Ray Hand, Ph.D.
PSYCHOLOGIST

3106 Norcrest Drive
Oklahoma City, Oklahoma 73121
voice 405-557-1989

www.rayhand.net
email rayhand@rayhand.net
fax 405-525-8477

PSYCHOLOGIST-CLIENT SERVICES AGREEMENT

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 I provide you with a Notice of Privacy Practices (the Notice) for use and disclosure of PHI for treatment, payment and health care operations. The Notice, attached to this Agreement, explains HIPAA and its application to your personal health information in greater detail. The law requires that I obtain your signature acknowledging that I have provided you with this information prior to beginning therapy. It is very important that you read them carefully. We can discuss any questions you have about the procedures before you provide your signature. 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 me unless: 1) I have already taken some action that relied on it; 2) if there are obligations imposed on me by your health insurer in order to process or substantiate claims made under your policy; or 3) if you have not satisfied any financial obligations you have incurred.

PSYCHOLOGICAL SERVICES

The first part of any psychological consultation involves an initial diagnostic assessment. The purpose of this initial evaluation is to identify your problems, concerns and symptoms so that you can receive immediate and efficient diagnosis and treatment. Part of the initial evaluation may involve you and/or your child completing questionnaires and psychological tests. Several hours of time may be required but it allows me to get necessary information about your concerns and symptoms in the most cost effective manner. A written report of this diagnostic evaluation is prepared and will be available to you or others you designate.

After the initial evaluation we will discuss treatment options and I will recommend a course of treatment to you. Treatment recommendations are based on the most current scientific literature and it is my responsibility to provide information regarding the procedures, goals and possible side effects of any psychological treatment. Psychological evaluation and treatment can be tremendously beneficial for many individuals but there are some risks. Potential risks may include the experience of intense feelings of sadness, anger, fear, guilt or anxiety. It is important to remember that these feelings may be quite normal and they are an important part of the therapeutic process.

The length of the evaluation or therapy is determined by the type of symptoms or issues you are addressing, your goals and the type of therapy necessary for treatment. I hope to provide the most effective evaluation and/or treatment in the shortest amount of time.

Discontinuing psychological services can be a constructive, useful process. It may occur at any time and may be initiated by the client or by the psychologist. If you decide to discontinue, I request that you tell me so we can discuss your reasons. Regardless of the reason for stopping an evaluation or treatment, I will make an appropriate referral if further services are needed.

MEETINGS

I normally conduct an initial intake session to obtain relevant background information and to identify your current needs and reasons for seeking therapy. During this time and the first several sessions, we can both decide if I am the best person to provide the services you need in order to meet your treatment goals. If you decide to begin psychotherapy, I will usually schedule one 45-minute session per week at a time we agree on, although some sessions may be longer or more frequent. If you schedule further appointments, please let me know if you can't make it. I can't charge insurance for missed appointments and don't like to charge clients. If you miss more than an appointment or two without notice I probably won't schedule further meetings.

PROFESSIONAL FEES

The charges for my services are based on the usual, customary and reasonable fee profiles for the Oklahoma City area. My fee for an Initial Psychological Interview is $175. The Psychotherapy fee is $150 per 45 minute psychological therapy session. This fee also includes my time spent on your behalf, including record keeping and consultation. Fees for psychological assessments vary according to the extent and nature of the assessment and can range from $250 to $2000. Please clarify assessment fees before proceeding with any psychological evaluation. I also encourage you to discuss fees with me at any time. My clients are expected to pay for services at the time that they are provided unless other arrangements have been made in advance. It is important for you to understand that I am ethically prohibited from billing health insurance companies for any forensic evaluation or forensic consultation.

CONTACTING ME

Due to my work schedule and off-site consulting agreements, I am rarely immediately available by telephone. My telephone is answered by RSVP Telephone Answering Service. A telephone secretary will take your message and immediately send me a text page. I will make every effort to return your call on the same day you make it. 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 or psychiatrist on call. If I will be unavailable for an extended time, I will provide you with the name of a colleague to contact, if necessary.

