Office (760) 547-7770
2725 Jefferson Street, Suite 102
Carlsbad, CA 92008

Laura L. McGrady PSY.D.
www.drlauramcgrady.com
email@drlauramcgrady.com

AGREEMENT FOR PROFESSIONAL SERVICES

Welcome to my practice. This document 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 new federal law that provides new privacy protections and new patient 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 for use and disclosure of PHI for treatment, payment and health care operations. The Notice, which is 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 at the end of this session. It is very important that you read these documents carefully and we can discuss any questions you might have. When you sign this document, it will also represent an agreement between us.

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 are experiencing. 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. There is no guarantee that entering treatment will reduce your symptoms or resolve your problems in your desired direction. On the other hand, psychotherapy has also been shown to have many benefits. Therapy often leads to better relationships, solutions to specific problems, and significant reductions in feelings of distress.

If you have any questions about my procedures, we should discuss them whenever they arise. Psychotherapy sometimes involves consulting with other professionals, and if necessary, transferring your care to another professional to help you. For example, I do not do court work (such as, but not limited to testifying in divorce and custody disputes, injuries, lawsuits, etc.). So if you need these services I will give you referrals to forensic psychologists who specialize in these cases.

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SESSIONS

I will usually schedule one 50-minute session per week at a time we agree on, although some sessions may be longer or more frequent. If they are shorter or longer for some reason, the fee will be adjusted according to the quarter hour. The frequency can vary depending upon need, schedules and finances.

PROFESSIONAL FEES

The fee for a regular individual therapy session is $150 and I accept cash, check and credit cards (VISA & MasterCard). In addition to weekly appointments, I charge $150 an hour for other professional services you may need. Other services include psychological testing, report writing, telephone conversations lasting longer than 15 minutes, consulting with other professionals with your permission, preparation of records or treatment summaries, and the time spent performing any other service you may request of me. I request that you pay the whole fee at the end of each session, unless we have a written agreement otherwise.

If you pass a check on insufficient funds, you will be liable for the amount of the check and a service charge of twenty-five dollars ($25) for the first check and a thirty-five dollars ($35) service charge for each subsequent check passed on insufficient funds.

CANCELLING APPOINTMENTS

A scheduled appointment means that time has been reserved only for you. Although it is best to keep regular appointments, there may be times when you cannot come in. You must call the above phone number at least 24 hours in advance to cancel the appointment. If you do not cancel more than 24 hours in advance, you will be charged the full normal fee for that session. The exceptions to this policy are sudden major illnesses or accidents in which you may be involved. It is important to note that insurance companies do not pay for missed or late-cancelled appointment fees and the patient/responsible party is held fully accountable for this charge.

MEDICARE

I have opted-out of Medicare in accordance to the Balance Budget Act of 1997 (Section 1802(b) of the Social Security Act). This law allows me to enter into a private contract with Medicare beneficiaries. If you are 65 or older, or will turn 65 within the next year, you will be required to review and sign two copies of the separate MEDICARE OPT-OUT CLIENT AGREEMENT provided. I will sign both and we will each keep a signed copy.

CONTACTING ME

Telephone Calls

Because of a full schedule with other clients and professionals, I am not immediately available by telephone. Your calls are answered by my 24 hour voice mail system. Please leave a message in my confidential voice mail box along with the best time to reach you, and I will call back as soon as possible. Brief phone calls (5-10 minutes) to change appointments or clarify information are welcome and will not be charged. However, if phone calls are greater than 15 minutes, they will be charged according to the quarter hour.

I will make every effort to return your call on the same day you make it, with the exception of weekends and holidays. If I will be unavailable for an extended time, I will provide you with the name of a colleague to contact, if necessary. If you are difficult to reach, please inform me of some times when you will be available.

If you are in crisis and feel that you can't wait for me to return your call, contact your family physician or the nearest emergency room or call one of the following 24-hour hotline numbers or dial 911:

San Diego Crisis Hotline
1-888-724-7240

San Diego Domestic Violence & Rape Hotline
1 (888) 385-4657

Domestic Violence & Sexual Assault Hotline
1 (800) 799-7233

San Diego Child Protective Services Hotline
1 (800) 344-6000

Email or Texting

I do consider all your communications with me private and do all I can to maintain confidentiality. However, because email/texting is not a secure or confidential medium, I cannot guarantee that any email/text that you may send to me will remain confidential. If you choose to email/text me, please restrict the communication to non-confidential matters (change of schedules). Also include a phone number where I may reach you if a reply is necessary. I do not monitor email/text messages continuously; so the most effective way to reach me is via phone. Do not use email or texting as a method for contacting me regarding an urgent matter.

