

Wynns Family Psychology
Psychological Solutions for Children, Adolescents, and Families

1135 Kildaire Farm Rd., Suite 200
Cary, NC 27511

Telephone: (919) 805-0182
Fax: 267-653-4529

MENTAL HEALTH SERVICE AND FEE AGREEMENT

Information Concerning My Practice, Financial Arrangements, Confidentiality and Patients' Rights

Welcome and thank you for the opportunity to offer our professional help to you. This document (the Agreement) contains important information about our professional services and business policies. **Although these documents are long and sometimes complex, it is very important that you read these policies carefully and ask for clarification when needed. When you sign this document, it will also represent an agreement between us.** You may revoke this Agreement in writing at any time. That revocation will be binding on us unless we have taken action in reliance on it; if there are obligations imposed on us by your health insurer in order to process or substantiate claims made under your policy; or if you have not satisfied any financial obligations you have incurred. Please let us know if we can clarify any of this information and if you have any other questions.

Psychological Services: We make every effort to provide you with the highest quality mental health services available. These services include: therapy for individuals, groups, couples and families; play therapy for children; educational and psychological evaluations; custody and visitation evaluations; and consultation. All independent contractors at Wynns Family Psychology hold doctoral level degrees in Clinical Psychology. All are also licensed to practice psychology in North Carolina or are currently completing their licensure hours under the supervision of a licensed psychologist. If your psychological services are not directly provided from Kristen Wynns, this contract is between you and your service provider; it is not between you and Wynns Family Psychology or any other member of Wynns Family Psychology. Your provider is an Independent Contractor and as such is solely responsible for determining the method, details and means of performing services. As an Independent Contractor, your provider is solely responsible for his/her clinical and non-clinical decisions and services, regardless of whether or not he/she has discussed the case with Dr. Wynns and/or other associates of Wynns Family Psychology, or engaged in any other outside peer review. **We do not provide emergency services,** though we certainly will make every attempt to be available to you as soon as possible should a crisis occur. For psychological emergencies, call 911 or go to the nearest hospital and ask for the psychiatrist on call.

Insurance/Payment: As health care providers, our relationship is with you and not your insurance company. Current research indicates that a treatment program that places the needs of the patient first is the most beneficial in the long run. Unfortunately, many insurance plans place significant limits on your choice of health care provider, on the amount of services that you can receive, and on the amount of money that can be charged for and spent on services. If you wish, we will assist you in understanding your insurance benefits for mental health services by contacting your insurer, so that you will be clear about what portion of our services will be reimbursed to you by your insurance company.

Please See Reverse →

We will also be happy to help you process your insurance claims for reimbursement by providing you with a receipt of services rendered, which contains all of the information needed for an insurance company to process a claim, and by helping you fill out your claim forms. It is your responsibility, should you desire reimbursement to yourself, to process the claim with your insurance provider. **Please be advised that we are “out of network” providers with insurance companies.** You should also be aware that your contract with your health insurance company requires that we provide it with information relevant to the services that we provide to you, including a clinical diagnosis. If we are required to provide additional clinical information we make every effort to release only the information about you that is necessary for the purposes requested. By signing this Agreement, you agree that we can provide requested information to your carrier. Please note that you always have the right to pay for our services without seeking insurance reimbursement in order to avoid the problems described above. **All charges are your responsibility from the date services are rendered, and payment for services is due in full on the date services are rendered.** Payment in full will be collected at every session. Checks are payable to Kristen Wynns, Ph.D., PLLC. If you prefer to pay via credit card, payment is due *before* your scheduled session. You may go to our website, www.wynnsfamilypsychology.com, and click on the link to PayPal. **Please include your name in the “Description” section so that your payment can be properly applied to your account.**