LIMITS ON CONFIDENTIALITY

The law protects the privacy of all communications between a client 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. There are other situations that require only that you provide written, advance consent. Your signature on this Agreement provides consent for the following:

- I may occasionally find it helpful to consult other health and mental health professionals about a case. During a consultation, I make every effort to avoid revealing the identity of my client. The other professionals are 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. I will note all consultations in your Clinical Record (which is called "PHI" in my Notice of Psychologist's Policies and Practices to Protect the Privacy of Your Health Information).
- You should be aware that I employ administrative staff. In most cases, I need to share protected information with these individuals for administrative purposes, such as billing. All staff members have been given training about protecting your privacy and have agreed not to release any information outside of the practice without my permission.
- Disclosures required by health insurers or to collect overdue fees are discussed elsewhere in this Agreement.

There are some situations where I am permitted or required to disclose information without either your consent or Authorization:

- If you are involved in a court proceeding and a request is made for information concerning your diagnosis and treatment, such information is protected by the psychologist-client privilege law. I cannot provide any information without your (or your personal or legal representative's) written 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.
- If a government agency is requesting the information for health oversight activities, I may be required to provide it for them.
- If a client files a complaint or lawsuit against me, I may disclose relevant information regarding that client in order to defend myself.
- If a client files a worker's compensation claim, I may disclose information relevant to that claim to the appropriate parties, including the Administrator of the Workers' Compensation Court.

There are some situations in which I am legally obligated to take actions, which I believe are necessary to attempt to protect others from harm and I may have to reveal some information about a client's treatment If such a situation arises, I will make every effort to fully discuss it with you before taking any action and I will limit my disclosure to what is necessary. These situations are unusual in my practice.

- If I have reason to believe that a child under the age of 18 years is the victim of abuse or neglect, the law requires a report to the appropriate government agency, usually the Department of Human Services. Once such a report is filed, I may be required to provide additional information.
- If I have reason to believe that a vulnerable adult is suffering from abuse, neglect, or exploitation, the law requires that I report to the appropriate government agency, usually the Department of Human Services. Once such a report is filed, I may be required to provide additional information.
- If a client communicates an explicit threat to kill or inflict serious bodily injury upon a reasonably identifiable victim and he/she has the apparent intent and ability to carry out the threat, or if a client has a history of violence and I have reason to believe that there is a clear and imminent danger that the client will attempt to kill or inflict serious bodily injury upon a reasonably identified person, I may be required to take protective actions. These actions may include notifying the potential victim, contacting the police, and/or seeking hospitalization for the client.
- If a client 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.

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 now or in the future. The laws governing confidentiality can be quite complex, and I am not an attorney. In situations where specific advice is required, formal legal advice may be needed.

PROFESSIONAL RECORDS

The laws and standards of my profession require that I keep Protected Health Information about you in your Clinical Record. Except in unusual circumstances that involve danger to yourself and/or others or where information has been supplied to me confidentially by others, you may examine and/or receive a copy of your Clinical Record if you request it in writing. Because these are professional records, they can be misinterpreted and/or upsetting to untrained readers. For this reason, I recommend that you initially review them in my presence, or have them forwarded to another mental health professional so you can discuss the contents. In most circumstances, I am allowed to charge a copying fee of $0.10 per page (and for certain other expenses). If I refuse your request for access to your records, you have a right of review, which I will discuss with you upon request.

CLIENT RIGHTS

HIPAA provides you with several new or expanded rights with regard to your Clinical Record and disclosures of protected health information. These rights include requesting that I amend your record; requesting restrictions on what information from your Clinical Record 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 a paper copy of this Agreement, the attached Notice form, and my privacy policies and procedures. I am happy to discuss any of these rights with you.

MINORS & PARENTS OR GUARDIANS

Clients under 18 years of age who are not emancipated and their parents or guardians should be aware that the law allows parents or guardians to examine their child's treatment records. Because privacy in psychotherapy is often crucial to successful progress, particularly with teenagers, it is my policy to request an agreement from parents or guardians that, during treatment, I will provide them only with general information about the progress of the child's treatment and his/her attendance at scheduled sessions. Other communication will require the child's agreement, unless I feel that the child is in danger or is a danger to someone else, in which case, I will notify the parents or guardians of my concern.

BILLING AND PAYMENTS

You will be expected to pay for each session at the time it is held, unless we agree otherwise. Any payment schedule for professional services will be established before initiating the service. Your signature below also acknowledges your understanding that Dr. Hand is ethically prohibited from billing health insurance companies for any forensic evaluation or forensic consultation.

