Newsome Therapeutic Practice, PLLC

535 West Second Street, Suite 207, Lexington, KY 40508
Office 859.955.8847 Mobile 740.701.6689 Web: NewsomeTherapeuticPractice.com

PSYCHOTHERAPIST-PATIENT SERVICES AGREEMENT

Revised 1/2019

Welcome to my practice. This 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 patient rights with regard to the use and disclosure of your Protected Health Information (PHI) that is used for the purpose of treatment, payment, and health care operations. Please read carefully and jot down any questions you might have so that we can discuss them. When you sign this document, it will 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. HIPAA requires that I provide you with a Notice of Privacy Practices for use and disclosure of PHI for 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 I obtain your signature acknowledging that I have provided you with this information at the beginning of treatment.

First-time appointments are scheduled on-line by navigating to: NewsomeTherapeuticPractice.com

- Navigate to the "schedule appointment" section on the website. Also, Once there, please create your login information and store in a secure location, as this will be your login to see your personal information, receive your receipts/expenses, and follow up on tax documentation.

- Please fill in the brief biographical information once prompted. This will give me a chance to know a bit more about you prior to our first meeting.

This is a secure encrypted Electronic Health Records (HER) system maintained by TherapyAppointment.com, and is fully compliant with HIPPA and PCI standards for protecting your private health and financial information (should you be paying for services using a credit card). Please do not transmit financial and/or personal information via unencrypted email. If sensitive information must be transmitted, please use the "encrypted message" feature located on the HER portal.

Please fill out the "register as a new patient/client" link, in addition to the "biographical information form." Once you establish your user id and password, you will be able to schedule and cancel appointments (please see missed appointments and cancellations section for further explanation regarding possible fees associated with cancellations, etc), in addition to deciding how you would like to be reminded of appointments, as well as sending or receiving encrypted email correspondence. You should receive a copy of this document upon completing the registration process.

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 many 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. I will 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.

THERAPY AND PHYSICAL SYMPTOMS: Physical symptoms are often the result of emotional stress. They can be reduced and even eliminated under certain therapy conditions. It is important, however, that an appropriate medical specialist review your current situation to ascertain the degree to which the symptom has a physical base. A physical exam is therefore required when a physical symptom is a primary concern. If there is a physical problem that affects your therapy, I will work closely with your medical specialist to coordinate treatments and services. It is important for you to let me know if there is persistent physical discomfort related to the therapy. A referral to another specialist will be considered.

MEDICATIONS IN PSYCHOLOGICAL THERAPY: Depending on symptoms and problems, medications may or may not be appropriate. If medications are considered I will discuss with you obtaining a medical evaluation and a possible trial of medication. It is your responsibility to inform your therapist and any treating physician of any and all prescribed medications. It is also vital that you are compliant with the course of treatment as prescribed by your physician.

SCHEDULING SESSIONS: Therapy sessions are usually scheduled one to two times per week for one 54-minute session (one appointment hour of 54 minutes duration). Later some sessions may be more or less frequent.

535 West Second Street, Suite 207, Lexington, KY 40508
Office 859.955.8847 Mobile 740.701.6689 Web: NewsomeTherapeuticPractice.com

MISSED APPOINTMENTS, CANCELLATIONS, RETURNED CHECKS: If you must cancel a session, please give at least 48 hours notice. Cancellations made with less than 24 hours notice will be billed at your prearranged hourly rate, unless alternative arrangements are made. If the cancelled appointment can be rescheduled within the same business week, there will be no late fee. The client grants permission for missed appointments (with less than 24 hours notice) to be charged to the credit card account on file with the EHR for the client. Checks returned for insufficient funds are charged a $35.00 handling fee. Once the fee and the amount of the returned check have been paid, then I will again accept checks. If a second check is returned then payment is to be in cash. Most major credit cards are accepted.

PROFESSIONAL FEES: My hourly fee is $130 per 54-minute hour, unless negotiated otherwise. In addition to weekly appointments, I charge 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 5 minutes, attendance at meetings with other professionals you have authorized, preparation of records or treatment summaries, and the time spent performing any other service you may request of me. Routine calls for the purpose of scheduling or billing information are an expected part of my service and not billed. If you become involved in legal proceedings that require my participation, you (or the responsible legal party calling me to provide information) will be expected to pay for all of my professional time, including preparation and transportation costs.

- If two or more parties will be responsible for services, Newsome Therapeutic Practice, PLLC may charge either party the full fee, or at our discretion, the fee may be charged disproportionately.
- All time involved in the preparation of written reports, telephone calls, communication with other professionals and travel will be billed at the same hourly rate.
- I understand that I will be responsible for any postage (first class postage rate) or copying fees ($0.50/page) incurred on my behalf by Newsome Therapeutic Practice, PLLC..
- Any time set aside in preparation for a subpoenaed court appearance, including actual appearances, preparation of testimony or reports to your attorney or the court, travel, depositions, or any schedule

535 West Second Street, Suite 207, Lexington, KY 40508
Office 859.955.8847 Mobile 740.701.6689 Web: NewsomeTherapeuticPractice.com

adjustments necessary to accommodate such a court appearance will be billed at an hourly rate of $250/ hour. Newsome Therapeutic Practice, PLLC will charge a retainer in advance of any agreed or subpoenaed court proceeding in a minimum amount of $2,500 (or such time estimated to be expended). This retainer shall be a deposit towards fees for professional time expended. If time expended is less than the retainer, the balance will be refunded within 30 days of termination of services. If time extended exceeds the retainer, the balance will be charged to the account/s on file.

