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**POLICIES AND PROCEDURES**

Welcome to DC Holistic Psychotherapy (DCHP). This document contains important information about the professional services and business policies at DCHP. It also explains some basic guidelines or “ground rules” that will enhance the therapeutic process. Please **read it carefully** and jot down any questions you might have so that we can discuss them during our initial meetings. Our shared understanding and following of these guidelines will support the most effective use of our time and efforts, and will reduce the possibility of future misunderstandings that could possibly interfere with the therapeutic process. When you sign this document, it will represent an agreement between us.

**PSYCHOTHERAPY**

Psychotherapy services cannot be easily described in general statements. Psychotherapy practices vary depending on the specific training and orientation of the therapist, the individual personalities of the therapist and the client, and particular problems the client is experiencing and the client is seeking. What most mental health professionals seem to agree on is that psychotherapy is a process of growth based on honesty, openness, and a willingness to try new behaviors. This process is best facilitated in an emotionally safe atmosphere that is based on mutual trust and understanding. In additional, for psychotherapy to be effective, it requires a very active effort on your part. Our collaboration in addressing your problem will be enhanced by the amount of time and effort you devote to our work *outside* of our therapy sessions as well as during our appointments.

Psychotherapy can have benefits and risks. Engaging in therapy often involves discussing unpleasant aspects of your life. Therefore you may experience uncomfortable feelings like frustration, sadness, guilt, anger, loneliness or helplessness. On the other hand, psychotherapy may help you change your unhealthy thoughts, behaviors and patterns and result in you learning more effective problem solving strategies, minimizing your overall distress, and experiencing more rewarding relationships.

**THE INTAKE INTERVIEW**

The intake interview typically extends over three sessions. During these sessions we will discuss your reasons for seeking treatment and some basic background information about you which may include questionnaires. For children, assessment typically includes observation of parent-child interaction and play. Policies, fees and scheduling will also be discussed in these meetings.

To the extent possible, I will offer you some first impressions of what our work will include and an individualized plan to follow. You are encouraged to participate fully the planning of your goals. Following the completion of our intake sessions you should evaluate this information alson with your own opinions to determine whether you feel comfortable working with your therapist. Therapy involves a noteworthy commitment of time, money and energy. You should be very thoughtful about the therapist you select. If you have questions or doubts about participating in therapy at the present time or specifically with your therapist, please talk to your therapist about your concerns. S/he will be more than happy to help you set up a meeting with another mental health professional for a second opinion.

**ENDING THERAPY**

Our goal at DCHP is to provide a quality services in the shortest period of time that is necessary for you to gain the benefit from therapy. You have the right to withdraw from therapy for any reason at any time. We ask that you agree to have a final session after you notify your therapist of your voluntary termination of psychotherapy, so that s/he may responsibly review and evaluate your reasons, and make recommendations related to the termination of services.

**MEETINGS**

Psychotherapy sessions, also called a therapy “hour” are 55 minutes long and often once per week at a time we agree on, although some sessions may be longer or more frequent. ***Once an appointment hour is scheduled, you*** ***will be expected to pay for it unless you provide 48 business hours advance notice of cancellation [unless we both agree that you were unable to attend due to***

***circumstances beyond your control]. It is important to note that insurance companies do not***

***provide reimbursement for cancelled sessions.*** If it is possible, I will try to find another time to

reschedule the appointment.

Please initial \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PROFESSIONAL FEES**

Our hourly fee is $\_\_\_\_\_\_\_\_. In addition to weekly appointments, we charge this amount for

other professional services you may need, though we will break down the hourly cost if we work

for periods of less than one hour. Other services include 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. If you become involved in legal proceedings that require our participation, you

will be expected to pay for all of our professional time, including preparation and transportation

costs, even if we are called to testify by another party. Because of the difficulty of legal

involvement, we charge $380.00 per hour for preparation and attendance at any legal proceeding.

**CONTACTING ME**

Due to our work schedule, I am often not immediately available by telephone. While the office

is usually open between 9 AM and 6PM, I probably will not answer the phone when I am

with a patient. When we are unavailable, our telephone is answered by voice mail that is

monitored frequently. We will make return your call as soon as possible, usually within 24 hours with the exception of weekends and holidays. If you are difficult to reach, please inform us of some times when you will be available. In emergencies, you can try our emergency number. If you are unable to reach us and feel that you can’t wait for us to return your call, contact your family physician or the nearest emergency room and ask for the psychiatrist on call. If we will be unavailable for an extended time, we will provide you with the name of a colleague to contact, if necessary.

