PRACTICE AGREEMENT

Lisa Ahern, Ph.D., PLLC

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Effective July 18, 2019

Welcome to my practice. This agreement contains important information about the practice and its 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) used for the purposes 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. This notice, which is attached to this Agreement, explains HIPAA and its application to your PHI in greater detail. The law requires that I obtain your signature acknowledging that I have provided you with this information at the beginning of your treatment. Please read it carefully and make note of any questions you may have. We can discuss any questions you have about the procedures during your appointment. When you sign this document, it will represent an agreement between us.

PSYCHOLOGICAL SERVICES

My services vary depending on your needs. There are many available methods used to help us reach your evaluation and/or treatment goals. Our first few sessions will involve an evaluation of your needs. By the end of the evaluation, I will be able to offer you some initial impressions of what your treatment will include and a plan to follow, if we decide to continue. If you have questions about procedures, they should be discussed with me whenever they arise.

PROFESSIONAL FEE SCHEDULE

**I reserve the right to alter and update the Fee Schedule at any time. All clients will be notified in writing of changes in fees at least 4 weeks prior to implementation.

Consultation/Treatment

Intake Appointment (60 minutes)	Rate
	$225.00
Individual and Family Therapy	
Length of Session	Rates
45 minutes	$175.00
30 minutes	$135.00
60 minutes	$225.00
Extended Time	Prorated based on hourly rate of $225
Group Therapy (60 minutes)	$100.00
Consultation	
60 minutes	$225.00
120 minutes	$450.00

Testing Services (Psychological, Psychoeducational, Neuropsychological)
Step 1: Intake Appointment (60 minutes) - $225.00

Step 2: Testing Procedures
The total cost of testing varies based on factors such as the nature of your concerns, the testing procedures, and the extent of documentation (i.e. report) prepared. I will provide you with an estimate of your testing and documentation fees by the conclusion of the intake appointment. This estimated cost may be different than the actual cost. The services and their corresponding fees are indicated below:

Face-to-face testing (per 30 minute session): $125.00 (most sessions typically take more than one hour)
Scoring/Interpretation/Preparation of Comprehensive Written Report (per hour): $200.00
Classroom Observation (per hour): $250.00
Consultation with teacher(s)/school administrators, treatment providers (per hour, pro-rated): $200.00
Attendance at school/IEP meeting (per hour, pro-rated): $250.00

Step 3: Feedback Session: appointment to review test results and recommendations (60 minutes): $225.00

Other Fees

Communications (email, phone)	15 minutes	$55.00
Document preparation	15 minutes	$55.00
Late cancellations (less than 24 hours notice)		$75.00
No show/missed appointment without notification		$175.00
Legal Proceedings	per hour	$500.00

*As fact or expert witness: $500.00 per hour time preparing for and giving deposition, and port to port fees $200.00 per hour; due in full and in advance based on estimate of time.

LEGAL PROCEEDINGS
I require a subpoena for deposition and testimony. Should I be subpoenaed for deposition and testimony, I may also object on the grounds of statutory privilege and may request a court order and a Qualified Protective Order in order to adhere to HIPAA and maximize the protection of patient confidentiality. There may be other reasons for objecting to a subpoena, depending on the details of the case. I will provide an estimate of the total number of hours the depositions and testimony will take and will track my time. Should the case take less time than estimated, I will immediately return funds for hours unused, and should the case take additional time, I will bill the client for the balance, with the balance due within 15 days of billing. The fee for depositions and testimony as a fact or expert witness is $500.00 per hour. I will estimate time at court or depositions in hourly increments and additional time will also be estimated and billed at the same $500.00 per hour rate to account for preparation. Travel will be billed at 200.00 per hour. I will provide a comprehensive estimate of time to the subpoenaing attorney and/or party. If my attorney reviews any subpoena or has involvement in the process you agree to pay 100% of all attorney's fees incurred by me. IMPORTANT: Should you attempt to subpoena me without paying my usual and customary fees (i.e., the full estimate) in advance, and refuse to rescind the subpoena, I will move to quash and/or file counter complaint for abuse of process, and you agree to pay 100% of attorney fees incurred by me, said fees to be rolled into your estimate.

