WILL THERAPY SERVICES CONTINUE?

In some sense, treatment goes on as long as it goes on. More specifically, services will continue until:

- Your treatment goals have been achieved
- You discontinue treatment by clearly indicating that you have no interest in continuing services with me or by repeatedly failing to keep scheduled appointments.
- We come to jointly feel that your needs cannot be adequately met here, in which case you will be referred to another and more appropriate provider.
- If you decide to stop treatment, it would be helpful to hold at least one final session to clarify the reason you've decided to terminate.

C. THERAPY CANCELLATION POLICY

Once an appointment hour is scheduled, you will be expected to pay for it unless you provide at least 24 hours (1 day) advance notice of cancellation, unless we both agree that you were unable to attend due to circumstances beyond your control. Exceptions to this policy are what would generally be considered emergencies and would not include being very busy at work, or having a baby sitter "no show", or just not feeling like coming in. If it is possible, I will try to find another time to reschedule the appointment, hopefully during the same week.

If you think you might have difficulty keeping regular appointments, discuss this with me at the beginning of our relationship to see what can be worked out If you cancel or miss appointments on a regular basis, I reserve the right to refuse to make another appointment

D. PROFESSIONAL FEES: PSYCHOLOGICAL TESTING

Fees vary depending on the type of evaluation. Fees range from $2000 for a basic evaluation to several thousand for complex forensic (legal) cases. Fees will be determined on a case-by-case basis, depending on the referral questions. My policy is to collect at least 50% of the fee at the time of initial service and the balance before the report is delivered. If you have to cancel, please let me know at least 48 hours (2 days) in advance. If you cancel with less notice, or "no show" for a scheduled appointment you will be charged a flat fee of $350.

E. PROFESSIONAL FEES: FORENSIC SERVICES

If you are or become involved in legal proceedings that require my participation, you will be expected to pay for my professional time even if I am called to testify by another party. Because of the difficulty of legal involvement, I charge a minimum of $250 per hour for preparation and attendance at any legal proceeding. If therapy or testing is in connection with a legal case, I will ask you to sign a separate contract, specifying the details of my involvement (see the ***Consent for Forensic Services*** form).

You will be asked to pay for forensic services prior to the service, either in full, or in the form of a to-be-agreed-upon retainer. If you have to cancel, please let me know at least 72 hours (3 days) in advance. If you cancel with less notice, or "no show" for a

scheduled appointment you will be charged a flat fee of $500. ***No insurance carriers consider forensic services to be health-related and typically refuse any coverage.***

F. BILLING AND PAYMENTS

All co-pays and payments are due at the time of the appointment and must be paid in full each session. If by the next visit you have not paid the amount owed, I reserve the right to hold off seeing you unless and until you have paid in full.

Please pay your co-pay by cash or check at the start of each session.

If your account has not been paid for more than 60 days and arrangements for payment have not been agreed upon, I have the option of using legal means to secure the payment. This may involve hiring a collection agency or going through small claims court. If such legal action is necessary, all legal costs will be included in the claim. In most collection situations, the only information I release regarding a patient's treatment is his/her name, the nature of services provided, and the amount due.

G. INSURANCE REIMBURSEMENT

If I am a participating provider with your carrier, I am required to file the insurance claims myself. If I do not participate with your plan, I may be able to fill out forms and provide you with whatever assistance I can in helping you receive the benefits to which you are entitled; however, you (and not your insurance company) are responsible for full payment of my fees.

You should also be aware that most insurance companies require you to authorize me to provide them with a clinical diagnosis. Sometimes I have to provide additional clinical information such as treatment plans or summaries, or copies of the entire record (this is **very** rare in my experience). I will provide you with a copy of any report I submit to your insurance carrier, if you request it.

This information will become part of the insurance company files and will probably be stored in a computer. Though all insurance companies claim to keep such information confidential, I have no control over what they do with it once it is in their hands. In some cases, they may share the information with a national medical information databank. Note the many recent reports on the number of such databanks that have become compromised by hackers and others.

Once we have all of the information about your insurance coverage, we will discuss what we can expect to accomplish with the benefits that are available and what will happen if they run out before you feel ready to end our sessions. It is important to remember that you always have the right to pay for my services yourself to avoid the problems described above [unless prohibited by contract].

H. WORKING TOGETHER WITH YOUR PRIMARY CARE PHYSICIAN AND OTHER HEALTH CARE PROFESSIONALS

I encourage you to have a primary health care physician who oversees your general care. You should have a general physical examination once a year. Please let me

know who that physician is. I will need their name, address and phone number. It would be good to have your authorization to communicate with your physician. I would like to work as a team to help you (see Authorization to Exchange Information form).

If you are seeing another health care professional and wish us to coordinate your care, please let me know who that person is and provide me with authorization to exchange information with them.

