MICHELLE MILLIGAN. MSW.LCSW
PSYCHOLOGICAL SERVICES AGREEMENT
Policies and Procedures

This Agreement contains important information about my professional services and business policies. Please review it, note any questions you might have, and we will discuss them further during intake. PLEASE SIGN, DATE, AND BRING THE ENTIRE FORM TO YOUR FIRST SESSION. 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 I have taken action in reliance on it; if there are obligations imposed on me 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.

PSYCHOLOGICAL SERVICES. Psychotherapy is an interactive process between and Patient that involves discussing and understanding the problems you are experiencing. The goal of psychotherapy is to reduce distress through the use of various therapeutic methods that address thinking, feeling, and behavior. Frequency of sessions and length of treatment can vary a great deal. At times, an evaluation for medication may be recommended; or you may wish to have family members participate in your sessions. Psychotherapy calls for active participation on your part, including deciding which treatment approaches you prefer. For psychotherapy to be most effective, you will need to continue to work on therapeutic issues between sessions.

Psychotherapy can have benefits and risks. You may wish to discuss individual, relationship, or family issues that are upsetting, causing you to experience such uncomfortable feelings as sadness, guilt, anger, frustration, loneliness, and helplessness. Benefits of psychotherapy often include stress reduction, relationship enhancement, and problem resolution, as well as improved understanding, skills, and abilities to address future challenges.

By signing this agreement, you are agreeing to commit to a process of self-reflection and change. This includes continuing to make effort outside the therapy session based on issues that were discussed during the session, in addition to any specific homework assignments that were given. You are also agreeing to provide as accurate information about your symptoms and issues of concern as possible. Withholding, omitting, or misrepresenting your symptoms or other information you provide during treatment more likely will interfere with therapy and may result in termination. Referrals will be provided when appropriate.

Because psychotherapy is an interactive process, I also encourage that any concerns you may have about our work be discussed with me in the privacy of our sessions, and that you do not misrepresent what I have said during sessions, either verbally or in print, to influence or argue with your family or friends. Information I may share with you in session is not intended to be used against others; and providing misleading or incorrect information about how I conduct my sessions has a significant potential to damage our ability to work together.

PROFESSIONAL FEES AND SESSIONS. Our first session will involve an evaluation of the problem that led you to seek treatment. I will gather relevant historical and diagnostic information, requiring that we meet for 60-90 minutes at the **Evaluation Rate of $175.00**. Following this, I will be able to offer you some impressions of what our work will include, and an initial Treatment Plan. Please discuss any questions or concerns you may have as they arise. If I determine that other treatment services may meet your needs more effectively, or if you wish to see a different provider, I will supply the appropriate referrals.

If we agree that therapy is indicated, and that we will work together, we will plan sessions accordingly. I usually schedule **one weekly 55-minute session** at the **Therapy Rate of $150.00**. This includes time to check in, pay fees, and schedule your next appointment; and the session length is determined by the insurance companies. In addition to weekly appointments, I charge this amount for other professional services you may need. I will break down the hourly cost if I work for periods of less than one hour. Other services include **report writing, telephone conversations lasting longer than 10 minutes, preparation of records or treatment summaries, attendance at meetings which you have authorized, and the time spent performing any other service you may request of me, or that becomes necessary during the course of treatment.** You may wish to review with your insurance carrier whether they reimburse for a 60-minute session, or whether they require a special preauthorization and diagnosis code. **Generally speaking, 60-minute sessions are standard practice.** Sixty-minute sessions may be subject to greater scrutiny by insurance carriers to justify utilization.

I do not provide therapy for the purpose of providing records or evidence for legal matters, and as such you should not enter into therapy with that dual purpose, as it could interfere with progress. If you do become involved in legal proceedings that require my participation, fees for my professional time are **$220.00 per hour**. Charges includes preparation time and transportation costs for any legal proceeding, even if I am summoned by opposing counsel. You will also be required to pay my attorney's fees for preparation, consultation, and any statements I may be required to make, either written or verbal. For court appearances, depositions, or any other legal matter requiring my presence, I charge a **minimum of $1,500.00**, due in advance.

