



WINCHESTER PSYCHOLOGICAL ASSESSMENT, LLC

OFFICE OF PAUL HILL, PSYD | WWW.PAULHILLPSYD.COM

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SERVICE AGREEMENT

I. PRIVACY POLICY/CONFIDENTIALITY

As a rule, I will disclose no information about you, or the fact that you are my patient, without your written consent. Health care providers are legally allowed to use or disclose records or information for treatment, payment, and health care operations purposes. However, I do not routinely disclose information in such circumstances, so I will typically ask your permission in advance, either through your consent at the onset of our relationship, or through your written authorization at the time the need for disclosure arises. You may revoke your permission, in writing, at any time, by contacting me.

There are some important exceptions to the rule of confidentiality – some exceptions created voluntarily by my own choice, and some required by law. I will also highlight situations where confidentiality is potentially, though not necessarily, at risk. If you wish to receive psychological evaluation services from me, you must sign this agreement indicating that you understand and accept my policies about confidentiality and its limits.

- **Emergency:** If you are involved in a life-threatening emergency and I cannot ask your permission, I will share information if I believe you would have wanted me to do so, or if I believe it will be helpful to you.
- **Child Abuse Reporting:** If I have reason to suspect that a child is abused or neglected, I am required by Virginia law to report the matter immediately to the Virginia Department of Social Services.
- **Adult Abuse Reporting:** If I have reason to suspect that an elderly or incapacitated adult is abused, neglected or exploited, I am required by Virginia law to immediately make a report and provide relevant information to the Virginia Department of Welfare or Social Services.
- **Health Oversight:** Virginia law requires that licensed psychologists report misconduct by a health care provider of their own profession. By policy, I also reserve the right to report misconduct by health care providers of other professions. By law, if you describe unprofessional conduct by another mental health provider of any profession, I am required to explain to you how to make such a report. If you are yourself a health care provider, I am required by law to report to your licensing board that you are in treatment with me if I believe your condition places the public at risk. Virginia Licensing Boards have the power, when necessary, to subpoena relevant records in investigating a complaint of provider incompetence or misconduct.
- **Court Proceedings:** If you are involved in a court proceeding and a request is made for information about your diagnosis and treatment and the records thereof, such information is privileged under state law, and I will not release information unless you provide written authorization or a judge issues a court order. If I receive a subpoena for records or testimony, I will notify you so you can file a motion to quash (block) the subpoena. However, while awaiting the judge's decision, I am required to place said records in a sealed envelope and provide them to the Clerk of Court. In civil court cases, therapy information is not protected by patient-therapist privilege in child abuse cases, in cases in which your mental health is an issue, or in any case in which the judge deems the information to be "necessary for the proper administration of justice." In criminal cases, Virginia has no statute granting therapist-patient privilege, although records can sometimes be protected on another basis. Protections of privilege may not apply if I do an evaluation for a third party or where the evaluation is court-ordered. You will be informed in advance if this is the case.
- **Serious Threat to Health or Safety:** Under Virginia law, if I am engaged in my professional duties and you communicate to me a specific and immediate threat to cause serious bodily injury or death, to an identified or to an identifiable person, and I believe you have the intent and ability to carry out that threat immediately or imminently, I am legally required to take steps to protect third parties. These precautions may include 1) warning the potential victim(s), or the parent or guardian of the potential victim(s), if under 18, 2) notifying a law enforcement officer, or 3) seeking your hospitalization. By my own policy, I may also use and disclose medical information about you when necessary to prevent an immediate, serious threat to your own health and safety. If you become a party in a civil commitment hearing, I can be required to provide your records to the

magistrate, your attorney or guardian *ad litem*, a CSB evaluator, or law enforcement officer, whether you are a minor or an adult.

- **Workers Compensation:** If you file a worker's compensation claim, I am required by law, upon request, to submit your relevant mental health information to you, your employer, the insurer, or a certified rehabilitation provider.
- **Records of Minors:** Virginia has a number of laws that limit the confidentiality of the records of minors. For example, parents, regardless of custody, may not be denied access to their child's records; and CSB evaluators in civil commitment cases have legal access to therapy records without notification or consent of parents or child. Other circumstances may also apply, and we will discuss these in detail if I provide services to minors.
- **Collections:** Information regarding your involvement in treatment or evaluation (i.e. dates of treatment or evaluation and billing record) may be released in the event that legal collection action becomes necessary by my office.
- **Insurance:** Information regarding your treatment, dates of services, diagnosis and treatment plans (and, in rare cases, the entire record) will be released to your insurance company if you choose to have my office file your insurance claims.
- **Complaints:** If you file a complaint or lawsuit against me, I may disclose relevant information regarding your treatment in order to defend myself.
- **Billing, Insurance Filing, and Payment:** I contract with a billing service to file insurance claims on your behalf, to manage collection of fees, to assist with insurance authorizations, and to provide payment receipts to you. This service does not have access to your treatment record and they are required to maintain the confidentiality of the data I provide for the billing services. Further, if you pay with a personal check, be aware that bank tellers may become aware that you are a client at my office when I make deposits to my business account.
- **Electronic Transmission:** I will, at times, share personal information about you with the billing service, insurance companies, or other entities with whom you authorize me to share information via electronic transmission, including fax machines, e-mail, or cellular telephones. Despite my efforts, these transmissions cannot be guaranteed to be secure.
- **Consultation:** At times I will consult with professional colleagues about aspects of your case. Your name and unique identifying characteristics will not be disclosed. The consultant is also legally bound to keep the information confidential.

