

POLICIES



INFORMATION FOR NEW CLIENTS

General Information about Reading, Filling Out and Signing Forms

Please carefully read over the Client Agreement and NC Notice Forms. These detail federal laws about protecting mental health care information and privacy. You are welcome to print them out and keep them for your records. You do not need to bring them with you to our initial consultation.

All clients must sign the Adult or Child Notice & Consent Forms, either for individual therapy, or as their child or teen's legal guardian.

Prior to our first consultation, please fill out the appropriate background forms for either Adult, Child under Six, Child/Teen or Sandplay Process/Consultation and bring these completed forms with you when we initially meet or send them to me at info@drheiko.com.

Information about Fees and Payment

I am not a participating provider with any insurance panels; as such, I am often designed by insurance companies as an "out-of-network provider". I have carefully considered the costs and benefits of being part of these panels, after about 20 years as a listed provider with most insurance companies. Since so many insurance companies have so many different provider payment scales and schedules as well as rules about how to practice, I have comfortably maintained this stance. As presented in my Client Agreement Form, I collect payment through personal check, cash or credit card at the time of service. I do provide every client with a "superbill", a receipt which contains the necessary information for you to submit to your insurance carrier for reimbursement of the fee.




PSYCHOTHERAPIST-CLIENT SERVICES AGREEMENT

Welcome to my practice. Please read this information carefully. This document (the 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 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 (the NC Notice Form) 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. Although these documents are long and sometimes complex, it is very important that you read them carefully before our next session. We can discuss any questions you have about the procedures at that time. When you sign this document, it will also 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. I reserve the right to change the privacy policies and practices described in this agreement at any time and will provide you with a revised notice by mail.

PSYCHOLOGICAL SERVICES

I am a NC Health Service Provider-Psychologist and Certified School Psychologist who has been teaching, supervising and in clinical practice in university, school and independent practice settings for over 30 years. I work with children, teenagers and adults individually, in families, and in groups. If the psychotherapeutic need you or your family experience is outside of my expertise, I will help you with appropriate referrals to other professionals.

Psychotherapy is not easily described in general statements. It varies depending on the mix of our personalities 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 can have benefits and risks. Since therapy often involves discussing unpleasant aspects of your life, you may experience uncomfortable and possibly intense emotions. On the other hand, psychotherapy has also been shown to have many bene-



fits. 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 initial session is a Diagnostic Child or Adult Interview and will last about 50 minutes. The first few sessions will involve an evaluation of your needs or your child's needs. By the end of the evaluation, I will be able to offer you some first impressions of what our work will include and a treatment plan to follow, if you decide to continue with therapy. You should evaluate this information along with your own opinions of whether you feel comfortable working with me. I will be happy to help you set up a consultation with another mental health professional for a referral or a second opinion, if you would like.


SESSIONS

I typically see clients initially for an assessment phase that lasts from 2 to 4 sessions. During this time, we can both decide if I am the best person to provide the services you need in order to meet your treatment goals. If psychotherapy is begun, I usually schedule one 45-minute session (one appointment hour = 45 minutes duration) per week at a time we agree on, although some sessions may be longer or more frequent. Please understand that regular clients are usually scheduled the same time and day each week. Priority in scheduling sessions is given to clients who are seen weekly, although I will make every effort to schedule regular bimonthly or monthly sessions.

Once an appointment hour is scheduled, you will be expected to pay for it unless you provide 24 hours advance notice of cancellation, unless I agree that you were unable to attend due to circumstances beyond your control (such as unpredictable crisis or illness). 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 your cancelled appointment within the week. Please leave a message if you must cancel with the date and time of your next week's regular appointment time, if you have one. I will call you to reschedule only if that time is reserved for another client.

PROFESSIONAL FEES

My hourly fees are attached to this form. In addition to weekly appointments, I charge differing amounts 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 10 minutes, consulting with other professionals with your permission, preparation of records or treatment summaries, and



the time spent performing any other service upon which we agree. If you become involved in legal proceedings that require my participation, you will be expected to pay for all of my professional time in increments of 4 hours. That would include preparation and transportation costs, even if I am called to testify by another party. As a result of the difficulty of legal involvement, I charge \$500 per hour for preparation, transportation and attendance at any legal proceeding. This cost is not reimbursable through insurance plans.