CLIENTS UNDER THE INFLUENCE

I reserve the right to refuse or terminate a session if you or anyone in the session is suspected to be under the influence of a mood altering substance. You will be responsible and charged for full payment of the normal fee.

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LIMITS ON CONFIDENTIALITY

The law protects the privacy of 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 state law and/or HIPAA. But, there are some situations where I am permitted or required to disclose information without either your consent or Authorization. If you are in danger of hurting yourself and/or someone else I am obligated to take protective action, including seeking hospitalization or contacting family members or others who can help provide protection. I will make every effort to discuss it with you before taking any action and I will limit my disclosure to what is necessary. If you inform me of any situations of child abuse, or abuse of elderly or legally dependent adults, I am legally obligated to make a report to the appropriate authorities and will do so. My duty to report also applies to situations that you tell me about that do not involve you directly. Also if you or your family member communicate to me that you pose a serious threat of physical violence against an identifiable victim, I must make reasonable efforts to communicate that information to the potential victim and the police. If I have reasonable cause to believe that you are in such a condition, as to be dangerous to yourself or others, I may release relevant information as necessary to prevent the threatened danger. Confidentiality may also be broken due to a court order or other legal situations. Please refer to the CALIFORNIA NOTICE OF PRIVACY PRACTICES for a more detailed explanation.

LITIGATION LIMITATION

It is important to understand how psychotherapy is affected by legal proceedings. I believe that it is in your best interest to protect your psychotherapy from the intrusiveness of legal proceedings. Here are three issues to consider:

1. If you place your mental status at issue in litigation initiated by you, the defendant (other side) has the right to obtain your psychotherapy records and/or testimony by your psychotherapist. Your adversary would have the right to know everything you've talked about in psychotherapy.

2. Forensic psychology (child custody evaluations, workers comp, lawsuits, etc.) is not one of my areas of expertise. If you are involved in legal proceedings, subpoenaing a therapist without forensic expertise to testify could hurt your case more than help it. Forensic psychologists do assessments (not psychotherapy) and are trained as expert witnesses in such cases.

3. The goals of legal proceedings (winning a case) do not mesh well with the goals of ongoing psychotherapy (exploring conflicted emotions and behavior in a safe, protected place). Psychotherapists are not allowed to have dual roles with a client which interfere with the client's therapy. [APA Ethical Principles & Code of Conduct: Standard 10.02(b): Standard 3.05; Standard 3.04]. Involvement in legal proceedings may necessitate termination of therapy.

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BILLING, PAYMENTS AND 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. It is very important that you find out exactly what mental health services your insurance policy covers. If you have a health insurance policy, it will usually provide some coverage for mental health treatment, however, you (not your insurance company) are responsible for full payment of my fees. You will be expected to pay for each session at the time it is held. As a courtesy to you, I will provide a bill that you can submit to your insurance company so that they can reimburse you directly. In some cases I can bill the insurance company directly after receiving your co-payment.

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

Due to the rising costs of health care, insurance benefits have increasingly become more complex. It is sometimes difficult to determine exactly how much mental health coverage is available. “Managed Health Care” plans such as HMOs and PPOs often require authorization before they provide reimbursement for mental health services. These plans are often limited to short-term treatment approaches designed to work out specific problems that interfere with a person’s usual level of functioning. It may be necessary to seek approval for more therapy after a certain number of sessions. While much can be accomplished in short-term therapy, some patients feel that they need more services after insurance benefits end.

You should also be aware that your contract with your health insurance company requires that I provide them with information relevant to the services that I provide to you. I am 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. Before I can disclose this information, both you and I must receive a written notification from the insurer stating what they are requesting, why they are requesting it, how long it will be kept and what will be done with the information when they are finished with it. 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 the insurance company computers. Though all insurance companies make assurances 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 insurance carrier.***

Once we have all of the information about your insurance coverage, we will discuss what we can expect to accomplish with the benefits that are available and what will happen if they run out before you feel ready to end your sessions. It is important to remember that you always have the right to pay for my services yourself to avoid the problems described above [unless prohibited by contract].