INSURANCE REIMBURSEMENT

With the exception of SoonerCare (Medicaid) for children I do not typically file insurance for clients. At the end of each session I will provide a Patient Service Record (PSR) that contains all the information necessary for you to file your own insurance. It is important to understand that your insurance plan may not cover out-of-network providers or may reimburse you for my services at a substantially reduced rate. You are agreeing here to be responsible for the fee we establish. If you have any questions about your insurance coverage you should ask your plan administrator.

If you choose to request reimbursement from your insurance company for your treatment expenses, you should be aware that your contract with your health insurance company likely requires that I provide it with information about my services to you. I am usually required to provide a clinical diagnosis. Sometimes I am required to provide additional clinical 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 about you that is necessary for the purpose requested. This information will become part of the insurance company files and will probably be stored in a computer. Though all insurance companies claim to keep such information confidential, I have no control over what they do with it once it is in their hands. In some cases, they may share the information with a national medical information databank. I will provide you with a copy of any report I submit, if you request it. By signing this Agreement, you agree that I can provide requested information to your carrier if you choose to request reimbursement for fees paid to me by you personally or through your insurance plan.

OKLAHOMA NOTICE FORM

Notice of Psychologists' Policies and Practices to Protect the Privacy of Your Health Information

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

I. Uses and Disclosures for Treatment, Payment, and Health Care Operations
I may *use* or *disclose* your *protected health information* (*PHI*), for *treatment, payment, and health care operations* purposes with your *consent*. To help clarify these terms, here are some definitions:

- "*PHI*" refers to information in your health record that could identify you.
- *"Treatment, Payment and Health Care Operations"*
  - *Treatment* is when I provide, coordinate or manage your health care and other services related to your health care. An example of treatment would be when I consult with another health care provider, such as your family physician or another psychologist.
  - *Payment* is when I obtain reimbursement for your healthcare. Examples of payment are when I disclose your PHI to your health insurer to obtain reimbursement for your health care or to determine eligibility or coverage.
  - *Health Care Operations* are activities that relate to the performance and operation of my practice. Examples of health care operations are quality assessment and improvement activities, business-related matters such as audits and administrative services, and case management and care coordination.
- "*Use*" applies only to activities within my office, such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.
- "*Disclosure*" applies to activities outside of my office, such as releasing, transferring, or providing access to information about you to other parties.

II. Uses and Disclosures Requiring Authorization
I may use or disclose PHI for purposes outside of treatment, payment, and health care operations when your appropriate authorization is obtained. An "*authorization*" is written permission above and beyond the general consent that permits only specific disclosures. In those instances when I am asked for information for purposes outside of treatment, payment and health care operations, I will obtain an authorization from you before releasing this information.

You may revoke all such authorizations at any time, provided each revocation is in writing. You may not revoke an authorization to the extent that (1) I have relied on that authorization; or (2) if the authorization was obtained as a condition of obtaining insurance coverage, and the law provides the insurer the right to contest the claim under the policy.

III. Uses and Disclosures with Neither Consent nor Authorization
I may use or disclose PHI without your consent or authorization in the following circumstances:

- **Child Abuse:** If I treat a child who appears to be the victim of physical or sexual abuse, I must report such to the nearest law enforcement agency or Oklahoma Department of Human Services.
- **Adult and Domestic Abuse:** If I have reason to believe that a vulnerable adult (defined below) is suffering from abuse, neglect or exploitation, I am required by law to make a report to either the Oklahoma Department of Human Services, the district attorney's office, or the municipal police department as soon as I become aware of the situation.

  A "vulnerable adult" means an individual who is an incapacitated person or who, because of physical or mental disability, incapability, or other disability, is substantially impaired in the ability to provide adequately for the care or custody of him or herself, or is unable to manage his or her property and financial affairs effectively, or to meet essential requirements for mental or physical health or safety, or to protect him or herself from abuse, neglect, or exploitation without assistance from others.
- **Health Oversight:** If you file a disciplinary complaint against me with the Oklahoma State Board of Examiners of Psychologists, they would have the right to view your relevant confidential information as part of the proceedings.