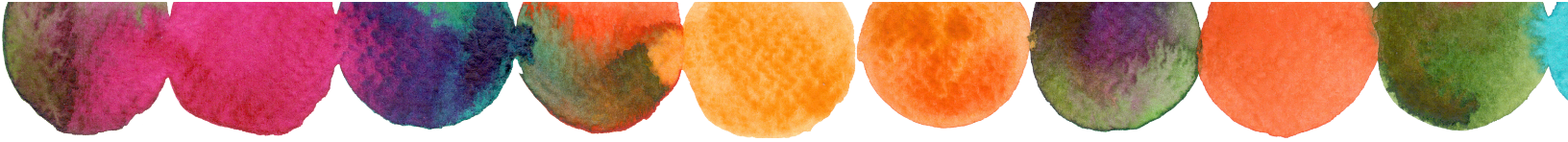
CONTACTING ME

Due to my work schedule, I am often not immediately available by telephone. While I am usually in my office between 8 AM and 5 PM, I do not answer the phone when I am with a client. My telephone is answered only by an automated, confidential voice mail that my office manager and I monitor frequently. I will make every effort to return your call on the same day you make it, with the exception of weekends and holidays. I will also use your cellphone for texting for appointment information, unless you indicate otherwise to me in writing. If you call and have not heard from me within a day of your call, I may not have received your initial message. Please call back in that case! Please note that when I return calls after my regular office hours, my phones outside of the office are blocked for caller ID and if your phone(s) are blocked as well, I will be unable to reach you directly. If you are difficult to reach, please inform me of some times and numbers on an unblocked phone 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 psychiatrist on call, or Hopeline, at 919.231.4525. If I will be unavailable for an extended time, I will provide you with the name of a colleague to contact, if necessary.

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 client. During a consultation, I make every effort to avoid revealing the identity of my client. 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 employ administrative staff. In most cases, I need to share protected information with my office manager for both clinical and administrative purposes, such as scheduling, billing and quality assurance. My office manager has been given training about protecting your privacy and has agreed not to release any information outside of the practice without my permission.

I also have contracts with an accountant and my malpractice carrier. As required by HIPAA, I have a formal business associate contract with these businesses, in which they promise to maintain the confidentiality of this practice data except as specifically allowed in the contract or otherwise required by law. If you wish, I 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.

If I believe that a client presents an imminent danger to his/her health or safety, I may be obligated to seek hospitalization for him/her or to contact family members or others who can help provide protection.


There are some situations where 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 the psychologist-client privilege law. I cannot provide any information without your written 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 client files a complaint or lawsuit against me, I may disclose relevant information regarding that client in order to defend myself.

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



There are some situations in which I am legally obligated to take action; these are situations in which it is necessary to attempt to protect others from harm and where I may have to reveal some information about a client's treatment. These situations are unusual in my practice.

If I have cause to suspect that a child under 18 is abused or neglected, or if I have reasonable cause to believe that a disabled adult is in need of protective services, the law requires that I file a report with the County Director of Social Services. Once such a report is filed, I may be required to provide additional information.


If I 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, if identifiable, and/or calling the police.

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.

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 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 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/or others or 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. In



most circumstances, I am allowed to charge a copying fee per page (and for certain other expenses). The exceptions to this policy are contained in the attached Notice Form. If I refuse your request for access to your records, you have a right of review, which I will discuss with you upon request.


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.