While this written summary of exceptions to confidentiality should prove helpful in informing you about potential issues, it is important that we discuss any questions or concerns you may have now or at any time in the future. 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.

By signing the document at its end, you are indicating that you have been informed about these policies and have been given the opportunity to ask questions about them, that you understand them, and that you consent to accept them as a condition of receiving psychological services.

II. EVALUATION PURPOSE

You agree to disclose the exact nature and purpose of the requested evaluation to Dr. Hill and/or relevant staff members prior to the onset of testing. There are legal and financial considerations (including for insurance) that may be relevant, depending on the purpose of the evaluation. You agree to disclose whether you have been court-ordered for the evaluation or whether you intend to use the evaluation in a legal matter. You must provide Dr. Hill a copy of the relevant Court Order prior to the onset of the evaluation.

III. FEES & BILLING POLICIES

Unless otherwise agreed upon between this office and third-party payer contracts, fees are as follows:

- Psychiatric Diagnostic Interview (Intake): \$215.00
- Psychological Testing Per Hour*: \$165.00
- Neuropsychological Testing Per Hour*: \$215.00
- Forensic Testing Per Hour*: \$215.00
- Misc. Consultation Per Hour: \$165.00

III. FEES & BILLING POLICIES continued...

- Broken Appointment Fee: \$55.00 (per hour of scheduled testing)
- Records Copying Fee Per Page: \$0.50 up to 50 pages; \$0.25 per page after 50 pages
- Form Completion**: \$15.00 per document unless otherwise negotiated

*Note. Test administration, scoring, interpretation, and report-writing time are billed at these rates.

**Note. We will charge to complete *any form* you ask us to complete that is not directly related to the evaluation at the immediate time of service. You or your representative will complete all relevant portions of the form or forms that pertain to you. Dr. Hill will only complete and sign portions of the form or forms that are designated for the professional.

Appointments are considered broken if cancelled within 24-hours of the appointment date and time, or if you are 10-minutes or more late for a one-hour appointment, or 15-minutes or more late for an appointment over one-hour. There is a Broken Appointment fee of \$50 per hour of scheduled testing. If an appointment is broken, a non-refundable \$100.00 deposit is required to reschedule the appointment. Copays are due at the time of service. Acceptable methods of payment include Visa, Mastercard, American Express and Discover, as well as cash. **NO PERSONAL CHECKS ARE ACCEPTED.** Credit cards are processed through Square, Inc. **A formal Psychological Evaluation Report will not be written until balances are paid in full.**

Many insurance companies may not pay for educational and other types of psychological testing. Our staff will confirm your benefits and attempt to determine whether services are likely to be covered, and will contact you and inform you if we learn testing will not be covered, and then discuss your options. If testing that is not covered is requested, or the insurance company otherwise declines payment, the patient or patient's legal guardian is responsible for payment. All non-covered testing fees must be paid in full before a formal Psychological Evaluation Report will be written.

Unpaid balances and collections: A Collections fee will be assessed at the rate of 33 and 1/3rd percent of the account balance.

Out-of-network insurance claims: If you request, we will file out-of-network insurance claim(s) to your insurance provider for you as a courtesy. With the exception of sending evaluation records to your insurance company for review upon formal request, we will provide no other insurance-claim support. We absolutely do not guarantee *any* monetary reimbursement from your insurance company. Reimbursements are decided by your insurance company alone.

IV. INSURANCE RELEASE OF INFORMATION

As acknowledged in Section I of this agreement, I _____ authorize the release of information and benefits assignments for insurance claims to the following: (Patient OR Parent/Guardian Name)

Insurance Company Name: _____

Signature of Patient OR Parent/Guardian: _____

V. SAFETY & SERVICE PERIOD

Safety: You understand Dr. Hill does not provide emergency services and that if you are experiencing a mental health emergency you should call 9-1-1, the National Suicide Prevention Lifeline at 1-800-273-8255, or visit your local hospital Emergency Room, in addition to informing your therapist, psychiatrist, or other provider where applicable. Service Period: Your active period of service begins on the date this document is signed, unless dated before the date of first contact appointment (intake), and terminates after your feedback (follow-up) appointment. Service will terminate 3-months after intake in the event we are no longer able to contact you.

VI. SIGNATURE OF AGREEMENT

By signing below, I acknowledge that I have read and understand this document, and that I agree to all the conditions contained herein.

Patient Name Printed _____

Patient Signature _____

Date _____

Parent/Guardian Name Printed _____

Parent/Guardian Signature _____

Date _____

Witness Signature _____

Date _____