- I agree to notify Newsome Therapeutic Practice, PLLC at least 48 hours in advance should I need to cancel an appointment. I understand that I will be charged the full regular session fee for any appointments that I miss or fail to cancel 48 hours in advance.
- I agree to pay any Newsome Therapeutic Practice, PLLC costs of collection including reasonable attorney fees.
- I understand that I will need to provide a valid credit card that will remain on file with Newsome Therapeutic Practice, PLLC, and I authorize Newsome Therapeutic Practice, PLLC to keep my signature on file for charges incurred on my account.

Name on card: _____ Name on card: _____
Credit Card (1) Number: _____ Credit Card (2) Number: _____
Expiration: _____3-digit security code: _____ Expiration: _____ 3-digit security code: _____
Billing zip code: _____ Billing zip code: _____
Cardholder signature: _____ Cardholder signature: _____

I have read the information above and agree to the terms set forth and outlined above.

_____ _____
Signature of Client (1) Signature of Client (2)
Date _____ Date _____

535 West Second Street, Suite 207, Lexington, KY 40508
Office 859.955.8847 Mobile 740.701.6689 Web: NewsomeTherapeuticPractice.com

PAYMENT OF FEES AND INSURANCE: Payment is due at the time of service or in advance. Payment schedules for other professional services will be agreed to when they are requested. 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. If such legal action is necessary, its costs will be included in the claim. 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. In lieu of accepting insurance plans, to accommodate the needs of my clients, I will provide information necessary for you to apply any therapy charges to your out-of-network maximum. Once this maximum is met for your out-of-network plan, your therapy expenses may be covered at a reduced rate. Each company has different policies regarding what is treatable, payment schedule, number of sessions covered, the amount of the co- payment, etc. Therefore, I encourage you to contact your company and determine what, if any, special requirements your particular health plan has, and if you are able to use your out-of-network plan by your company. It is the client's responsibility to be aware of his/her coverage. Out-of-network therapy services require that you pay for your services in full at the end of each session. Once this is completed I will provide you (via email, print, or online) the copy of your bill and your "superbill" for each session that can be provided to your insurance provider. If we have already provided you service, payment for those charges become your responsibility. Any service that is requested by the client and provided by the therapist without regard to payment being covered by the insurance plan will be billed at the rate agreed upon between the client and the therapist for that service. The rate per 1-hour session is $130.00 and will be billed at the beginning of each session. For example: if the client requests a marital counseling session and agrees to pay $130.00 for the session, the client will pay the $130.00 using check, cash, FSA/HSA card, debit or credit card, then you will provide your receipts to your insurance company to be added to your out-of-network maximum. With your cooperation and help, you should be able to work out these details with your insurance company and we will be able to concentrate on

caring for your mental health needs. I, _____, agree to pay $ _____ for each counseling session I request. If you are still interested in using your health insurance, many plans (usually PPO) have out-of-network benefits, and I will be happy to give you the form to submit for reimbursement. Keep in mind that I will still have to give you a mental disorder diagnosis, which will still be part of your permanent health record. Sometimes I have to provide additional clinical information such as treatment plans or summaries, or in rare cases copies of the entire record. 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. I make every effort to remind you of your appointments by providing you access to your client portal, which has all your previous and upcoming appointments, and by providing you an automated email or text message sent to your computer or phone approximately 1.5 to 2 days prior to your scheduled appointment. We request 48 hours' notice for cancellations. Cancellations made prior to this window are rescheduled with no penalty. Cancellations made without 24 hours' notice but prior to the start of the session incur a $65 late-cancellation fee. No-shows or cancellations made after the start of the session incur the full fee. In the event that you need to cancel your appointment, please do so 24 hours ahead of time so that I may rebook that appointment slot. I will make every effort to reschedule your appointment the same week. If we are unable to find a suitable time, you will be charged $65 or half session cost.

CONTACTING ME: Due to my work schedule I am often not immediately available by telephone. On days I see patients I am usually in my office between 8 AM and 7 PM. I routinely do not answer the phone when I am with a patient. When I am unavailable, you will reach my confidential voice mail, which I monitor daily. Established patients are given my cell phone number for emergencies and routine scheduling contact. I also routinely return most calls from the office on my cell phone. I will make every

effort 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 mental health specialist 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.

EMAIL: My business email address is Ben@NewsomeTherapeuticPractice.com. Please do not send or share confidential information via email. If you wish to send confidential email correspondence, you can safely send and receive secure email using the EHR portal through TherapyAppointment.com. Emails sent/received through this portal are encrypted to protect your privacy, and a HIPPA approved form of electronic correspondence. I plan to read email daily, however this is not always the case.