MINORS & PARENTS

I respect the right of children to independently consent to and receive mental health treatment. While privacy in psychotherapy is very important, particularly with teenagers, parental involvement is also essential to successful treatment and this requires that some private information disclosed by a child or teen be shared with parents. It is my policy not to provide treatment to a child or teen under 16 unless he/she agrees that I can share whatever information I consider necessary with his/her parents. For teens 16 and over, I request an agreement with my client allowing me to share general information about the progress of the teen's treatment and his/her attendance at scheduled sessions. I expect parents or guardians to respect that communication between myself as therapist and their child/teen/ward is confidential. The exception would be if I believe that the child is in danger or is a danger to someone else. In such a case, I will notify the parents of my concern. Before giving parents any information, I will discuss the matter with the child or teen, if possible, and do my best to handle any objections he/she may have. In situations involving separated or divorced families, both parents (legal guardians) must sign and submit the Shared Custody Agreement Form before any initial consultation session date is set. Parents must also arrange to agree upon payment terms with my practice before that initial consultation session as well.

BILLING AND PAYMENTS



You will be expected to pay for each session at the time it is held, unless we agree otherwise. Adolescent clients who drive themselves to my office should be provided with payment from parents for each session. Payment schedules for other professional services will be agreed to when they are requested. In circumstances of unusual financial hardship, I may be willing to negotiate a fee adjustment or payment installment plan. A late fee of \$50 per month will be assessed against any balance outstanding over 45 days. Any returned checks will be charged a fee of \$50.

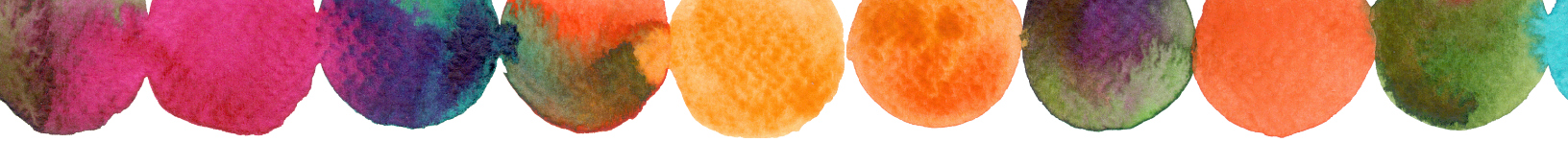
If your account has not been paid for more than 60 days and arrangements for payment have not been agreed upon, I have the option of using legal means to secure the payment. This may involve hiring a collection agency which will require me to disclose otherwise confidential information. In most collection situations, the only information I release regarding a client's treatment is his/her name, the nature of services provided, and the amount due. If such legal action is necessary, its 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. If you have a health insurance policy, it will usually provide some coverage for mental health treatment. I will give you a superbill to provide you with psychological information to help you receive the benefits to which you are entitled; however, you are responsible for full payment of my fees at the time of service. I do not accept assignment of insurance payments,

You need to 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 to help you understand the information you receive from your insurance company. If it is necessary to clear confusion, I will be willing to call the company on your behalf. I am not a participating provider with any insurance panels; as such, I am often designated as an "out-of-network provider".

You should also be aware that if you submit my bill to your health insurance company, they often require me 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. 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 I have no control over what the company does with it once it is in their hands. I will provide you with a copy of any re-



port I submit for your initial review, and have you send it to the insurer directly. By signing this Agreement, you agree that I can provide requested information to your carrier.

Your signature on the Child/Teen or Adult Consent Form indicates that you have read the information in this document and agree to abide by its terms during our professional relationship. I look forward to working with you!

NOTICE OF PSYCHOLOGISTS' POLICIES AND PRACTICES TO PROTECT THE PRIVACY OF YOUR HEALTH INFORMATION

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

I may use or disclose your protected health information (PHI), for treatment, payment, and health care operations purposes with your consent. 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, coordinate or manage your health care and other services related to your health care. An example of treatment would be when I consult with another health care provider, such as your family physician or another psychologist.
- 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 are activities that relate to the performance and operation of my practice. Examples of health care operations are quality assessment and improvement activities, business-related matters such as audits and administrative services, and case management and care coordination.

“Use” applies only to activities within my office such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.

“Disclosure” applies to activities outside of my office, such as releasing, transferring, or providing access to information about you to other parties.