I. PROFESSIONAL RECORDS

State and Federal law and the standards of my profession require that I keep treatment records. You are entitled to receive a copy of your records, or I can prepare a summary for you instead. Because these are professional records, they can be misinterpreted and/or upsetting to untrained readers. If you wish to see your records, I recommend that you review them in my presence so that we can discuss the contents. I am sometimes willing to conduct a brief 10-15 minute review meeting without charge. Meetings to review other evaluations and written reports will be billed at my regular fee-for-service rates. Clients will also be charged an appropriate fee for any professional time spent in responding to information requests (an attorney requests a written summary of treatment or a special report for a legal proceeding, and so on). ***Insurance carriers do not reimburse for these services.***

J. HOLDING THE INFORMATION YOU PROVIDE TO ME CONFIDENTIAL

Everything you tell me is strictly confidential. ***You own this information***. I will not disclose any information outside this office about you unless you give me specific written permission. ***But there are a few exceptions***.

Such situations have only very rarely occurred in my practice. If a similar situation occurs, I will make every effort to fully discuss it with you before taking any action. In sum, the information you share with me may be disclosed without your written permission only under the following circumstances:

- A Court orders me to share information about you.

- You have a medical or psychological emergency, and a doctor or hospital needs information to treat you.

- You present a potential danger to yourself and/or specific others and I have to contact the police or a Crisis Center.

- You threaten to seriously hurt a specific person. I have a legal duty to warn the person threatened, and notify the police.

- I believe there may be child abuse or neglect, or abuse or neglect of an elderly person or vulnerable adult. By Maryland and DC law, I must report this to Child or Adult Protective Services.

- If you report that you were abused as a child, I may have to notify Child Protective Services.

I may occasionally find it helpful to consult other professionals about a case. During a consultation, I make every effort to avoid revealing the identity of my clients. The consultant is also legally bound to keep the information confidential. If you don't object, I will not tell you about these consultations unless I feel that it is important to our work together.

While this written summary of exceptions to confidentiality should prove helpful in informing you about potential problems, it is important that we discuss any questions or concerns that you may have at our next meeting. I will be happy to discuss these issues with you if you need specific advice, but formal legal advice may be needed because the laws governing confidentiality are quite complex, and I am not an attorney.

If you still have questions, I'll be glad to discuss them with you.

K. NOTICE OF PRIVACY PRACTICES (UNDER HIPAA)

This notice describes how information about you may be used by Ron Wynne, PhD and disclosed and how you can get access to this information. Please review it carefully.

The Health Insurance Portability & Accountability Act of 1996 (HIPAA) is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally have to be kept confidential. This Act gives you, the client, significant new rights to understand and control how your health information is used. "HIPPA" provides penalties for covered entities that misuse personal health information.
As required by HIPAA, I have prepared this explanation of yow we are required to maintain the privacy of your health information and how I may use and disclose your health information.

I may use and disclose your medical records only for one or more of the following purposes: ***Treatment, Payment, and Healthcare Operations.***

- **Treatment** means providing, coordinating, or managing healthcare and related services by one or more healthcare provider. An example of this would include a physical examination.
- **Payment** means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.
- **Healthcare Operations** include the business aspects of running this practice, such as conducting quality assessment and improvement activities, auditing, cast-management analysis, and customer services. An example would be an internal quality assessment review.

I may also create and distribute health information by removing all references to individually identifiable information.

I may contact you to provide appointment reminders or information about treatment alternatives or other health related benefits and services that may be of interest to you.

Any other uses and disclosures will be made only with your specific written authorization. You may revoke such authorization in writing and I am required to honor and abide by that written request, except to the extent that I have already taken actions relying on your authorization.

Below are your rights with respect to your protected health information. You can exercise these rights by presenting a written request to me:

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family member, other members, other relatives, close personal friends, or any other person identified by you. I am, however, not required to agree to a requested restriction. If we do agree to a restriction, I must abide by it unless you agree in writing to remove it.

- The right to reasonable requests to receive confidential communications of protected health information from us be alternative means or at alternative locations.

- The right to inspect and copy your protected health information.

- The right to amend your protected health information.

- The right to receive an accounting of disclosures of protected health information.

- The right to obtain a paper copy of this notice from me upon request.

I am required by law to maintain the privacy of your protected health information and to provide you with notice of my privacy practices with respect to protected health information.

This notice is effective as of April 14, 2003. I am required to abide by the terms of this Notice of Privacy Practices. I reserve the right to change the terms of this Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that I maintain. I will post the Notice of Privacy Practices and you may request a written copy of a revised Notice of Privacy Practices from me.

You have recourse if you feel that your privacy protections have been violated. You have the right to file a written complaint with me or with the Maryland Department of Health & Human Services Office of Civil Rights about violations of the provisions of this notice or the policies and procedures of this office. I will not retaliate against you for filling a complaint.

For more information on HIPAA or to file a complaint, please contact:

The U.S. Department of Health & Human Services
Office of Civil Rights
200 Independence Avenue, S.W.
Washington, D.C. 20201
(202) 619-0257
Toll Free: 1-877-696-6775

Your signature on the Consent for Services form indicates that you have read the information in this document and agree to abide by its terms during our professional relationship.