Insurance companies do not reimburse for completion of FMLA or disability paperwork. I am willing to send medical records, but I will not complete any forms unless I have adequate information from you. **I will not**

do any disability paperwork for any individuals who have been in therapy for less than 8 sessions. There is a **$150.00 per hour fee for any letters of support, paperwork, forms, or reports, such as those related to FMLA, short- or long-term disability, or Social Security Disability, including time to complete, copies of records, and faxing or mailing, with a minimum of $25.00 per letter or form.**

CANCELLATIONS: Please provide at least **24 hours advance notice** to cancel or reschedule an appointment, excluding an emergency (to be determined by me) or my unexpected need to cancel. If adequate notice is not given, a **$150.00 fee will be assessed to your account,** or the amount determined by your insurance carrier**.** It is important to note that insurance companies do not provide reimbursement for **canceled sessions**. To cancel a session, please call me at (302) 416-6805 and speak to me, leave a message if I am not available. If more than 2 appointments are missed without adequate notice, or if you miss 3 consecutive appointments in a row, we will need to reconsider our agreement to work together. Successful therapy depends on consistent attendance, and I may therefore close your file. If you fail to reschedule or I have no contact with you for 30 days, I will consider your file to be closed due to inactivity.

CONTACTING ME. I am often not immediately available by telephone. While I am usually in my office between 9 AM and 7 PM Monday Wednesday, and Thursday, I will not answer the phone when I am with a patient. You are welcome to leave a voice mail for me, which I check regularly. I will make every effort to return your call within 48 hours, with the exception of weekends, holidays, and other days that I am not in my office. If you are difficult to reach, please inform me of times when you will be available. **Because e-mail is a secure methods of communication, I do use it in my practice; please review my Electronic Communication Policy**. **If you text me, I well not respond to your message.**
If you need immediate assistance and are unable to reach me, please contact a **Crisis Intervention** at **(302) 577-2484; or (800) 345-6785;** call **988**, your **family physician**, or visit your **nearest emergency room**. If I will be unavailable for an extended time, I will provide you with the contact information of a trusted colleague. Please review charges for extended telephone calls on my Office Financial Policy.

BILLING AND PAYMENT. Payment for each session is due at the time it is held, unless other arrangements have been made and agreed upon. If you are using insurance, I will process your claim but request that you pay your estimated portion at the time of service. **If charges are denied by your insurance company for any reason, payment remains your responsibility.** If your insurance does not cover longer sessions, you may be charged for additional time beyond the 60-minute session. If you are paying out-of-pocket and cannot afford my fee, I am willing to work with you to arrange a mutually-agreed-upon hourly rate. **If your account has not been paid for more than 45 days and arrangements for payment have not been made,** I have the option of using legal means to secure the payment such as a collection agency or small claims court, which will require me to disclose otherwise confidential information. 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. [If such legal action is necessary, its costs will be included in the claim.]

INSURANCE REIMBURSEMENT. It is very important to evaluate what mental health services your insurance covers. In most cases, my office will send claims directly to your insurance company. In cases where I am not a Provider for your insurance plan, we may first bill you for the charges and then process claims requesting reimbursement be sent directly to you. If your insurance benefits expire and you wish to continue treatment, I will discuss a payment agreement with you. Please also understand that, in order to process claims, most insurance companies require that I provide them with information relevant to your treatment, such as a diagnosis, treatment plan or treatment summary. Every effort will be made to release only the minimum information about you that is necessary. Though all insurance companies claim to keep such information confidential, I have no control over how they manage this data once it is submitted. **I do not submit secondary claims.**

PROFESSIONAL RECORDS. State law and the standards of my profession require that I keep treatment records. You are entitled to receive a copy of your Clinical Records or a summary by providing a written request and a copying fee. Because they are professional records and may be misinterpreted, I strongly recommend that we review your chart together so that I may address any questions as they arise.

In very rare instances, I may also keep Psychotherapy Notes. These Notes are for my own use and are designed to assist me in providing you with the best treatment. While the contents of Psychotherapy Notes vary from client to client, they can include the contents of our conversations, my analysis of those conversations, and how they impact on your therapy. While insurance companies can request and receive a copy of your Clinical Record, they cannot receive a copy of your Psychotherapy Notes without your written, signed Authorization. Insurance companies cannot require your Authorization as a condition of coverage nor penalize you in any way

for your refusal. Please be advised that generally I do not keep psychotherapy notes. Please note that while I do take notes during session, these notes are shredded and do not become part of your treatment records.

Please review the **Notice of Privacy Practices** for detailed information regarding the Health Insurance Portability and Accountability Act (HIPAA), a federal law that provides privacy protection and patient rights with regard to the use and disclosure of your Protected Health Information used for the purpose of treatment, payment, and health care operations. Please review the **Protocol for Secure Storage, Transfer, and Access to Client Records** for information on your records and how to access them. Please also review the **Private Practice Electronic Communication Policy** for information on social media, text messaging, and email due to confidentiality, security, and privacy issues. This agreement is intended to coordinate with these documents.

