Meghan Crosby Budinger, LCPC, LLC
9 S Hickory Ave, Bel Air, MD 21014 * (443) 961-1181
meghan@belaircounseling.com * www.belaircounseling.com

PRACTICE & PRIVACY POLICIES

Welcome to my psychotherapy practice. This document (the Agreement) contains important information about my professional services and business policies. It also contains summary information about the Health Insurance Portability and Accountability Act (HIPAA), a federal law that provides privacy protections and client rights with regard to the use and disclosure of your Protected Health Information (PHI) used for the purpose of treatment, payment, and health care operations. HIPAA requires that we provide you with a Notice of Privacy Practices (the Notice). The Notice is attached to this Agreement and explains the application of HIPAA to your PHI in greater detail. The law requires that we obtain your signature acknowledging that we have provided you with this information at the end of this session. Please take time to read my Practice & Privacy Policies agreement carefully and let me know if you have any questions or need more information. When you sign the *Acknowledgement and Consent for Treatment* at the end of this document, it will represent an agreement between us. You may revoke this Agreement in writing at any time.

ENGAGING IN PSYCHOTHERAPY

I applaud you for taking steps to address areas of your life that are causing distress through psychotherapy. Psychotherapy is an active form of treatment that requires hard work on both of our parts. In order for psychotherapy to be effective, you will be asked to think about and practice things we talk about both during and outside of our sessions. Psychotherapy can have risks and benefits. Because psychotherapy often involves discussing aspects of your life you wish to change, you may experience strong or uncomfortable emotions such sadness, guilt, shame, or anger. On the other hand, psychotherapy has also been shown to have many benefits. Psychotherapy can lead to reduction in distressing psychological symptoms, greater understanding of self and others, improvements in relationships, solutions to specific problems, and enhanced quality of life. However, there are no guarantees of what you will experience. By the end of your initial intake evaluation, I will be able to share my initial clinical impressions with you. At this time, we will also discuss and create shared goals for psychotherapy. There may be occasions in which even after an initial phone consultation I feel that my background and experiences are not the right fit for your treatment needs. If that should occur, I would explain why and offer recommendations on other treatments and/or therapists which may better meet your needs. You may also decide that I am not the right psychotherapist for you at any time. Should that occur I encourage you to inform me as I am happy to assist you in locating another therapist.

CONFIDENTIALITY

I take very seriously the confidentiality of the personal information that my patients share with me. This agreement was prepared to clarify my legal and ethical responsibilities regarding this important issue. Personal information that you share with me may be entered into your records in written

form. I make every effort to protect the confidentiality of your records including locking paper records in a locked file cabinet in a locked office and storing electronic files on a password protected computer and are uploaded via a password protected internet connected to a password protected database. Persons from outside my office are not allowed access to your clinical records except in the circumstances outlined below in the *Release of Information to Others* and *Exceptions to Confidentiality* sections.

A Note Regarding Minors

The therapeutic relationship is one of trust. Often times, children and adolescents disclose information to me that they expect me to keep in confidence just as an adult would. As a practice, I bring accompanying parent(s)/guardian(s) in at the end of an individual session with a minor patient and ask the child or adolescent to help me summarize or explain what was worked on. By consenting to services with me, you are agreeing that I may hold your child's therapy disclosures confidential. Out of respect for my patients and their privacy, in general, I would only disclose information to parents or guardians without a minor patient's consent if I believe the minor is engaging in activities which could put him or her in danger. I am not permitted to disclose any information about adult (18 years or older) patients to their parents without their permission even if the patient is living with their parent(s) and even if their parent(s) are paying for their treatment. I do not provide custody evaluations. I do not testify in court as a witness and do not provide court testimony for marital or custody disputes.

Professional Consultation

On occasion, I may find it helpful to consult other health and mental health professionals about a patient. During a consultation, I make every effort to avoid revealing the identity of the patient. The other professionals are also legally bound to keep the information confidential. I will note all consultations in your clinical record.

RELEASE OF INFORMATION TO OTHERS

By law, the sharing of information in your record is done only with your written, expressed permission. If you would like to me share your information, I will provide you with an *Authorization for Release of Protected Health Information* form to complete. This release specifies what information you are consenting me to release, to whom, and for what time period. You can revoke your permission at any time by providing me with written notice.

EXCEPTIONS TO CONFIDENTIALITY

There are several important exceptions to the above policy regarding your confidentiality in which disclosure is required by law. The following are the exceptions and limits to confidentiality and represent instances in which confidential information may be released to others without your expressed written permission:

a. When I believe you present a serious danger to harm yourself

b. When I believe you present a serious danger of violence to others. In these cases I am also obligated by law to warn identified others.

c. When there is reasonable suspicion of child, elder or dependent adult abuse, or neglect

d. When you have given written consent specifying a third party with whom your file will be shared

e. Pursuant to a lawfully issued subpoena

f. When I am defending myself against a claim, or subject to investigation, review, or audit

h. When minors (under 18 years of age) are seen in therapy, the parent or legal guardian holds the legal privilege regarding releasing their clinical records

If you have any questions about confidentiality, please discuss them with me.