LIMITS ON CONFIDENTIALITY: The law protects the privacy of all communications between a patient 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 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 (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 share office space with other mental health professionals. Often I need to share protected information with these individuals for administrative purposes, such as scheduling, billing and quality assurance. All of the mental health professionals are bound by the same

rules of confidentiality. The office manager has been given training about protecting your privacy and has agreed not to release any information outside of the practice without the permission of a professional staff member.

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

· 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. In custody disputes the Judge can order that information be provided for the "best interest of the child."

· If a government agency is requesting the information for health oversight activities, I may be required to provide it for them.

· If a patient files a complaint or lawsuit against me, I may disclose relevant information regarding that patient in order to defend myself.

· If a patient files a worker's compensation claim, I must, upon appropriate request, provide relevant information, to the appropriate parties, including the patient's employer, the worker's compensation insurer.

· Under the Patriot Act I may disclose your health information to authorized federal officials who are conducting national security and intelligence activities or providing protective services to the President or other important officials. By law I cannot reveal when I have disclosed such information to the government. 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 patient's treatment. These situations are unusual in my practice. If I know or have reasonable cause to believe that a child or vulnerable adult is neglected or abused, the law requires that I file a report with the appropriate governmental agency, usually the Cabinet for Families and Children. Once such a report is filed, I may be required to provide additional information. If a patient communicates an actual threat of physical violence against a clearly identified or reasonably identifiable victim or a threat of a specific violent act, I may be required to take protective actions. These actions may include notifying the potential victim, contacting the police, or seeking hospitalization for the patient. 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. Unless requested otherwise, correspondence is sent in regular business envelopes with Newsome Therapeutic Practice, PLLC letterhead. 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: You should be aware that, pursuant to HIPAA, I can keep Protected Health Information about you in two sets of professional records. One set is larger and constitutes your Clinical Record. It includes information about your reasons for seeking therapy, a description of the ways in which your problem impacts on your life, your diagnosis, the goals that we set for treatment, your progress towards those goals, your medical and social history, your treatment history, any past treatment records that I receive from other providers, reports of any professional consultations, your billing records, and any reports that have been sent to anyone, including reports to your insurance carrier. Except in unusual circumstances that involve danger to yourself and others or if the record makes reference to another person (unless such other person is a health care provider) and I believe that access is reasonably likely to cause substantial harm to such other person, 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. You are entitled to one free copy of your records. However, I am allowed to charge a copying fee of $.50 per page (and for certain other expenses) for any subsequent copies. The exceptions to this policy are contained in the attached Notice Form. If I refuse your request for access to your Clinical Records, you have a right of review, which I will discuss with you upon request. In addition, I also can keep a set of Psychotherapy Notes, however I use this option very rarely. 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 your therapy. They also contain particularly sensitive information that you may reveal to me that is not required to be included in your Clinical Record. They can also include information from others provided to me confidentially. These Psychotherapy Notes are kept separate from your Clinical Record. Your Psychotherapy Notes are not available to you and cannot be sent to anyone else, including insurance companies 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 to provide it.

PATIENT RIGHTS: HIPAA provides you with several new or expanded rights with regard to your Clinical Records and disclosures of protected health information. These rights include requesting that I amend your record; requesting restrictions on what information from your Clinical Records 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.

535 West Second Street, Suite 207, Lexington, KY 40508
Office 859.955.8847 Mobile 740.701.6689 Web: NewsomeTherapeuticPractice.com

MINORS: If you are under 18 years of age, please be aware that the law allows guardians and/or parents 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 that they consent to give up their access to their child's records. If they agree, I will provide them only with general information about the progress of the child's treatment, and his/her attendance at scheduled sessions. Any other communication will require the child's authorization, unless I feel that the child is in danger or is a danger to someone else, in which case, I will notify the parents of my concern. Significant dangers also include unprotected sex and drug use beyond experimental use of marijuana or alcohol. Before giving parents any information, I will discuss the matter with you, if possible, and do my best to handle any objections.

CONSULTATION: Benjamin Newsome, EdS, LPCC (license #: 246008), is an independently licensed psychotherapist, and does not work under any supervisor, nor does he share specific PHI with any other clinician. However, there may be times where it will be helpful for the Counselor to discuss the Client's case with other mental health professionals to gain feedback and insight. In such cases no records will be shared and no protected information beyond the general details of the case will be discussed. In all these cases the Counselor will work to resolve each situation without disclosing any protected information when possible, and when it is not possible, the Counselor will work to expose as little of the Client's protected information as is strictly necessary.

PSYCHOTHERAPIST-PATIENT SERVICES AGREEMENT YOUR SIGNATURE BELOW INDICATES THAT YOU HAVE BEEN GIVEN THE PSYCHOTHERAPIST-PATIENT SERVICES AGREEMENT AND AGREE TO ITS TERMS.

_____(Client Name-Print) _____(Date)

_____(Client Signature)

_____(Parent or Guardian Signature, if applicable)

_____ (Office Staff or Therapist)