Schedule of Fees: (1) Individual, Couples, or Family Therapy Session (60 minutes: \$140.00/ 75 minutes: \$165.00/ 90 minutes: \$190.00). The first appointment is a 75 minute session (\$165.00 charge.) **Please note that “therapy time” includes the last 15 minutes left for your psychologist to complete a session note.** Thus 60 minutes = 45 minutes face-to-face time, 75 minutes = 60 minutes face-to-face time, and 90 minutes = 75 minutes face-to-face time. (2) Group Therapy session (75 minute session): \$75.00 (3)Evaluation: Educational, psychological and custody evaluations provided. If you are having an evaluation, we will provide you a separate form with detailed descriptions of what evaluations involve and the cost. (4) All other services, including phone calls, letters, email (reading or responding), and telephone consultation (psychiatrists, physicians, teachers, guidance counselors, attorneys, etc.) are billed at \$165.00 per hour. Meetings attended on your behalf are also billed at \$165 per hour, including travel time. (5) Depositions as fact or expert witness \$250.00 per hour time preparing for and giving deposition, port to port; testimony as fact or expert witness \$350.00 per hour time preparing for and giving testimony, port to port. If we receive a subpoena to testify with respect to your case, the above fees apply no matter who issues the subpoena. (6) Late Fees & Returned Checks: **If you do not pay in full on the date services are rendered, finance charges are added if you do not make a payment within 30 days.** Late charges are computed at 20% monthly for any balance over 30 days old. If your account has not been paid for more than 60 days and arrangements for payment have not been agreed upon, we have the option of using legal means to secure the payment. This may involve hiring a collection agency or going through small claims court, which will require us to disclose otherwise confidential information such as your name, address, phone number, services rendered, or the amount due. If legal action or a collection agency is necessary, you will be responsible for paying any fees involved. **Regarding fees for returned checks, there is a \$35 fee for each returned check in addition to late fees.** (7) No Show/Late Cancel: Full fee.

Cancellations and Rescheduling: Your appointment time is reserved exclusively for you. Please help us serve you better by keeping scheduled appointments. **The full fee is charged for appointments missed and for appointments cancelled less than 48 hours in advance.** It is important to note that insurance companies do not provide reimbursement for missed or cancelled sessions.

Confidentiality & Patients' Rights: The law protects the privacy of all communications between a patient and a psychologist. In most situations, we can only release information about your treatment to others if you sign a written Authorization form that meets certain legal requirements imposed by HIPAA. There are other situations that require only that you provide written, advance consent. Your signature on this Agreement provides consent for those activities, as follows:

--Please note that we do discuss cases internally at Wynns Family Psychology in peer supervision, and by signing you give permission for these discussions. We sometimes consult other health and mental health professionals about a case. During a consultation, we make every effort to avoid revealing your identity. The other professionals are also legally bound to keep the information confidential.

--Disclosures required by healthcare insurers or for overdue fee collection are discussed elsewhere in this Agreement.

As a general rule, outside of peer consultation, we will not disclose information regarding a patient unless authorized to do so by the patient in writing. However, there are legal exceptions to this rule of confidentiality; these are described in the attached Notice of Privacy Practices, The Health Insurance Portability and Accountability Act. HIPAA is a federal law that provides privacy protections and patient 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. The Notice explains HIPAA and its application to your personal health information in greater detail. The law requires that we obtain your signature acknowledging that we have provided you with this information.

Minors & Parents: In the state of North Carolina, children and adolescents less than 18 years of age cannot independently consent to or receive mental health treatment without parental consent. While privacy in psychotherapy is very important, particularly with adolescents, parental involvement is also essential to successful treatment and this may require that some private information be shared with parents. It is our policy not to provide treatment to a child under 18 unless he/she agrees that we can share general information about the progress of his/her treatment and attendance at scheduled sessions. Before giving parents any information, we will discuss the matter with the minor if possible, and do our best to handle any objections he/she may have, unless we feel that the child is in danger or is a danger to someone else, in which case, we will notify the parents (or other authorities) of our concern immediately and regardless of any objections the minor may have to us doing so.

Parents, Informed Consent & Divorce: If you share legal custody and your divorce decree notes that you must inform the other parent of health appointments, please note that our services fall under this, and you may be in violation of a court order if you fail to inform the other parent of our services with your child. Also note that to provide consent for

treatment for your child you must either have sole legal custody OR have shared legal custody, and if you have no legal custody you cannot provide consent for treatment. **By signing below you are stating that you have the legal right to consent for this child.**

Contacting Your Psychologist: Please note we will not answer the telephone when we are with a client. When we are unavailable, our telephone is answered by confidential voice mail that we monitor frequently. We will make every effort to return your call on the same day you make it, or at least within 24 hours, with the exception of weekends and holidays.