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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 FOR PROFESSIONAL SERVICES, the attached CALIFORNIA NOTICE OF PRIVACY PRACTICES, and my privacy policies and procedures. I am happy to discuss any of these rights with you.

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

Patient Name: _____

Signature: _____ **Date:** _____

Responsible Party's Name: _____

Signature: _____ **Date:** _____

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Patient Information

Name: _____ Date of Birth: _____ Age: _____

Social Security Number: _____ Male/Female (circle) M F

Address: _____

City: _____ State: _____ Zip: _____

May I send mail to you at this address? (circle) Yes No

Home Number: _____ Mobile: _____ Work: _____

Which number may I use to contact you and/or leave a message? _____

_____

Marital Status: _____ Date of Present Marriage: _____

Name of Spouse: _____ Date of Birth: _____

Names and ages of children: _____

List persons living in your home: _____

_____

Occupation: _____ Employer: _____

How long in this occupation? _____ How long with this employer? _____

Education: (List highest level of education attained): _____

Church Affiliation (if applicable): _____

Who Referred You: _____ May I thank them for referring you? (circle) Yes No

Person to notify in case of an emergency:

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Relationship to You: _____

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Patient Health History

Patient Name:_____

Person completing the form (if other than patient):_____

Name of Guardian (If applicable):_____

Primary Care Physician:_____Date of Last Exam:_____

Current Medical Condition(s):_____

Any perinatal or developmental abnormalities? No Yes (If yes, please explain on back of form)

Are you currently taking any prescription or "over the counter" medication(s)? No Yes

If yes, please identify the name, current dosage, and date began for each:_____

_____

Do you have any allergies: No Yes If yes, please list:_____

Have you received any Psychological/Psychiatric treatment before? No Yes

If yes, please show the total number of outpatient visits you have had: _____

What was your age at the first visit?_____

Have you had any inpatient/hospital treatment for mental health or substance abuse? No Yes

If yes, please list facility(ies) date(s) and length(s) of stay(s):_____

_____

Do you smoke cigarettes? No Yes If yes, how many per day?:_____

How much alcohol do you drink per week on average? Drinks per week:_____

Have you had problems with your drinking (legal, health, work, relationship)?_____

What caused you to get help now?_____

_____

Please indicate if you are experiencing any of the following symptoms:

Yes / No - Suicidal Thoughts/Impulses
Yes / No - Homicidal Thoughts/Impulses
Yes / No - Appetite Problems
Yes / No - Sleep Problems
Yes / No - Physical Complaints
Yes / No - Anger/Irritability
Yes / No - Isolation/Social Withdrawal
Yes / No - Anxiety/Panic
Yes / No - Phobia
Yes / No - Bingeing/Purging
Yes / No - Poor Impulse Control
Yes / No - Violence Toward Others
Yes / No - Destruction of Property
Yes / No - Strange or Unusual Behavior
Yes / No - Confused or Irrational Thinking
Yes / No - Bothersome Repetitive Thoughts or Behaviors
Yes / No - Self-mutilation

Signed Patient/Guardian: _____*Date:*_____

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NOTICE OF PRIVACY PRACTICES

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. Disclosures for Treatment, Payment, and Health Care Operations

I may *use* or *disclose* your *protected health information* (*PHI*), for certain *treatment, payment, and health care operations* purposes without your *authorization*. In certain circumstances I can only do so when the person or business requesting your PHI gives me a written request that includes certain promises regarding protecting the confidentiality of your PHI. 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 or another healthcare provider diagnoses or treats you. An example of treatment would be when I consult with another health care provider, such as your family physician or another psychologist, regarding your treatment.
  – *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* is when I disclose your PHI to your health care service plan (for example your health insurer), or to other health care providers contracting with your plan, or administering the plan, such as case management and care coordination.
- "*Use*" applies only to activities within my [office, clinic, practice group, etc.] such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.
- "*Disclosure*" applies to activities outside of my [office, clinic, practice group, etc.], such as releasing, transferring, or providing access to information about you to other parties.
- *"Authorization"* means your written permission for specific uses or disclosures.

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. In those instances when I am asked for information for purposes outside of treatment and payment operations, I will obtain an authorization from you before releasing this information. I will also need to obtain an authorization before releasing your psychotherapy notes. *"Psychotherapy notes"* are notes I have made about our conversation during a private, group, joint, or family counseling session, which I have kept separate from the rest of your medical record. These notes are given a greater degree of protection than PHI.