- **Judicial or administrative 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 the information without written authorization from you or your personal or legally appointed representative, or a court order. The privilege does not apply when you are being evaluated 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:** If you communicate to me an explicit threat to kill or inflict serious bodily injury upon a reasonably identifiable person, and you have the apparent intent and ability to carry out that threat, I have the legal duty to take reasonable precautions. These precautions may include disclosing relevant information from your mental health records, which is essential to protect the rights and safety of others. I also have such a duty if you have a history of physical violence of which I am aware, and I have reason to believe there is a clear and imminent danger that you will attempt to kill or inflict serious bodily injury upon a reasonably identifiable person.
- **Worker's Compensation:** If you file a worker's compensation claim, you will be giving permission for the Administrator of the Worker's Compensation Court, the Oklahoma Insurance Commissioner, the Attorney General, a district attorney (or a designee for any of these) to examine your records relating to the claim.

IV. Client's Rights and Psychologist's Duties

Client's Rights:

- *Right to Request Restrictions* You have the right to request restrictions on certain uses and disclosures of protected health information about you. However, I am not required to agree to a restriction you request.
- *Right to Receive Confidential Communications by Alternative Means and at Alternative Locations* – You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations. (For example, you may not want a family member to know that you are seeing me. Upon your request, I will send your bills to another address.)
- *Right to Inspect and Copy* – You have the right to inspect or obtain a copy (or both) of PHI in my mental health and billing records used to make decisions about you for as long as the PHI is maintained in the record. I may deny your access to PHI under certain circumstances, but in some cases you may have this decision reviewed. On your request, I will discuss with you the details of the request and denial process.
- *Right to Amend* – You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. I may deny your request. On your request, I will discuss with you the details of the amendment process.
- *Right to an Accounting* – You generally have the right to receive an accounting of disclosures of PHI regarding you. On your request, I will discuss with you the details of the accounting process.
- *Right to a Paper Copy* – You have the right to obtain a paper copy of the notice from me upon request, even if you have agreed to receive the notice electronically.

Psychologist's Duties:

- I am required by law to maintain the privacy of PHI and to provide you with a notice of my legal duties and privacy practices with respect to PHI.
- I reserve the right to change the privacy policies and practices described in this notice. Unless I notify you of such changes, however, I am required to abide by the terms currently in effect.
- If I revise my policies and procedures, I will provide you with a revised notice by mail.

V. Complaints

If you are concerned that I have violated your privacy rights, or you disagree with a decision I made about access to your records, please contact me to discuss your concerns and to obtain further information. You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services. I can provide you with the appropriate address upon request.

VI. Effective Date

This notice will go into effect on **April 14, 2003**.

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3106 Norcrest Drive
Oklahoma City, Oklahoma 73121
voice 405-557-1989

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email rayhand@rayhand.net
fax 405-525-8477

YOUR SIGNATURE BELOW INDICATES THAT YOU HAVE READ DR. RAY HAND'S PSYCHOLOGIST-CLIENT AGREEMENT AND AGREE TO ITS TERMS.

YOUR SIGNATURE ALSO SERVES AS AN ACKNOWLEDGEMENT THAT YOU HAVE RECEIVED THE HIPAA NOTICE FORM DESCRIBED ABOVE.

BY SIGNING BELOW, YOU ALSO INDICATE THAT YOU CONSENT TO SERVICES FOR YOURSELF AND/OR YOUR CHILD AND AGREE TO ABIDE BY THE TERMS AND CONDITIONS STATED ABOVE.

IN ADDITION AND IF APPLICABLE, YOUR SIGNATURE CONFIRMS YOUR AGREEMENT TO BE RESPONSIBLE FOR THE FULLY EXPLAINED EVALUALTION FEE OF $_____.

_____ _____

Print Client Name Signature [Client, Guardian or Authorized Representative] Date

_____

Mailing Address City State Zip Code

_____

Contact Phone Numbers Home Work Cell

Please complete if client is a minor:

SoonerCare-
Medicaid Information: ID#:_____ CLIENT Date of Birth:_____

In the past 90 days please state the Number of Days your child has:

In Restrictive Placement: ____ Incidents of Self Harm: _____ Absent from School: _____

Suspended from School: ____ Not permitted to return to Daycare: _____

By signing this document, I am certifying that I am legally authorized to consent to psychological treatment for the above-named child client, if the client mentioned above is a minor.

_____

Signature of Guardian or Authorized Representative Date

_____

Contact Phone Relationship to Child Client

Rev. 02/12