COMMUNICATION

Email

I prefer using email communication for administrative purposes only, such as making appointments. Please do not email me content related to our psychotherapy sessions, as email is not completely secure or confidential. You should also know that any emails I receive from you and any responses that I send to you become a part of your treatment record. Please do not contact me via e-mail for emergencies.

Phone

If you need to contact me between sessions, please call me at (443) 961-1181. Voicemail is checked a minimum of twice daily. I will make every effort to return your call within 24 hrs with the exception of weekends and holidays. I do not hold 24/7 on call hours. In an emergency, patients should call the National Suicide Prevention Lifeline (800) 273-8255, call 911, or visit their local emergency department. Frequent or lengthy phone consultations may indicate the need to adjust your treatment plan to better meet your needs.

Fax

I can accept faxes via my office number listed above. Faxes are transmitted to me digitally and retrievable only via a password protected mailbox.

Social Media

I do not accept friend or contact requests from any current or former patients or their immediate family members on any social networking site (Facebook, LinkedIn, etc). I believe that adding my patients as friends or contacts on these sites can compromise your confidentiality and our respective privacy. It may also blur the boundaries of our therapeutic relationship.

CANCELLATIONS & LATENESS

Because scheduling of an appointment involves the reservation of time specifically for you, a minimum of 24 hours notice is required for re-scheduling or canceling your appointment. The normal session fee will be charged for sessions missed without such notification. Occasional exceptions occur if it is agreed that a late cancellation was unavoidable. If you are running late for your appointment, please call me as soon as possible to let me know you will be late. If you arrive late, please understand that we will still need to end on time as other patients may be waiting for their appointment. If you are requesting a bill from me to send to your insurance company, be aware

that insurance companies do not reimburse for missed sessions. If you cancel or no-show for multiple sessions, then you may be referred to another therapist who can better meet your needs.

PAYMENT & FEES

I am considered an "out of network" provider, which means I do not submit directly to insurance companies for payment. This was a conscious business decision which allows for greater freedom in treatment and protects my patients' confidentiality. Payment is due at the time of service. Generally, payment is collected prior to our session beginning. Payment is accepted in the form of cash, check, or credit card. Statement of accounts and/or invoices that are used to submit to insurance companies for reimbursement are created upon request and may take up to 2 business days to prepare. A fee of $35 will be charged for returned (overdrawn) checks to cover the fee my bank charges me, and checks will no longer be accepted as payment from patients after a returned check. If you fail to pay, your account may be referred for collection. In that event you will be responsible for all costs and expenses of collection, including reasonable attorneys' fees.

In addition to appointments, you may require or request professional services such as attendance at meetings, consultations with other professionals which you have authorized, preparation of records, or treatment summaries. The fee for these services is $125 per 60 minutes and is prorated.

Fees are evaluated annually and if warranted, fee increases generally take effect on January 1st. Those currently in treatment will be notified of any increases 30 days in advance of the effective date.

Fee Schedule:

Initial visit/evaluation (90-110 minutes)	$200
Individual, couples, or family psychotherapy (45-50 minutes)	$125
Attendance at meetings (e.g., IEP), consultation, or similar professional services	$125/hr
Returned checks	$35

Please initial each item and sign below to acknowledge your understanding of the practice payment policies.

_____ I understand that payment is due at the time of service.

_____I understand that this practice does not accept payment from insurance companies

_____I understand that I may be charged the full session fee for a missed session not cancelled at least 24 hours in advance.

_____ I understand that multiple late cancellations may result in termination from the practice.

INSURANCE INFORMATION

If you would like to be given monthly invoices which you can submit to your insurance company for potential reimbursement, please complete the following section. Your insurance carrier determines whether and how much they will reimburse. Please call your member services department for information on "out of network" benefits.

Insurance Carrier: _____ Member ID: _____

Policy Holder Name: _____Policy Holder DOB: ___/___/____

ACKNOWLEDGEMENT & CONSENT FOR TREATMENT

Your signature below indicates that you have read the above agreement and agree to its terms. Your signature also serves as an acknowledgement that you have been provided a copy of the Notice of Privacy Practices. Finally, your signature indicates you have been given the opportunity to ask questions about any of the above.

For minors in which parents are in the process of separating, are separated, or have joint legal custody, both parents must consent to treatment.

_____

Patient Name (print)

_____

In case of minor, Parent/Guardian Name (print)

_____ _____

Patient or in case of minor, Parent/Guardian signature Date

_____

In case of minor, Parent/Guardian (print)

_____ _____

In case of minor, Parent/Guardian signature Date

_____

Clinician (print)

_____ _____

Clinician signature Date