You may revoke or modify all such authorizations (of PHI or psychotherapy notes) at any time; however, the revocation or modification is not effective until I receive it.

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:** Whenever I, in my professional capacity, have knowledge of or observe a child I know or reasonably suspect, has been the victim of child abuse or neglect, I must immediately report such to child protective services. Also, if I have knowledge of or reasonably suspect that mental suffering has been inflicted upon a child or that his or her emotional well-being is endangered in any other way, I may report such to the above agencies.

- **Adult and Domestic Abuse:** If I, in my professional capacity, have observed or have knowledge of an incident that reasonably appears to be physical abuse, abandonment, abduction, isolation, financial abuse or neglect of an elder or dependent adult, or if I am told by an elder or dependent adult that he or she has experienced these or if I reasonably suspect such, I must report the known or suspected abuse immediately to the adult protective services agency or the local law enforcement agency.

  I do not have to report such an incident if:

  1) I have been told by an elder or dependent adult that he or she has experienced behavior constituting physical abuse, abandonment, abduction, isolation, financial abuse or neglect;

  2) I am not aware of any independent evidence that corroborates the statement that the abuse has occurred;

  3) the elder or dependent adult has been diagnosed with a mental illness or dementia, or is the subject of a court-ordered conservatorship because of a mental illness or dementia; and

  4) in the exercise of clinical judgment, I reasonably believe that the abuse did not occur.

- **Health Oversight:** If a complaint is filed against me with the California Board of Psychology, the Board has the authority to subpoena confidential mental health information from me relevant to that complaint.

- **Judicial or Administrative Proceedings:** If you are involved in a court proceeding and a request is made about the professional services that I have provided you, I must not release your information without 1) your written authorization or the authorization of your attorney or personal representative; 2) a court order; or 3) a subpoena duces tecum (a subpoena to produce records) where the party seeking your records provides me with a showing that you or your attorney have been served with a copy of the subpoena, affidavit and the appropriate notice, and you have not notified me that you are bringing a motion in the court to quash (block) or modify the subpoena. The privilege does not apply when you are being evaluated for a third party or where the evaluation is court-ordered. I will inform you in advance if this is the case.

- **Serious Threat to Health or Safety:** If you or your family member communicate to me that you pose a serious threat of physical violence against an identifiable victim, I must make reasonable efforts to communicate that information to the potential victim and the police. If I have reasonable cause to believe that you are in such a condition, as to be dangerous to yourself or others, I may release relevant information as necessary to prevent the threatened danger.

- **Worker's Compensation**: If you file a worker's compensation claim, I may disclose to your employer your medical information created as a result of employment-related health care services provided to you at the specific prior written consent and expense of your employer so long as the requested information is relevant to your claim provided that is only used or disclosed in connection with your claim and describes your functional limitations provided that no statement of medical cause is included.

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 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 and/or psychotherapy notes 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 for which you have neither provided consent nor authorization (as described in Section III of this Notice). 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.

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.
- Revisions to my Notice of Privacy Practices will be posted on the effective date and you may request a written copy from me.

V. Questions and Complaints

If you have questions about this notice, disagree with a decision I make about access to your records, or have other concerns about your privacy rights, you may contact me at:

Laura L. McGrady, Psy. D.
2725 Jefferson Street, Suite 102
Carlsbad, CA 92008
(760) 547-7770

If you believe that your privacy rights have been violated and wish to file a complaint with me, you may send your written complaint to:

Laura L. McGrady, Psy.D.
2725 Jefferson Street, Suite 102
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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.

You have specific rights under the Privacy Rule. I will not retaliate against you for exercising your right to file a complaint.

VI. Effective Date

This notice will go into effect on July 1, 2007.

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NOTICE OF PRIVACY PRACTICES

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You have the right to refuse to sign this document.

I, _____ , have received a copy of Laura L. McGrady, Psy.D.'s Notice of Privacy Practices.

Patient's Printed Name: _____

Signature: _____

Parent's/Guardian's Printed Name: _____

Signature: _____

Date: _____

FOR OFFICE USE ONLY

Laura L. McGrady, Psy.D. attempted to obtain written acknowledgment of receipt of the Notice of Privacy Practices, however, was unable to obtain it because:

_____ The patient refused to sign

_____ Communication barriers prohibited obtaining the acknowledgment

_____ An emergency situation prevented this office from obtaining the acknowledgment

Other (see below)

_____

_____

_____