Robyn Claar, Ph.D., PLLC

PRACTICE AGREEMENT

Welcome to my practice. I am an independent practitioner. This document 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 protection and patient rights with regard to use and disclosure of your Protected Health Information (PHI) used for the purpose of treatment, payment, and health care operations. HIPAA requires that I provide you with a Notice of Privacy Practice (please see the separate document) for use and disclosure of PHI for treatment, payment and health care operations. The law requires that I obtain your signature acknowledging that I have provided you with this information at the beginning of your treatment. Although this document is long, it is important that you please read it carefully. We can discuss any questions you have during your appointment. When you sign this document, it will represent an agreement between us.

PSYCHOLOGICAL SERVICES

My services vary depending on your needs. Our first few sessions will involve an evaluation of your needs. By the end of the evaluation, I will be able to offer you some initial impression of what your treatment will include and a plan to follow, if we decide to continue working together. If you have questions about procedures, please feel free to discuss them with me at any time.

PROFESSIONAL FEE SCHEDULE

The following fee schedule outlines the services available and the current fees associated with those services. Please note that these fees are reviewed periodically and subject to revision. Existing patients will receive a grace period before their fees are adjusted.

**Intake Appointments** Length of Session Rates

 60 minutes $260.00

 90 minutes $390.00

**Therapy Sessions**

 45 minutes $195.00

 30 minutes (pre-arranged) $130.00

 60 minutes (pre-arranged) $260.00

 90 minutes (pre-arranged) $390.00

**Psychological Testing Services**

**Step 1:**Intake Appointment (60 minutes = $260, 90 minutes = $390)

**Step 2:** Testing procedures: The total cost of testing varies based on factors such as the nature of your concerns, the actual testing procedures, and the extent of documentation (i.e. report) prepared. I will provide you with an estimate of your testing and documentation fees at the conclusion of the intake appointment. Please be advised that testing typically takes two plus hours. The estimated cost may be different than the actual cost. The services and their corresponding fees are indicated below:

Face-to-face testing (per hour): $260

Scoring/Interpretation/Comprehensive Report (per hour):  $195

Classroom Observations (per hour): $260

Consultation with teacher(s), (per hour, prorated):  $260

Attendance at school/IEP meeting (per hour, prorated):  $260

**Step 3:**Appointment to review test results and recommendations

45 minutes $195.00

60 minutes $260.00

**Early Kindergarten Testing**

IQ only: $260

IQ and Achievement: $520

Full evaluation with report: $725

**Other Fees**

Legal Proceedings per hour/billed in 15 minute increments $600.00

Communications (email, phone) 15 minutes $65.00

Document preparation 15 minutes $65.00

Late cancellations $100.00

No show $195.00

\*\*I reserve the right to alter and update the Fee Schedule

BILLING AND PAYMENTS

You will be expected to pay for each session at the time it is held, unless we agree otherwise. I accept the following methods of payment: credit card, check, and cash. Checks should be made out to Robyn Claar, Ph.D., PLLC. Late charges will be added to accounts with any balance over 30 days old. Late Fees are calculated at a rate of 2% monthly. If your account has not been paid for more than 60 days and you have not arranged payment, I have the option of using legal means to secure payment, including collection agencies or small claims. In most collection situations, the only information released regarding a patient’s treatment is his/her name, the nature of services provided, and the amount due. (If such legal action is necessary, the costs will be included in the claim.) Please note that if you become involved in any legal proceedings that require my participation, you will be expected to pay for all of my professional time, including preparation and transportation costs, even if I am called to testify by another party. Due to the difficulty of legal involvement, my fee is $600 per hour for preparation and attendance at any legal proceeding and will be due in full at the end of each business day.You are strongly discouraged from having me subpoenaed or requesting that records be provided for the purpose of litigation. Although you are responsible for the testimony fee, it does not mean that my testimony will be solely in your favor. Asking a therapist to provide confidential records or testify can damage the trust built in a therapeutic relationship with you and/or your child, especially if you/your child is still actively participating in therapy.

