

**PAUL BAIL, PH.D. aka LEOMINSTER WELLNESS**

**This document consists of two parts. Please read both carefully.**

**PART 1: OUTPATIENT SERVICES CONTRACT AND INFORMED CONSENT**

**PSYCHOLOGICAL SERVICES**

Psychotherapy is not easily described in general statements. It varies depending on the personalities of the psychologist and patient, and the particular problems you bring forward. There are many different methods I may use to deal with the problems that you hope to address. Psychotherapy is not like a medical doctor visit. Instead, it calls for a very active effort on your part. In order for the therapy to be most successful, you will have to work on things we talk about both during our sessions and at home.

Psychotherapy can have benefits and risks. Since therapy often involves discussing unpleasant aspects of your life, you may experience uncomfortable feelings like sadness, guilt, anger, frustration, loneliness, and helplessness. On the other hand, psychotherapy has also been shown to have benefits for people who go through it. Therapy often leads to better relationships, solutions to specific problems, and significant reductions in feelings of distress. But there are no guarantees of what you will experience.

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 first impressions of what our work will include and a treatment plan to follow, if you decide to continue with therapy. You should evaluate this information along with your own opinions of whether you feel comfortable working with me. Therapy involves a large commitment of time, money, and energy, so you should be very careful about the therapist you select. If you have questions about my procedures, we should discuss them whenever they arise. If your doubts persist, I will be happy to help you set up a meeting with another mental health professional for a second opinion.

**MEETINGS**

I normally conduct an evaluation that will last for 3 sessions. During this time, we can both decide if I am the best person to provide the services you need in order to meet your treatment goals. A session is 45 minutes (one appointment hour of 45 minutes duration). Once an appointment hour is scheduled, you will be expected to pay for it unless you provide 24 hours advance notice of cancellation. My specialty is brief time-limited therapy, 10 sessions or less.

**BILLING AND PAYMENTS**

You will be expected to pay for each session at the time it is held, unless we agree otherwise or unless you have insurance coverage which requires another arrangement. Payment schedules for other professional services will be

agreed to when they are requested. In circumstances of unusual financial hardship, I may be willing to negotiate a fee adjustment.

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. 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.

### **INSURANCE REIMBURSEMENT**

It is important to evaluate what resources you have available to pay for your treatment. You (not your insurance company) are responsible for full payment of my fees. It is very important that you find out exactly what mental health services your insurance policy covers. **Blue Cross normally pays for 10 sessions, but you should check your individual policy.** It is necessary to seek approval for more therapy after a certain number of sessions, and this is at the discretion of the insurance reviewer. While a lot can be accomplished in short-term therapy, some patients feel that they need more services after insurance benefits end. You always have the right to pay for extended services yourself if your insurer refuses to authorize additional sessions.

You should carefully read the section in your insurance coverage booklet that describes mental health services. If you have questions about the coverage, call your plan administrator. Of course I will provide you with whatever information I can based on my experience and will be happy to help you in understanding the information you receive from your insurance company. If it is necessary to clear confusion, I will be willing to call the company on your behalf.

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. This information will become part of the insurance company files and will probably be stored in a computer. Though insurance companies have a duty to keep such information confidential, I have no control over what they do with it once it is in their hands. I will provide you with a copy of any report I submit, if you request it.

### **CONTACTING ME**

I am often not immediately available by telephone. You may call me during normal business hours at 978 821-4430. When I am unavailable, my telephone is answered by voice mail. I will try to return your call on the same day you make it, with the exception of weekends and holidays. If you are difficult to reach, please inform me of some times when you will be available. If you are unable to reach me and feel that you can't wait for me to return your call, contact your family physician or the nearest emergency room and ask for the psychologist on call. If I will be away or unavailable for an extended time, I will provide you with the name of a colleague to contact, if necessary.

### **PROFESSIONAL RECORDS**

The laws and 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.

The laws and standards of my profession require that I keep treatment records. You are entitled to receive a copy of the records unless I believe that seeing them would be emotionally damaging, in which case I will be happy to send them to a mental health professional of your choice. Because these are professional records, they can be misinterpreted and/or upsetting to untrained readers. I recommend that you review them in my presence so that we can discuss the contents. Patients will be charged an appropriate fee for any time spent in preparing information requests.