***Limits and Exceptions to Confidentiality:***

There are some situations in which we are legally obligated to take actions, which we believe are

necessary to attempt to protect others from harm and we may have to reveal some information

about a patient’s treatment. These situations are unusual in our practice.

If such a situation arises, we will make every effort to fully discuss it with you before taking any

action and we will limit our disclosure to what is necessary.

**Child Abuse:** If we have reason to suspect that a child is abused or neglected, we are required by law

to report the matter immediately to the District of Columbia Department of Social Services.

**Adult and Domestic Abuse:** If we have reason to suspect that an adult is abused, neglected or

exploited, we are required by law to immediately make a report and provide relevant information to the District of Columbia Department of Welfare or Social Services.

**Health Oversight:** The District of Columbia Department of Health has the power, when necessary, to subpoena relevant records should we be the focus of an inquiry.

**Judicial or Administrative Proceedings:** If you are involved in a court proceeding and a request is

made for information about your diagnosis and treatment and the records thereof, such information is

privileged under state law, and we will not release such information without the written authorization of you or your legal representative, or a subpoena (of which you have been served, along with the proper notice required by state law). However, if you move to quash (block) the subpoena, we are required to place said records in a sealed envelope and provide them to the clerk of court of the appropriate jurisdiction so that the court can determine whether the records should be released. The privilege does not apply when you are being evaluated for a third party or where the evaluation is court ordered. You will be informed in advance if this is the case.

From time to time, clients find themselves in judicial proceedings and as a result we receive subpoenas to produce documents and/or to appear at a deposition, a hearing or a trial. If we receive a subpoena or other process to produce your records you will receive notice of same from the party who subpoenas the records. If you or your counsel subpoena the records, that will constitute your consent to produce the records. If another person subpoenas your records and you object to the records being produced, then you must contact us immediately to tell us of your objection and you must file a motion to quash the subpoena in court to bar the production of the records. If you do not object within the time set forth in the subpoena or within 14 days of service of the subpoena, whichever is longer, then that shall constitute your consent that the records may be produced. If we find it necessary to obtain counsel to file pleadings in court or to appear in court to contest a subpoena then you will be responsible for those reasonable attorneys’ fees. ***Finally, if we are subpoenaed to appear in court or at a deposition to testify in any legal proceeding in which you are a party about matters related to you, then you agree to pay for our time at the rate of $300.00 per hour.***

**Serious Threat to Health or Safety:** If we are engaged in our professional duties and you

communicate to me a specific and immediate threat to cause serious bodily injury or death, to an

identified or to an identifiable person, and we believe you have the intent and ability to carry out that

threat immediately or imminently, we must take steps to protect third parties. These precautions may

include (1) warning the potential victim(s), or the parent or guardian of the potential victim(s), if under

18; or (2) notifying a law enforcement officer.

**There are some situations where we are permitted or required to disclose information without**

**either your consent or authorization:**

If you are involved in a court proceeding and a request is made for information

concerning your diagnosis and treatment, such information is protected by the therapist/ patient

privilege law. We cannot provide any information without your (or your legal

representative’s) written authorization, or court order. If a subpoena is served on us with

appropriate notices, we may have to release information in a sealed envelope to the clerk

of the court issuing the subpoena. If you are involved in or contemplating litigation, you

should consult with your attorney to determine whether a court would be likely to order

us to disclose information.

If a government agency is requesting the information for health oversight activities, we

may be required to provide it for them.

If a patient files a complaint or lawsuit against us, we may disclose relevant information

regarding that patient in order to defend ourselves.

If a patient files a worker’s compensation claim, we must, upon appropriate request,

provide a copy of any mental health report.

The law protects the privacy of all communications between a patient and a therapist. In most

situations, we can only release information about your treatment to others if you sign a written

authorization form that meets certain legal requirements imposed by HIPAA. There are other

situations that require only that you provide written, advance consent. **Your signature on this**

**Agreement provides consent for the following activities:**

We may occasionally find it helpful to consult other health and mental health

professionals about a case. During a consultation, we make every effort to avoid

revealing the identity of our patient. The other professionals are also legally bound to

keep the information confidential. If you don’t object, we will not tell you about these

consultations unless we feel that it is important to our work together. We will note all

consultations in your Clinical Record (which is called patient health information “PHI” in our Notice of Therapist’s Policies and Practices to Protect the Privacy of Your Health Information).