The following fees are in effect for legal action:

1.         Legal Proceedings: $600/hour (billable in 15 minute increments)
2.         Communication (email, phone):  $260/hour (billable in 15 minute increments)

3. Document Preparation: $260/hour (billable in 15 minute increments)

The minimum charge for a court appearance:  $1800

A retainer of $1800 is due at least 72 business hours before the scheduled court appearance. If I am subpoenaed and the case is reset with less than 72 business hours’ notice prior to the beginning of the day of the scheduled subpoena, trial, and/or testimony, then you will be charged $600 (in addition to the original retainer of $1800 for having to appear in court). All fees listed above are doubled if I am scheduled to be out of town at the time of the court appearance.

INSURANCE REIMBURSEMENT

If you have an insurance policy, it will usually provide some coverage for behavioral health treatment. Because I am an out-of-network provider for all insurance companies in my private practice, I will provide you with a receipt at the time of service to submit to your insurance company for direct reimbursement. I strongly encourage you to contact your insurance company prior to services to determine your out-of-network benefits. **I am not able to see patients with Medicare or Medicaid insurance in this office; by signing this agreement, you are confirming that you do not have Medicare or Medicaid insurance. If you enroll in either Medicare or Medicaid at a later time, you agree to notify Dr. Claar immediately.**

You also should be aware that if you request reimbursement from your insurance carrier, your contract with your health insurance carrier requires that I provide them with information relevant to the services that I provide to you. I am required to provide a clinical diagnosis and a service code. Sometimes I am asked to provide information such as treatment plans or summaries or copies of your entire Clinical Record. In such situations, I will make every effort to release only the minimum information that is necessary for the purpose requested. Although all insurance companies claim to keep information confidential, I cannot control what they do with the information once they have it. By signing this Agreement, you agree that I can provide requested information to your insurance carrier if you decide to submit claim forms to them for reimbursement.

CANCELLATION POLICY

Your appointment time is reserved exclusively for you. Once this appointment hour is scheduled, you will be expected to pay for it unless you provide 24 hours advance notice of cancellation. It is important to note that insurance companies do not provide reimbursement for cancelled sessions. In the event of inclement weather, contact me directly for the day’s schedule.

CONTACTING ME

Due to the nature of my work, I am often not immediately available; I do not answer the phone when I am with a patient. When I am unavailable, my telephone is answered by voicemail, which I monitor frequently every day. Please leave a message for me if you get my voicemail, and I will make every effort to respond within 24 hours (with the exception of weekends and holidays). If you cannot reach me and feel that you have an emergency, call 911 or go to the nearest emergency room and ask for the psychiatrist on call. If I will be unavailable for an extended period of time, you will be notified and provided with contact information for another clinician, if necessary.

EMAIL AND TEXTING

Should you decide to contact me via email or text, please note that neither is a secure means of communication, and you are accepting the risk associated with transmitting personal information over the internet or cellular network. Emails and texts should be limited to scheduling, as they are not a means by which I can provide appropriate clinical care. By signing this agreement, you are providing me with permission to send protected health information in unencrypted emails and texts if you choose to communicate with me via these means. Please note that I will take every precaution to guard the privacy and security of personal health-related information, consistent with federal HIPAA standards. These precautions include use of an electronic mail account established on a separate server and use of an electronic signature to ensure that communications are in fact sent by me.

Please recognize that despite these precautions and the fact that they increase the security of email communications between us, your privacy could be breached. If there is a breach of your PHI, I will immediately inform you of the nature and extent of the information involved, the person who obtained the unauthorized access and whether that person has an independent obligation to protect the confidentiality of the information, and the extent to which the risk has been mitigated, such as by obtaining a signed confidentiality agreement from the recipient.