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. An “authorization” is written



permission above and beyond the general consent that permits only specific disclosures. In those instances when I am asked for information for purposes outside of treatment, payment and health care 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 all such authorizations (of PHI or psychotherapy notes) at any time, provided each revocation is in writing. You may not revoke an authorization to the extent that (1) I have relied on that authorization; or (2) if the authorization was obtained as a condition of obtaining insurance coverage, and the law provides the insurer the right to contest the claim under the policy.

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: If you give me information that leads me to suspect child abuse, neglect, or death due to maltreatment, I must report such information to the county Department of Social Services. If asked by the Director of Social Services to turn over information from your records relevant to a child protective services investigation, I must do so.

Adult and Domestic Abuse: If information you give me gives me reasonable cause to believe that a disabled adult is in need of protective services, I must report this to the Director of Social Services.

Health Oversight: The North Carolina Psychology Board has the power, when necessary, to subpoena relevant records should I 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 the professional services that I have provided you and/or the records thereof, such information is privileged under state law, and I must not release this information without your written authorization, or a court order. This 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.

Serious Threat to Health or Safety: I may disclose your confidential information to protect you or others from a serious threat of harm by you.



Worker's Compensation: If you file a workers' compensation claim, I am required by law to provide your mental health information relevant to the claim to your employer and the North Carolina Industrial Commission.

IV. Client's Rights and Psychologist's Duties

Client'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 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.

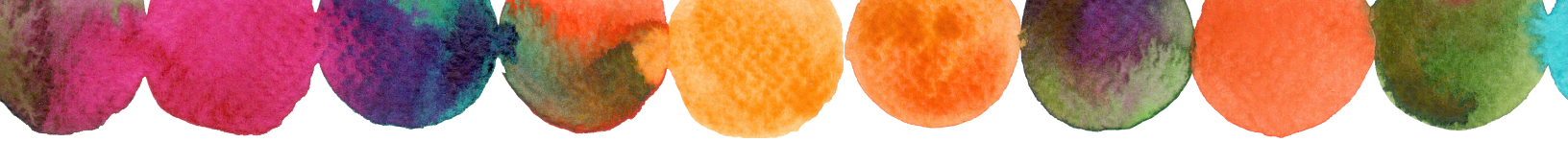
Right to Amend – You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. I may deny your request. On your request, I will discuss with you the details of the amendment process.

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.

If I revise my policies and procedures, I will provide you with a revised notice by mail.

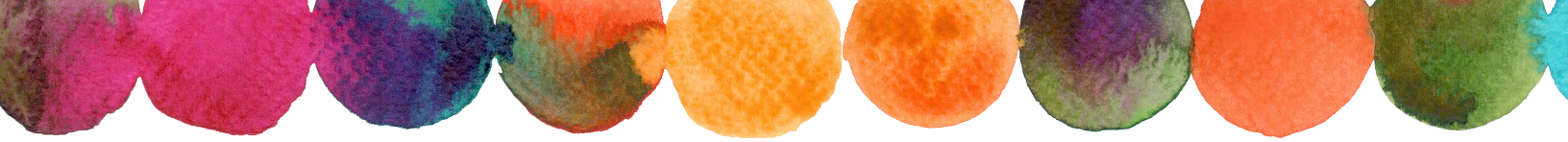
V. Complaints

If you are concerned that I have violated your privacy rights, or you disagree with a decision I made about access to your records, please bring this to my attention as soon as possible. You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services.

VI. Effective Date, Restrictions and Changes to Privacy Policy

This notice will go into effect on April 14, 2003.

I reserve the right to change the terms of this notice and to make the new notice provisions effective for all PHI that I maintain. I will provide you with a revised notice by mail.



CANCELLATION POLICY

I understand that you occasionally will be unable to be present at your scheduled appointment. When this happens, I ask that you notify the office as soon as possible, so that I may make your appointment time available to another client. Unless it is an emergency, or you or your child become urgently sick, you will need to provide 24 hours cancellation notice, or you will be charged the full fee for your session. Whenever possible, I do try to reschedule a missed appointment within the week.

I have read and I understand the policy stated above and agree to accept responsibility as described.

Please Print Name

Client Signature

Date