### **MINORS**

If you are under eighteen years of age, please be aware that the law may provide your parents the right to examine your treatment records. I will ask your parents if they are willing to give up access to your records. If they agree, I will provide them only with general information about our work together, unless I feel there is a high risk that you will seriously harm yourself or someone else. In this case, I will notify them of my concern. I will also provide them with a summary of your treatment when it is complete. Before giving them any information, I will discuss the matter with you, if possible, and do my best to handle any objections you may have with what I am prepared to discuss.

### **CONFIDENTIALITY**

In general, the privacy of all communications between a patient and a psychologist is protected by law, and I can only release information about our work to others with your written permission. But there are a few exceptions.

(1.) In most legal proceedings, you have the right to prevent me from providing any information about your treatment. In some proceedings involving child custody and those in which your emotional condition is an important issue, a judge may order my testimony if he/she determines that the issues demand it.

(2.) There are some situations in which I am legally obligated to take action to protect others from harm, even if I have to reveal some information about a patient's treatment. For example, if I believe that a child, elderly person, or disabled person is being abused, I must file a report with the appropriate state agency.

(3.) If I believe that a patient is threatening serious bodily harm to another, I am required to take protective actions. These actions may include notifying the potential victim, contacting the police, or seeking hospitalization for the patient. If the patient threatens to harm himself/herself, I may be obligated to seek hospitalization for him/her or to contact family members or others who can help provide protection.

These situations have 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.

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 patient. 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.

**IMPORTANT: PLEASE RESPOND IN WRITING OR BY EMAIL INDICATING THAT YOU HAVE RECEIVED AND READ THIS CONTRACT AND ARE IN AGREEMENT. YOUR RETURN EMAIL WILL BE THE EQUIVALENT OF YOUR SIGNATURE.**

**NOTE: Unencrypted email is not a 100% secure means of communication. If you have concerns about the privacy of email, please print out a copy of this, sign it, and bring it to your first appointment.**

If you have any questions about anything outlined above, please contact me for clarification before signing – 978 821-4430

## **PART 2: STANDARD HIPAA NOTIFICATION**

### **PRIVACY POLICIES OF**

**PAUL BAIL PH.D. aka LEOMINSTERWELLNESS**

**HIPAA – Health Insurance Portability and Accountability Act**

### **REQUIRED NOTICES**

#### **Notice of Information Practices**

THIS NOTICE DESCRIBES HOW PERSONAL HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

#### **Understanding Your Health Record/Information**

Each time you visit a provider, a record of your visit is made. Typically, this record contains your diagnoses, treatment, and a plan for future care or treatment. This information, often referred to as your health or medical record, serves as a:

- basis for planning your care and treatment
- means of communication among the many health professionals who contribute to your care
- legal document describing the care you received
- means by which you or a third-party payer can verify that services billed were actually provided
- a tool with which we can assess and continually work to improve the care we render and the outcomes we achieve

Understanding what is in your record and how your health information is used helps you to: ensure its accuracy, better understand who, what, when, where, and why others may access your health information, and make more informed decisions when authorizing disclosure to others.

#### **Our Responsibilities**

I am required to:

- maintain the privacy of your health information
- provide you with a Notice as to our legal duties and privacy practices with respect to information
- we collect and maintain about you
- abide by the terms of this Notice
- notify you if we are unable to agree to a requested restriction
- accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations.

We reserve the right to change our practices and to make the new provisions effective for all protected health information we maintain. Should our information practices change, we will mail you a revised notice. We will not use or disclose your health information without your authorization, except as described in this notice.

### **How We Will Use or Disclose Your Health Information**

#### **Disclosures that require your explicit consent:**

(1) Treatment. *With your consent* we will communicate with other mental health care providers (such as a psychiatrist) or substance abuse care providers, or with your primary care physician if this is necessary in order to properly coordinate care. This might be especially true if you are taking psychiatric medications. It may be important to communicate with your prescriber.

(2) Communication with family. *With your written permission*, we may disclose to a family member, other relative, close personal friend or any other person you identify, health information relevant to that person's involvement in your care or payment related to your care.