Email is not a secure form of communication and confidentiality cannot be guaranteed. We will respond should you choose to email us regarding non-clinical issues such as appointment scheduling. **Please note we will not engage in “therapy” nor respond to casual “chats” via email. If you choose to share clinical information via email, we will bill for the time reading it and discuss it with you at your next therapy session or offer to schedule a phone consultation.**

In Case Of An Emergency: **As noted above, we do not provide emergency services, and thus you should exercise one of the following options in an emergency: contact your psychiatrist or primary care physician, go to the nearest hospital emergency room and ask to speak with the psychiatrist on call, and/or follow your insurance carrier’s emergency procedures.**

PLEASE BE SURE AND COMPLETE ALL INFORMATION ON PAGE 5. THANK YOU.

NPP ACKNOWLEDGEMENT OF RECEIPT FORM

This form, when completed by you, acknowledges that you have had the opportunity to review the HIPPA Notice of Privacy Practices. I understand that if requested I may have a copy to keep.

I, (print full legal name) _____, acknowledge that I have reviewed a copy of the Notice of Privacy Practices for Wynns Family Psychology on this date _____ (month, day, year).

Signature of Patient or Personal Representative

Date

If the acknowledgment is signed by a personal representative of the patient, the name of the patient and a description of such representative's authority to act for the patient must be provided.

Patient's name (Printed)

Authority to act for patient (e.g., parent or legal guardian) – (Printed)

Therapist-Patient Services Agreement

YOUR SIGNATURE BELOW INDICATES THAT YOU HAVE READ AND UNDERSTOOD THIS DOCUMENT AND AGREE TO ABIDE BY ITS TERMS DURING OUR PROFESSIONAL RELATIONSHIP. Please ask for clarification of any information you are unclear about. By signing below you are also certifying that you have been given a copy of the Notice of Privacy Practices.

I have read and understand the Service and Fee Agreement. I agree to the statements herein and terms of payment, to include payment of fees listed for fact or expert witness testimony.

This document was discussed with me and any questions I had were discussed as well.

Name of Patient (Printed)

Date

Name of Patient (Printed)

Date

Signature of Patient or Personal Representative

**** FOR OFFICE USE ONLY ****

**Out-of-Network Mental Health Benefits
For Out-Patient Care / Office Visits**

1. Is there a deductible? Yes No
If yes, amount of deductible?
If yes, is that a calendar year or a benefit year?
If benefit year, dates?
If yes, how much of the deductible have they met to date?
2. Pre-authorization required? Yes No
3. What percent do they cover and what percent is left for the client to cover?
Insurance pays: _____
Patient pays: _____
4. Are there session limits? Yes No
If yes, # allotted per year?
If yes, is that a calendar year or a benefit year?
If benefit year, dates?
If yes, how many of the allotted have they used to date?
5. Do they cover family and/or group therapy in addition to individual therapy? (CPT codes)
- | | | |
|--------------------|-----|----|
| Individual (90806) | Yes | No |
| Family (90847) | Yes | No |
| Group (90853) | Yes | No |
6. Do they cover psychological testing? (96101)
Any restrictions on testing, such as diagnoses they won't allow testing for or types of tests?

**In-Network Mental Health Benefits
For Out-Patient Care / Office Visits**

1. Is there a deductible? Yes No
If yes, amount of deductible?
If yes, is that a calendar year or a benefit year?
If benefit year, dates?
If yes, how much of the deductible have they met to date?
2. Pre-authorization required? Yes No
3. What percent do they cover and what percent is left for the client to cover?
Insurance pays: _____
Patient pays: _____
4. Are there session limits? Yes No
If yes, # allotted per year?
If yes, is that a calendar year or a benefit year?
If benefit year, dates?
If yes, how many of the allotted have they used to date?
5. Do they cover family and/or group therapy in addition to individual therapy? (CPT Codes)
- | | | |
|--------------------|-----|----|
| Individual (90806) | Yes | No |
| Family (90847) | Yes | No |
| Group (90853) | Yes | No |
6. Do they cover psychological testing? (96101)
Any restrictions on testing, such as diagnoses they won't allow testing for or types of tests?