To guarantee availability I require a four week notice for depositions or testimony. I will make every effort to be available if less than four weeks notice is given, but I may have scheduling conflicts with too little notice. I require ½ of the hourly estimate to hold the date; this holding fee is fully returnable if I am notified five full business days prior to said date that my services will not be needed. The remaining ½ of

the estimate is due in full five full business days prior to the date. Should cancelation occur less than five full business days in advance, the money will be returned minus an hourly fee of $200.00 for the time held (which covers time lost with clients in the office that day), and minus any preparation hours that have already been spent on the case (billed at the $500.00/hr). After the deposition or testimony has taken place I do not offer refunds for any reason.

Attorneys may pay by any form of check, credit card (or cash); parties must pay by cashier's check, credit card, or cash. Late Fees & Returned Checks: If a balance accrues for any reason, it is due within 14 days of the invoice date. I will inform you of your balance and charge your credit card (if on file). If for some reason there is an outstanding balance after 14 days a finance charge of 10% will be added for each two weeks of outstanding balance. A collection agency will be notified if the bill has not been paid within 30 days. If an attorney must be hired to collect the past due balance, all fees for this service will be charged to you as well. Regarding returned check fees, you will owe any fees the bank charges me for the bounced check, any fees for time I must spend talking with the bank or you to rectify the situation (billed at $200/hour in 15-minute increments), plus any late fees that apply. Regarding delinquent accounts, you are responsible for, in full, and will be charged for, in full, any and all time I spend trying to collect on the account (billed at $200/hour), and/or any and all fees of any outside services, such as an attorney or credit collector, hired to collect the debt.

BILLING AND PAYMENTS

You will be expected to pay for each appointment at the time it is held, unless we agree otherwise. I accept the following methods of payment: credit card, check, and cash. Checks should be made out to Lisa Ahern, Ph.D., PLLC. Late charges will be added to accounts with any balance over 30 days old. Late Fees are calculated at a rate of 2% monthly. If your account has not been paid for more than 60 days and you have not arranged payment, I have the option of using legal means to secure payment, including collection agencies or small claims. In most collection situations, the only information released regarding a client's treatment is his/her name, the nature of services provided, and the amount due. (If such legal action is necessary, the costs will be included in the claim.)

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. I am an out-of-network provider for most insurance companies, but will provide you with a claim form and receipt of payment per your request. You will be required to submit these forms to your insurance company for direct reimbursement. *I strongly encourage you to contact your insurance company prior to services to determine your out-of network benefits and for you to request pre-authorization if necessary.*

If you request reimbursement from your insurance carrier, your contract with your health insurance carrier requires that I provide them with information relevant to the services that I provide to you. I am required to provide a clinical diagnosis and a service code. Sometimes I am required to provide additional clinical information such as treatment plans, summaries, or copies of your entire Clinical Record. 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 most likely be stored electronically. 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 per your request. Should my involvement with your insurance company regarding pre-authorization exceed 15 minutes, you will be required to pay for the time at a rate of $55 per 15 minute increment.

24-HOURS NOTICE OF CANCELLATION POLICY

Your appointment time is reserved exclusively for you. If you are unable to keep this appointment, please notify me as soon as possible. If you cancel your appointment with at least 24 hours notice, you will not be charged for missing the appointment. However, if you cancel your appointment with less than 24-hours notice, you will be charged for half of the session fee ($75.00). If you fail to come to your appointment altogether and without any prior notification, you will be charged for the full session rate of $150.00. It is important to note that insurance companies do not provide reimbursement for late cancellation or no show charges. In the event of inclement weather, please check your email and voicemail for messages from me informing you of the day's schedule. You should also contact me directly if concerned about inclement weather.

CONTACTING ME

Due to the nature of my work, I am often not immediately available. Please leave a message for me if you get my voicemail and I will make every effort to respond within 24 business hours (with the exception of weekends and holidays). Should you decide to contact me via email, please note that *this is not a secure means of communication* and you are accepting the risk associated with transmitting personal information over the internet.

