CROSSROADS
PSYCHOLOGICAL
ASSOCIATES

10784 HICKORY RIDGE ROAD • COLUMBIA, MD 20144-3646

PH. 410/964-0425 FAX 410/964-0515

Crossroads Psychological Associates is a group of independent contractors comprised of well-trained professionals dedicated to bring you the highest quality treatment, in a warm caring environment.

This information sheet contains answers to the most frequently asked questions. However, if you have any other questions or concerns, please feel free to ask any staff member.

APPOINTMENTS

All patients are seen on an appointment basis. Each therapist will schedule your appointment time. We try to see all patients on time and request that you extend the same courtesy to us. **Please check in with the Receptionist when you come for an appointment.**

If you are unable to keep an appointment, please give your therapist 24 hours notice, so that this time may be offered to another patient. You will be charged a fee for any appointment you missed that you did not cancel within this time frame.

We do not follow the Howard County Schools closing schedule. If weather conditions are bad, please check with your therapist regarding your appointment.

MEDICATION REFILLS

Prescriptions are written during your session with Dr. Renbaum or Dr. Band and unless discussed, you will have enough medication to last until your next appointment. Please schedule appointments accordingly. If you need an emergency refill please note: **It may take up to 5 days for the provider to get back to you or your pharmacy.**

PAYMENTS/INSURANCE

Every effort is made to keep down the cost of counseling. Payment is due at the time of service. Any other balance is due and payable upon receipt of monthly statement, and a finance charge of 1.5% will be added monthly as necessary to the unpaid balance until debt is paid out. We do not accept assignment of Insurance benefits as payment unless you have prior arrangements with your therapist. If you have insurance coverage, we will be glad to file for you as a courtesy. The assignment of any benefits your policy allows will be made to the insured. It is your responsibility to follow up with insurance if necessary. Insurance does not always cover all of treatment. You are responsible for providing the business office with your insurance information and updating us with changes which may occur during your treatment. Many plans require pre-authorization and or treatment plans for mental health services, please check with your insurance carrier.

SMOKING is prohibited inside the office

TELEPHONE CALLS

Therapy sessions are not interrupted except in the case of extreme emergency. Please leave your message with the office personnel or on voice mail and the therapist will return your call at the earliest opportunity. If you have an emergency before or after business office hours, please call our answering service: ***1/866-962-9211***.

Providers reserve the right to bill for telephone calls that exceed the normal message limits.

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OUTPATIENT SERVICES CONTRACT

Welcome to Crossroads Psychological Associates LLC, a group of independently operating mental health practitioners. Read this document as it contains important information regarding your treatment, private health information, and details about the agreement you are making between you and your specific clinician. This document contains important information about your clinician's professional services and business policies. For minors less than 18 years of age, a legal guardian can only authorize Consent. You will be asked to initial and sign on the last page of this document; please return that page and keep the remaining pages for your record. If you have questions, please address your concerns with your clinician.

PSYCHOLOGICAL SERVICES

Psychotherapy is not easily described in general statements. It varies depending on the personalities of the psychologist and patient, and the particular issues you bring forward. There are many different methods that can be used to deal with the problems that you hope to address. Psychotherapy is a partnership calling 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. Research has demonstrated that psychotherapy has 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.

The 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

Once psychotherapy is begun, we will meet according to a schedule we agree on. *Once an appointment hour is scheduled, you will be expected to pay for it unless you provide 24-hours advance notice of cancellation* with the exception of illness or an emergency situation.

PROFESSIONAL FEES

Each clinician at Crossroads Psychological Associates sets his or her own fees, which will be discussed prior to your initial session. Your session fee is identified on the final page of this form. In addition to weekly appointments, your regular hourly rate may be charged for other professional services you may need, though 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 15-minutes, attendance at meetings with other professionals you have authorized, and time spent performing any other service you may request of me. If you become involved in legal proceedings that require my participation, you will be expected to pay for my professional time even if I am called to testify by another party. Because of the liability and complexity of legal involvement, I charge a higher hourly rate for preparation and attendance at any legal proceeding. We will discuss this rate if it becomes necessary, and it will be no more than twice my regular hourly rate.

BILLING AND PAYMENTS

You will be expected to pay for each session at the time it is held. 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 or payment installment plan.

If your account has not been paid for more than 60 days and arrangements for payment have not been agreed upon, a 1.5% finance charge will be added to the unpaid balance and 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. If you account is turned over to a third party, you will be responsible for all collection fees, interest, court costs, and attorney fees. 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

In order for us to set realistic treatment goals and priorities, it is important to evaluate what resources you have available to pay for your treatment. If you have a health insurance policy, it will usually provide some coverage for mental health treatment. I will fill out forms and provide you with whatever assistance I can in helping you receive the benefits to which you are entitled; however, *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. 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. Insurance Companies often require authorization before they provide reimbursement for mental health services. Also, it may be necessary to seek approval for more therapy after a certain number of sessions.