#### **Disclosures that you implicitly consent to by entering into a therapeutic contract:**

(3) Payment. We will use your health information for payment without your consent from the third party payer you designate, including Blue Cross, Medicare, Medicaid, or other health insurance. The information on or accompanying the bill will be *limited* to that information necessary to establish the claims for which reimbursement is sought. For example, the bill may include information of the dates, types and costs of therapies and services, and a general description of the general purpose of each treatment session or service.

(4) Emergencies. In a psychiatric emergency where your life or physical well being, or the life or physical well being of someone else, is in serious danger, we may for that brief period, without your consent, communicate to other professionals the minimum amount of information necessary to establish your safety or the safety of another identifiable person.

(5) Mandated Reporting. In cases of child abuse or neglect, elder abuse, or the abuse or neglect of a handicapped person we are legally required to report the relevant information concerning the abuse or neglect to the appropriate state-mandated authority, such as DCF.

**Note:** We take your privacy very seriously. The situations described under 4 and 5 are extremely rare. In such cases we make every effort to discuss the disclosure with you beforehand and to try to obtain your consent. Furthermore, we limit the information disclosed to the bare minimum necessary to fulfill our legal responsibility,

### **Your Health Information Rights**

- Although your health record is the physical property of the provider, the information in your health record belongs to you. You have the following rights:
- You may request that we not use or disclose your health information for a particular reason related to treatment, payment, or general health care operations, and/or to a personal representative or guardian. We ask that such requests be made in writing. Although we will consider your request, please be aware that we are not required to accept it or to abide by it.
- If you are dissatisfied with the manner in which or the location where you are receiving communications from us that are related to your health information, you may request that we provide you with such information by alternative means or at alternative locations. Such a request must be made in writing, and can be submitted to me.
- We will attempt to accommodate all reasonable requests.
- You may request to inspect and/or obtain copies of health information about you, which will be provided to you in the time frames established by law. If you request copies we will charge you a reasonable fee.
- If you believe that any health information in your record is incorrect or if you believe that important information is missing, you may request that we correct the existing information or add the missing information. Such requests must be made in writing, and must provide a reason to support the amendment.
- You may request that we provide you with a written accounting of all disclosures made by us during the time period for which you request (not to exceed 6 years). We ask that such requests be made in writing. Please note that an accounting will not apply to any of the following types of disclosures: disclosures made for reasons of treatment, payment or health care operations; disclosures made to you or your legal representative, or any other individual involved with your care with your written consent; disclosures as a result of subpoena; and disclosures for national security purposes. You will not be charged for your first accounting request in any 12-month period. However, for any requests that you make thereafter, you will be charged a reasonable, cost-based fee.
- You have the right to obtain a paper copy of our Notice of Information Practices upon request.
- You may revoke an authorization to use or disclose health information, except to the extent that action has already been taken. Such a request must be made in writing.

### **For More Information or to Report a Problem**

If have questions and would like additional information, you may contact me directly at Paul Bail, Ph.D., PO Box 7551, Fitchburg MA 01420 978 821-4430

If you believe that your privacy rights have been violated, you may file a complaint with us. These complaints must be filed in writing. You may also file a complaint with the secretary of the federal Department of Health and Human Services. There will be no retaliation for filing a complaint.

The date these policies went into effect is April 1, 2003. You will be notified of any future changes to these policies.

**PLEASE ACKNOWLEDGE IN WRITING OR BY RETURN EMAIL THAT YOU HAVE RECEIVED THE HIPAA INFORMATION. IF YOU ACKNOWLEDGE BY EMAIL, YOUR RETURN EMAIL IS THE EQUIVALENT OF YOUR SIGNATURE ACKNOWLEDGING RECEIPT OF THIS. I**

If you have any questions about the policies described above, please contact me for clarification before signing.

**NOTE: Unencrypted email is not a 100% secure means of communication. If you have concerns about the privacy of email, please print out a copy of this, sign it, and bring it to your first appointment.**

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If you prefer not to reply by email, please print out the form, affix your signature below and bring it to your first appointment.

**SIGNATURE** (if not "signing" by return email)

***I have read both the above contract/informed consent AND the HIPAA privacy notice. If I had any questions about these I have received a satisfactory response. I acknowledge my receipt of these and I consent to the procedures and principles described above.***

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Signature

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Date signed

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Your printed name