LIMITS ON CONFIDENTIALITY

In general, the law protects the privacy of all communication between a patient and a psychologist. In most situations, I can only release information about your treatment to others if you sign a written authorization form that meets certain legal requirements imposed by HIPAA. However, I must release information without consent in the following situations:

* If I believe that a patient presents an imminent danger to him/herself, I may be required to seek hospitalization for the patient, or contact family members or others who can help provide protection.
* If there is cause to suspect that a child under 18 is abused or neglected or reasonable cause to believe that a disabled adult is in need of protective services, the law requires that a report be filed with the appropriate agency. Once such a report is filed, additional information may be required.
* If there is reason to believe that a patient presents an imminent danger to the health and safety of another, I may be required to disclose information in order to take protective actions, including initiating hospitalization, warning the potential victim, and/or calling the police.
* If a patient files a complaint or lawsuit against me, I may disclose relevant information regarding that patient in order to defend myself.

If such a situation arises in which confidential information needs to be released, I will make every effort to fully discuss it with you before taking any action, and I will limit my disclosure to only information that is necessary.

It is important for you to know that if you are involved in a court proceeding and a request is made for information concerning the professional services that I provided you, such information is protected by the psychologist-patient privilege law. I cannot provide any information without your Authorization or a court order. If you are involved in or contemplating litigation, you should consult with your attorney to determine whether a court would be likely to order me to disclose information.

My practice maintains its own records. Your PHI may not be accessed by others without your authorization. However, in the event of my death or incapacitation, my colleague, Dr. Rebecca Dingfelder, will oversee the short-term clinical operations of my practice. By signing this Agreement, you are consenting to allow Dr. Dingfelder access to your Clinical Record in order to contact you regarding my status and to assist with you with seeking alternative clinical services as needed. If ever I am unable to access your Clinical Record to communicate with you during a clinical emergency, I will ask Dr. Dingfelder to access your Clinical Record during an emergency to assist you with accessing emergency services as well as to contact other parties involved, including law enforcement, to ensure your safety and that of others. Dr. Dingfelder follows the same rules of confidentiality expected of all psychologists. She will protect your privacy and will not further release your PHI without your Authorization.

PATIENT RIGHTS

HIPAA provides you with several new or expanded rights concerning your Clinical Records and disclosures of protected health information. These rights include requesting that I amend your record; requesting restrictions on what information from your Clinical Records is disclosed to others; requesting an accounting of most disclosures of protected health information that you have neither consented to nor authorized; determining the location to which protected information disclosures are sent; having any complaints you make about my policies and procedures recorded in your records; and the right to view and copy your records. I will be happy to discuss any of these rights with you. These rights are explained further in the Privacy Notice.

MINORS AND PARENTS

Parental involvement is essential to successful treatment and therefore some private information should be shared with parents. It is my policy only to share information that is considered necessary with a minor patient’s parents, such as general information about the progress of the child’s treatment and his/her attendance at scheduled sessions. Before giving parents any information I will discuss this information with the child, if possible, and an attempt will be made to handle any objections he/she may have.

Children over the age of eighteen also have the right to independently consent to and receive mental health treatment without parental consent and, in that situation, information about that treatment cannot be disclosed to anyone without the patient’s agreement.

Disclosure of Minor’s Treatment Information to Parents

Therapy is most effective when a trusting relationship exists between the psychologist and the patient. Privacy is especially important in earning and keeping that trust. As a result, it is important for children to have a “zone of privacy” where they feel free to discuss personal matters without fear that their thoughts and feelings will be immediately communicated to their parents. This is particularly true for adolescents who are naturally developing a greater sense of independence and autonomy.

It is my policy to provide you with general information about your child’s treatment, but NOT to share specific information your child has disclosed to me without your child’s agreement. This includes activities and behavior that you would not approve of — or might be upset by — but that do not put your child at risk of serious and immediate harm. However, if your child’s risk-taking behavior becomes more serious, then I will need to use my professional judgment to decide whether your child is in serious and immediate danger of harm. If I feel that your child is in such danger, I will communicate this information to you.