You should be aware that we practice with other mental health professionals and that we

employ administrative staff. In most cases, we need to share protected information with

these individuals for both clinical and administrative purposes on an as needed only, such as scheduling, billing and quality assurance. All of the mental health professionals are bound by the same rules of confidentiality. All staff members have been given training about protecting your

privacy and have agreed not to release any information outside of the practice without the

permission of a professional staff member.

We may also have contracts with an accountant, cleaning service, and an answering service.

As required by HIPAA, we have a formal business contract with this/these business(es),

in which it/they promise to maintain the confidentiality of this data except as specifically

allowed in the contract or otherwise required by law. If you wish, we can provide you

with the names of these organizations and/or a blank copy of this contract.

Disclosures required by health insurers or to collect overdue fees are discussed elsewhere

in this Agreement.

* While HIPAA does not include confidentiality protections regarding billing, if you use a credit card to pay for services your billing information will be disclosed to the credit card processing company which is used (square, paypal, etc.)

If a patient threatens to harm himself/ herself, we may be obligated to seek hospitalization

for him/her, or to contact family members or others who can help provide protection.

While this written summary of exceptions to confidentiality should prove helpful in informing

you about potential problems, it is important that we discuss any questions or concerns that you

may have now or in the future. The laws governing confidentiality can be quite complex, and we

are not attorneys. In situations where specific advice is required, formal legal advice may be

needed.

**PROFESSIONAL RECORDS**

You should be aware that, pursuant to HIPAA, we keep Protected Health Information about you

in two sets of professional records. One set 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 we 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, 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 our presence, or have them forwarded to another

mental health professional so you can discuss the contents. In most circumstances, we are

allowed to charge a copying fee of $0.25 per page and for certain other expenses. The exceptions

to this policy are contained in the attached Notice Form. If we refuse your request for access to

your Clinical Record, you have a right of appeal of such denial, which we will discuss with you

upon your request.

In addition, we also keep a set of Psychotherapy Notes. These Notes are for our own use and are

designed to assist us 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, analysis of those conversations, and how they impact on your therapy. They also

contain particularly sensitive information that you may reveal to us that is not required to be

included in your Clinical Record. These Psychotherapy Notes are kept separate from your

Clinical Record. While insurance companies can request and receive a copy of your Clinical

Record, they cannot receive a copy of your Psychotherapy Notes without your signed, written

authorization. Insurance companies cannot require your authorization as a condition of coverage

nor penalize you in any way for your refusal. You may examine and/or receive a copy of your

Psychotherapy Notes unless we determine that such information does not exist or cannot be

found, or such disclosure would be injurious to your health or well being.

**Electronic/ digital recording of sessions** is prohibited unless agreed in writing by both the therapist and patient(s).

**PATIENT RIGHTS**

HIPAA provides you with several new or expanded rights with regard to your Clinical Record and

disclosures of protected health information. These rights include requesting that we amend

your record; requesting restrictions on what information from your Clinical Record is

disclosed to others; requesting an accounting of most disclosures of protected health

information that you have neither consented to nor authorized; determining the location to

which protected information disclosures are sent; having any complaints you make about

my policies and procedures recorded in your records; and the right to a paper copy of this

Agreement, the attached Notice form, and my privacy policies and procedures. I am happy

to discuss any of these rights with you.

These rights are in more detail below:

*Right to Request Restrictions* –You have the right to request restrictions on certain uses and disclosures of protected health information about you. However, we are not required to agree to a restriction your 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 us. Upon your request, we 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

psychotherapy notes in our mental health and billing records used to make decisions about you for as

long as the PHI is maintained in the record. We may deny your access to PHI under certain

circumstances, but in some cases you may have this decision reviewed. On your request, we 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. We may deny your request. On your request, we 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, we 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 this notice from us upon request, even if you have agreed to receive the notice electronically.

Therapist’s Duties:

We are required by law to maintain the privacy of PHI and to provide you with a notice of our legal

duties and privacy practices with respect to PHI.

We reserve the right to change the privacy policies and practices described in this notice. Unless we

notify you of such changes, however, we are required to abide by the terms currently in effect.