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, or copies of the entire record (in rare cases). 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.

CONTACTING ME

I am often not immediately available by telephone, and my office hours vary from week to week. Furthermore, while I am in the office I will not answer the phone when I am with a client. When I am unavailable, please leave a voicemail indicating you name, phone number, and a time when you can be reached. My telephone is answered by a confidential voicemail that I monitor frequently, and I will make every effort to return your call as soon as possible. Voicemail is often checked less frequently on weekends and holidays. *If you are unable to reach me and feel that you can't wait for me to return your call, contact the Crossroads Emergency number at 866-962-9211.* This number is also provided on the Crossroads website at www.CrossroadsPsych.net and on our general phone at 410-964-0425.

PROFESSIONAL RECORDS

The laws and standards of my profession require that I keep treatment records. If you wish to see your records, I recommend that you review them in my presence since professional records can be misinterpreted by untrained readers. I can conduct a review meeting with you or provide a summary. In rare situations, I may request that your records first be reviewed by a third party. Patients will be charged an appropriate fee for any professional time spent in responding to information requests, including sending records to another party.

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. It is my policy to request an agreement from parents that they give me authority to make decisions about what information will or will not be disclosed. If they agree, I will provide them only with general information about our work together, unless I feel there is critical information they need to know regarding safety of a minor. In this case, I will notify them of my concern but make every effort to discuss the disclosure with the minor prior to contacting his or her parents. Also, *Consent for Treatment must be made by the custodial parent in the event of divorce.*

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 with your written permission (See HIPAA information for additional details). If

your therapy includes families or a spouse/partner, written permission must be granted by all persons involved (excluding minors). You can authorize permission by signing a Release of Information form we will provide.

However, there are a few exceptions to the privilege of confidentiality:

In some legal proceedings (such as issues of child custody) a judge may order my testimony if he/she determines that the issues demand it.

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.

If I believe that a patient presents a specific and imminent danger to themselves or another, I am required to take protective actions. These actions may include notifying the potential victim, contacting the police, and/or seeking hospitalization for the patient.

The staff at Crossroads Psychological Associates is involved in the scheduling, billing, and organization or records. Each has been trained regarding confidentiality, and will view only that information which is essential to perform their job. If you work with more than one treatment provider at our practice, you will be asked to sign an In-House Release of Information.

In some circumstances I find it helpful to consult other professionals about a case. During a consultation, I will avoid revealing the identity of my patient. The consultant(s) 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 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.

MARYLAND NOTICE FORM

Notice of Psychologist's Policies and Practices to Protect the Privacy of Your Patient's Health Information (PHI)

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.

Please be advised that, for the remainder of this document, *Therapist* refers to the specific therapist indicated at the end of this document.

I. Uses and Disclosures for Treatment, Payment, and Health Care Operations

Your Therapist may *use* or *disclose* your *protected health information* (*PHI*), for *treatment, payment, and health care operations* purposes with your *written authorization*. 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 Your Therapist provides, coordinates, or manages your health care and other services related to your health care. An example of treatment would be when your therapist consults with another health care provider, such as your family physician or another psychologist.
– *Payment* is when Your Therapist obtains reimbursement for your healthcare. Examples of payment are when Your Therapist discloses 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 the 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 this practice group such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.
"*Disclosure*" applies to activities outside of this practice group, such as releasing, transferring, or providing access to information about you to other parties.
"*Authorization*" is your written permission to disclose confidential mental health information. All authorizations to disclose must be on a specific legally required form.

II. Other Uses and Disclosures Requiring Authorization

Your Therapist may use or disclose PHI for purposes outside of treatment, payment, or health care operations when your appropriate authorization is obtained. In those instances when your therapist is asked for information for purposes outside of treatment, payment, or health care operations, Your Therapist will obtain an authorization from you before releasing this information. Your Therapist will also need to obtain an authorization before releasing your Psychotherapy Notes. "*Psychotherapy Notes*" are notes your therapist has made about the conversation during a private, group, joint, or family counseling session, which have been kept separate from the rest of your medical record. These notes are given a greater degree of protection than PHI.

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

III. Uses and Disclosures without Authorization

Your Therapist may use or disclose PHI without your consent or authorization in the following circumstances:

Child Abuse – If your therapist has reason to believe that a child has been subjected to abuse or neglect, the therapist must report this belief to the appropriate authorities.

Adult and Domestic Abuse – Your Therapist may disclose protected health information regarding you if your therapist reasonably believes that you are a victim of abuse, neglect, self-neglect or exploitation.