***Example***: If your child tells me that he/she has tried alcohol at a few parties, I would keep this information confidential. If you child tells me that he/she is drinking and driving or is a passenger in a car with a driver who is drunk, I would not keep this information confidential from you. If your child tells me, or if I believe based on things I learn about your child, that your child is addicted to drugs or alcohol, I would not keep that information confidential.

***Example***: If your child tells me that he/she is having voluntary, protected sex with a peer, I would keep this information confidential. If your child tells me that, on several occasions, the child has engaged in unprotected sex with strangers or in unsafe situations, I will not keep this information confidential.

You can always ask me questions about the types of information I would disclose. You can ask in the form of “hypothetical situations,” such as: “If a child told you that he or she were doing \_\_\_\_\_\_\_\_, would you tell the parents?”

Even when we have agreed to keep your child’s treatment information confidential from you, I may believe that it is important for you to know about a particular situation that is going on in your child’s life. In these situations, I will encourage your child to tell you, and I will help your child find the best way to do so. Also, when meeting with you, I may sometimes describe your child’s problems in general terms, without using specifics, in order to help you know how to be more helpful to your child.

Disclosure of Minor’s Treatment Records to Parents

Although the laws of North Carolina may give parents the right to see any written records I keep about your child’s treatment, by signing this agreement, you are agreeing that your child should have a “zone of privacy” in his/her/their meetings with me, and you agree not to request access to your child’s written treatment records.

Parent/Guardian Agreement Not to Use Minor’s Therapy Information/Records in Custody Litigation

When a family is in conflict, particularly conflict due to parental separation or divorce, it is very difficult for everyone, particularly for children. Although my responsibility to your child may require my helping to address conflicts between the child’s parents, my role will be strictly limited to providing treatment to your child. You agree that in any child custody/visitation proceedings, neither parent will seek to subpoena my records or ask me to testify in court, whether in person or by affidavit, or to provide letters or documentation expressing my opinion about parental fitness or custody/visitation arrangements.

Please note that your agreement may not prevent a judge from requiring my testimony, even though I will not do so unless legally compelled. If I am required to testify, I am ethically bound not to give my opinion about either parent’s custody, visitation suitability, or fitness. If the court appoints a custody evaluator, guardian *ad litem*, or parenting coordinator, I will provide information as needed, if appropriate releases are signed or a court order is provided, but I will not make any recommendation about the final decision(s). Furthermore, if I am required to appear as a witness or to otherwise perform work related to any legal matter, the party responsible for my participation agrees to reimburse me at the rate of $600 per hour for time spent traveling, speaking with attorneys, reviewing and preparing documents, testifying, being in attendance, and any other case-related costs.

Parent/Guardian of Minor Patient:

Please initial after each line and sign below, indicating your agreement to respect your child’s privacy:

I will refrain from requesting detailed information about individual therapy sessions with my child. I understand that I will be provided with periodic updates about general progress, and/or may be asked to participate in therapy sessions as needed. \_\_\_\_\_\_\_\_\_\_

Although I may have the legal right to request written records/session notes since my child is a minor, I agree NOT to request these records in order to respect the confidentiality of my child’s/adolescent’s treatment. \_\_\_\_\_\_\_\_\_\_

I understand that I will be informed about situations that could endanger my child. I know this decision to breach confidentiality in these circumstances is up to the therapist’s professional judgment, unless otherwise noted above.

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By signing below I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, acknowledge that I

 (Print) Your Full Name

understand and accept all the terms in the above agreement for services provided by my clinician. I also acknowledge that I have received the HIPAA Notice Form described above.

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Patient’s Signature (required for patients 18 years or older) Date

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Parent or Legal Guardian’s Signature (required for minor patients 17 or younger) Date