If we revise our policies and procedures, we will provide our patients with a notice at their next

scheduled session.

**MINORS & PARENTS**

Children of any age have the right to independently consent to and receive mental health

treatment without parental consent and, in that situation information about that treatment cannot

be disclosed to anyone without the child’s agreement. While privacy in psychotherapy is often

crucial to successful progress, particularly with teenagers, parental involvement is also essential

to successful treatment, particularly with younger children and this requires that some private

information be shared with parents. It is our policy not to provide treatment to a child under age

13 unless he/she agrees that we can share whatever information we consider necessary with

his/her parents. For children age 13 and over, we request an agreement between the patient and

his/her parents allowing us to share general information about the progress of the child’s

treatment and his/her attendance at scheduled sessions. We will also provide parents with a

summary of their child’s treatment when it is complete. Any other communication will require the

child’s authorization, unless we feel that the child is in danger or is a danger to someone else, in

which case, we will notify the parents of our concern. Before giving parents any information, we

will discuss the matter with the child, if possible, and do our best to handle any objections he/s/he

may have.

**BILLING AND PAYMENTS**

You will be expected to pay for each session at the time it is held, unless we agree otherwise.

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, we have the option of using legal means to secure the payment. This may

involve hiring a collection agency or going through small claims court which will require us to

disclose otherwise confidential information. In most collection situations, the only information

we 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 and attorneys fees will be included in the

claim and you hereby agree to pay all such costs.

**INSURANCE REIMBURSEMENT**

While we do not participate with any insurance panels as in-network providers, we can assist you in seeking reimbursement for any out of network benefits you may have through your insurance plan, health or flexible spending accounts. Upon request we will provide you with statements with the proper coding and documentation to submit to your insurance company.

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. We will assist you to fill out forms

in helping you receive the benefits to which you are entitled; however, you (not your insurance company) are responsible for full payment of our fees. It is very important that you find out exactly what mental health services your insurance policy covers.

Please 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. 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.

Please also be aware that your contract with your health insurance company may require that

we provide it with information relevant to the services that we provide to you. We are required to

provide a clinical diagnosis and brief substantiation of that diagnosis. Sometimes we are required

to provide additional clinical information; such as a treatment plan. This information is limited to

the dates of treatment and a brief description of the services provided, including the type of

therapy provided. 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, we 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. We

will provide you with a copy of any report we submit, if you request it. By signing this

Agreement, you agree that we can provide requested information to your 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 our services yourself to avoid the problems described above, unless prohibited by

contract.

**Complaints**

If you are concerned that we have violated your privacy rights, or you disagree with a decision we have made about access to your records, you may file a complaint with DC Holistic Psychotherapy,

or with the Secretary of the Department of Health and Human Services. To file a complaint with

our office, contact DC Holistic Psychotherapy, HIPPA Coordinator at her office. All complaints

must be submitted in writing. You will not be penalized 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 person listed above can provide you with the appropriate address upon request.

VI. Effective Date, Restrictions and Changes to Privacy Policy

This notice went into effect on April 14th, 2003 We reserve the right to change the terms of this notice and to make the new notice provisions effective for all PHI that we maintain. We will provide you with a revised notice at the first scheduled treatment

visit after any revisions occur.

**DC Holistic Psychotherapy**

**Patient Consent to Policies and Procedures**

I understand that, under the Health Insurance Portability and Accountability Act of 1996 (HIPPA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly or indirectly. Provide information to a third party for the patient to be reimbursed. Conduct normal healthcare operations. For example, to evaluate the quality of care you receive from us.

I have received a copy of DC Holistic Psychotherapy’s Privacy Practices containing a more complete description of the uses and disclosures of my health information. I have been given the right to review DC Holistic Psychotherapy’s Notice of Privacy Practices prior to signing this consent. I understand that DC Holistic Psychotherapy has a right to change its Notice of Privacy Practices (such as: if the Privacy Officer changes or there is a change in the law). I may contact DC Holistic Psychotherapy at any time to obtain a current copy of the Notice of Privacy Practices. I understand that I may request in writing that DC Holistic Psychotherapy restrict how my private information is used or disclosed to carry out treatment, payment, or health care operations. I also understand DC Holistic Psychotherapy

is not required to agree to my requested restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that DC Holistic Psychotherapy has taken action relying on this consent.

Patient Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Patient Initial 48 hour Cancelation Policy :\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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