Emails should be limited to scheduling, as they are not a means by which I can provide appropriate clinical care. I will also document any clinically-related information sent via email in your/your child's medical record. If you cannot reach me and feel that you have an emergency, call 911 or go to the nearest emergency room and ask for the psychiatrist on call. If I will be unavailable for an extended period of time, you will be notified and provided with contact information for another clinician, if necessary.

TCBH and Lisa Ahern, PhD, PLLC have a presence on certain social media venues so that individuals can access information regarding services and resources. However, I practice a strict policy of not "friending" and/or communicating with current or previous clients or their families through social media (e.g., Facebook, Instagram, LinkedIn, etc…). I enforce this policy to protect your privacy and to keep the boundaries of our therapeutic relationship clear.

CONFIDENTIALITY

In general, the law protects the privacy of all communication between a client 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 document 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 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.

- My practice (Lisa Ahern, Ph.D., PLLC) maintains its own secure client records, stored separately from other providers within the Triangle Center for Behavioral Health. Your confidential information may not be accessed by other providers without your written authorization. However, in the event of my death or incapacitation, a representative of Triangle Center for Behavioral Health will oversee the short-term clinical operations of my practice. By signing this form, you are consenting to allow that individual access to your records in order to contact you regarding my status and to assist you with seeking

alternative clinical services as needed. If ever I am unable to access your records or communicate with you during a clinical emergency, a representative may access your records in my absence. By signing this form, you are consenting to allow this individual to contact you during an emergency and assist you with accessing emergency services, as well as contact other parties involved in the emergency situation, including law enforcement, in order to ensure your safety and that of others.

- You should also be aware that I have a contract with TheraNest, LLC, a web-based company that provides billing, clinical documentation, credit card merchant, and calendar/patient scheduling services. As required by HIPAA, I have a formal business associate contract with TheraNest, LLC, in which it promises to maintain the confidentiality of your protected health information, except as specifically allowed in the contract or otherwise required by law.

- If I believe that a client presents an imminent danger to him/herself, I may be required to seek hospitalization for the client, or contact family members or others who can help provide protection.

There are some situations in which I am 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 the professional services that I provided you, such information is protected by psychologist-patient privilege law. I cannot provide any information without your authorization, or a court order. If you are involved in or contemplating litigation, you should consult with your attorney to determine whether a court would be likely to order me to disclose information.

- 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, and my services are being compensated through worker's compensation benefits, I must, upon appropriate request, provide a copy of the patient's record to the patient's employer or the North Carolina Industrial Commission.

There are 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 there is cause to suspect a child under 18 is abused or neglected, or reasonable cause to believe that a disabled adult is in need of protective services, the law requires that a report be filed with the appropriate agency. Once such a report is filed, additional information may be required.

- If there is reason to believe that a client presents an imminent danger to the health and safety of another, I may be required to disclose information in order to take protective actions, including initiating hospitalization, warning the potential victim, and/or calling the police.

Minors and Parents

Parental involvement is essential to successful treatment and this may require that some private information be shared with parents. It is our policy only to share information that is considered necessary

with a minor client's parents. This includes general information about the progress of the child's treatment and his/her attendance at scheduled sessions. Before giving parents any information, this will be discussed with the child, if possible, and an attempt will be made to handle any objections he/she may have.

Children over the age of eighteen 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 client's agreement. It is important that any questions or concern that you may have now or in the future be discussed immediately with me.

PATIENT RIGHTS

HIPAA provides you with several new or expanded rights concerning 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 view and copy your records. I will be happy to discuss any of these rights with you. These rights are explained further in the Privacy Notice.

By signing below I, _____, acknowledge that I
(Print) Client's Full Name

understand and accept all the terms in the above agreement for services provided my clinician. I

also acknowledge that I have received the HIPAA Notice Form described above.

_____ _____
Client's Signature (required for clients 18 years or older) Date

_____ _____
Parent or Legal Guardian's Signature (required for minor clients 17 or younger) Date