LIMITS ON CONFIDENTIALITY. All communications between a patient and a psychologist is protected by the Psychologist-Patient Privilege law. In most situations, release information about your treatment can only be given with your written Authorization, noting the following exceptions:

1. If you inform me that you are threatening serious bodily harm to yourself or someone else, I must take protective action that may include hospitalization, contacting the police, and/or notifying the potential victim. I may also contact family members or others who can help provide protection. I will more likely contact the person you have designated as your Emergency Contact in addition to any professional assistance.
2. If I believe a child under 18, elderly or disabled person is being abused, neglected, or exploited, I am required to file a report to the appropriate agency, usually the Office of Child Protective Services and law enforcement. Once such a report is filed, I may be required to provide additional information. If abuse, neglect or exploitation occurred in the past, I am still required to file a report to the appropriate agency if the child (or elderly or disabled person) is still at risk (e.g. still in the home) or if it is reasonable to believe that other children (or elderly or disabled persons) may be at risk based on the description of those past actions.
3. If a judge (court-order) requires me to testify about you or you are accused of a crime and use your sanity as a defense. If you are involved in a court proceeding and a request is made for information concerning the professional services I provided you, such information is protected by the psychologist-patient privilege law. I cannot provide any information without your or your 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.
4. If you file a complaint or a lawsuit against me, I will use my records to defend myself.
5. If a medical emergency arises while you are in session, I will telephone the Emergency Contact designated on your Intake Form.
6. If you file a worker's compensation claim and I am providing services related to that claim, I must provide appropriate reports to the Worker's Compensation Commission or the insurer.
7. If a government agency is requesting the information for health oversight activities, I may be required to provide it for them.

The above situations are rare and I will make every effort to fully discuss it with you before taking any action. Let's discuss any concerns that you may have regarding the above. The laws governing confidentiality are complex, and certain situations may require legal advice. If I consult with another professional about a case, I will make every effort to avoid revealing identifying information. The consultant is also legally bound to keep the information confidential. Please also know that I work in an office with other professionals where protected information may be shared for administrative purposes and confidentiality is protected.

Your signature on this Agreement also provides consent for those activities, as follows:

- 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 patient. 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.

- Please be aware that I may practice with other mental health professionals and that I may in the future employ administrative staff. In most cases, I need to share protected information with these individuals for both clinical and administrative purposes, such as scheduling, billing and quality assurance. All of the mental health professionals are bound by the same rules of confidentiality. All staff members are given training about protecting your privacy and agree not to release any information outside of the practice without the permission of a professional staff member.

Your signature below indicates that you have read this Agreement, understand the contents, and agree to abide by its terms during our professional relationship. A copy will be provided upon request.

Electronic Signatures. Any signatures (including any electronic symbol or process attached to, or associated with, and adopted by a Person with the intent to sign, authenticate or accept such document) on all clinical and administrative documents may be executed by electronic signature, which shall be considered as an original signature for all purposes and shall have the same force and effect as an original signature. Without limitation, "electronic signature" shall include faxed versions of an original signature or electronically scanned and transmitted versions (e.g., via pdf) of an original signature, a typed name or electronic symbol.

_____
Print Name of Patient

_____ _____
Signature of Patient Date

_____ _____
Michelle Milligan, LCSW Date

PLEASE SIGN TO ACKNOWLEDGE THAT YOU HAVE READ THE NOTICE OF PRIVACY PRACTICES, PROTOCOL FOR CLIENT RECORDS, AND ELECTRONIC COMMUNICATION POLICY. ALL FORMS ARE AVAILABLE ON MY WEBSITE.

Your signature below indicates that you have received a copy of the **Notice of Privacy Practices (HIPAA)**, and that we have reviewed any concerns you might have regarding this Notice.

_____ _____
Signature of Patient Date

Your signature below indicates that you have received a copy of the **Protocol for the Secure Storage, Transfer, and Access to Client Records**, and that we have reviewed any concerns you might have regarding this Notice.

_____ _____
Signature of Patient Date

Your signature below indicates that you have received a copy of the **Electronic Communication Policy**, and that we have reviewed any concerns you might have regarding this Notice. Your signature also acknowledges that if you use text messages, you are violating your own confidentiality; that you are aware that your message may be deleted with no response; and that if you want to ensure a response, you must leave a voicemail.

_____ _____
Signature of Patient Date