Health Oversight Activities – If Your Therapist receives a subpoena from the Maryland Board of Examiners of Psychologists because they are investigating the practice, Your Therapist must disclose any PHI requested by the Board.

Judicial and Administrative Proceedings – If you are involved in a court proceeding and a request is made for information about your diagnosis and treatment or the records thereof, such information is privileged under state law, and Vanderhorst and Associates will not release information without your written authorization or a court order. The privilege does not apply when you are being evaluated or 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 your therapist a specific threat of imminent harm against another individual or if your therapist believes that there is clear, imminent risk of physical or mental injury being inflicted against another individual, your therapist may make disclosures that your therapist believes are necessary to protect that individual from harm. If your therapist believes that you present an imminent, serious risk of physical or mental injury or death to yourself, your therapist may make disclosures he/she considers necessary to protect you from harm.

IV. Patient's Rights and Psychologist's Duties

Patient's Rights:

Right to Request Restrictions – You have the right to request restrictions on certain uses and disclosures of protected health information. However, Your Therapist is 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 a therapist. On your request, Your Therapist 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 the practice's mental health and billing records used to make decisions about you for as long as the PHI is maintained in the record. Your Therapist may deny your access to PHI under certain circumstances, but in some cases you may have this decision reviewed. You have the right to inspect or obtain a copy (or both) of Psychotherapy Notes unless the therapist believes the disclosure of the record will be injurious to your health. On your request, the therapist will discuss with you the details of the request and denial process for both PHI and Psychotherapy Notes.

Right to Amend – You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. Your Therapist may deny your request. On your request, your therapist 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. On your request, your therapist 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 Your Therapist upon request, even if you have agreed to receive the notice electronically.

Therapist's Duties:

Your therapist is required by law to maintain the privacy of PHI and to provide you with a notice of the legal duties and privacy practices with respect to PHI.

Your Therapist reserves the right to change the privacy policies and practices described in this notice. Unless Your Therapist notifies you of such changes, however, the practice is required to abide by the terms currently in effect.
If Your Therapist revises the policies and procedures, Your Therapist will post a revised copy in a prominent place in the waiting room, provide a copy through your therapist at the next session of therapy or mail a copy to you.

V. Complaints

If you believe your privacy rights have been violated, you may file a complaint. This complaint must be in writing and addressed to: Daniel Zimet, PhD - Privacy Officer, Crossroads Psychological Associates LLC, 10784 Hickory Ridge Road, Columbia MD 21044. You may also contact the Maryland Psychological Association or the Maryland Board of Examiner's of Psychologists for further information. There will be no retaliation for filing a complaint.

You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services. The organizations listed above can provide you with the appropriate address upon request.

VI. Effective Date, Restrictions, and Changes to Privacy Policy

This notice goes into effect on April 14, 2003.
I reserve the right to change the terms of this notice and to make the new notice provisions effective for all PHI that I maintain. I will provide you with a revised notice by posting a revised copy in a prominent place in the waiting room, providing a copy through your therapist at the next session of therapy or mailing a copy to you.

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Please carefully read and initial the following items. If you have any questions or do not understand what is being asked, do not initial or sign this paper! Instead, discuss your concerns or confusion with your therapist. If you are comfortable signing this page, please return it to the receptionist and retain the previous pages (pages 1-4) for your record.

I understand that by signing this document I am consenting to treatment with _____.

A fee for service, which may vary depending on the length and type of service provided, is _____ per hour.

I understand the billing arrangement, cancellation policy (24 hours notice) and insurance policy (out of network).

I authorize the release of information necessary to process claims with my insurance provider.

I have been informed of how to contact my therapist, and how to proceed in the case of an emergency when my therapist is not immediately available. The Crossroads Emergency number is 866-962-9211.

I have been informed of laws regarding confidentiality and limits to confidentiality.

I understand that my therapist may seek consultation from other professionals regarding my case and that information that might specifically identify me as a patient will be withheld during these consultations.

I understand that my therapist may request that I sign a Release of Information permitting communication with the individual/organization I specify.

I have received a complete copy of this Outpatient Services Contract as well as policies regarding the HIPAA Security Rule. I understand that I can also access these documents on the Crossroads website at www.CrossroadsPsych.net

Your signature below indicates that you have read and understand the information in this document and agree to abide by its terms during our professional relationship.

Signature of Patient or Legal Guardian: _____**

Printed Name: _____

Date: _____

*** NOTE: If you are the parent(s)/guardian(s) who is (are) bringing a minor to us for services, your signature above attests that all other legal parents/guardians are aware of and consent to these services. If this is not the case, please notify us immediately*.

Updated 6/18/08