



Susan Rudnicki, Ph.D.

Agreement for Psychological Services

Welcome to my clinical psychology practice. I appreciate the opportunity to be of service to you and/or your family. This document contains important information about my professional services and business policies and answers the questions most often asked by clients. After you read this information we will discuss how these issues apply to your situation. You may keep a copy of this document to refer to it later as needed. Please read all of it and mark any parts that are not clear to you. Write down any questions you may have so we can discuss them at our first visit. I know that reading this information can be time-consuming and perhaps overwhelming, but it is important that we come to a mutual understanding and agreement of our expectations as we develop a professional relationship. When you have read and fully understood this document, I will ask you to sign it. I will sign it as well and provide a copy to you for your future reference.

My Professional Background

I am a clinical health psychologist, certified personal trainer, certified group exercise instructor, and wellness speaker. I attended Brandeis University and graduated Magna Cum Laude with a B.A. degree in Psychology in 1992. I received an M.S.Ed. from the University of Pennsylvania in 1993 and a Ph.D. in Clinical and Health Psychology in 2001 from MCP Hahnemann University with a GPA of 4.0.

I am an active member of the Georgia Psychological Association, having served the roles of Midwinter Conference Chair (2007) and Newsletter Editor (2008-2009) for the past Division of Private Practice. I am currently serving on the Public Education Committee. Prior to my private practice, I worked in diverse treatment settings, including outpatient and inpatient hospitals, school systems and university counseling centers.

What to Expect from Our Professional Relationship

As a professional psychologist, I will use my best knowledge and skills to help you make changes. I will adhere to the ethical standards of the American Psychological Association (APA) and the Georgia Psychological Association (GPA). In your best interest, the APA puts limits on the relationship between the therapist and a client, and I will abide by these. Let me explain these limits, so you will not think they are personal responses to you.

First, I am educated and trained to practice psychology-not medicine, law, finance, or any other profession. I am not able to give you advice from these other professional viewpoints.

Second, state laws, regulations, and the rules of the APA require me to keep what you tell me confidential (that is, private). You can trust me not to tell anyone else what you tell me, except in certain limited situations (I explain what those are later in the confidentiality section of this document). This is part of my effort to maintain your privacy.

Third, in your best interest, and following the standards of my profession, I can only serve the role of providing you with psychological services. I cannot have any other role in your life. I cannot, now or ever, be a close friend or socialize with any of my clients. I cannot become a therapist to someone who is already my friend. I cannot have a business relationship with any of my clients, other than the therapy relationship.

Appointments and Cancellations

Appointments are generally 50 minutes in length. The frequency of your appointments will depend upon your needs. When an appointment is missed, my schedule is disrupted, as I am unable to make this time available to other clients. For this reason, 24 hours notice is required of your intent to cancel an appointment. If you cancel an appointment without 24 hours notice, or if you miss an appointment, you will be charged the full amount of the session. As these charges are not covered by insurance, it is the patient's responsibility, and is due within one week of the missed appointment.

Contacting Me

Due to my work schedule, I am often not immediately available by telephone. While I keep regular daytime office hours, I probably will not answer the phone when I am with a client. When I am unavailable, my telephone is answered by voicemail. I will make every effort to return your call on the same day you make it, with the exception of weekends and holidays. If you have an emergency and you cannot wait for a return phone call, dial 911 or go to the nearest emergency room.

Limits on Confidentiality

The law protects the privacy of all communications between a patient and a therapist. 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 HIPPA. 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:

1. I may occasionally find it helpful to consult other health and mental health professional about a case. During a consultation, I make every effort to avoid revealing the identity of my patient. The other professionals are also

legally bound to keep the information confidential. If you do not 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 Policies and Practices to protect the privacy of your health information).

2. You should be aware that I practice with other mental health professionals and that I employ administrative staff. In most cases, I need to share protected information with these individuals for both clinical and administrative purposes, 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.
3. I also have contracts with certain Managed Health Care companies. As required by HIPPA, I have a business associate contract with these companies, in which they promise to maintain the confidentiality of this data except as specifically allowed in the contract or otherwise required by law. If you wish, I can provide you with the names of the organizations and/or a blank copy of this contract.
4. If a patient threatens to harm himself/herself, I may be obligated to seek hospitalization for him/her or to contact family members or others who can help provide protection.
5. Any request for the records of a couple must include a signed release from both parties. In-group and couples treatment, the record belongs to all parties and confidentiality rules apply to single parts as well as the entire record.

There are some situations where I am permitted or required to disclose information without either your consent or authorization:

1. If you are involved in a court proceeding and a request is made for information concerning my professional services, such information is protected by the therapist-patient 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.
2. If a government agency is requesting the information for health oversight activities, I may be required to provide it for them.
3. If a patient files a complaint or lawsuit against me, I may disclose relevant information regarding the patient in order to defend myself.
4. If a patient files a worker's compensation claim, and I am providing treatment related to the claim, I must, upon appropriate request, furnish copies of all medical reports and bills.

There are some situations in which I am legally obligated to take actions, which I believe are necessary to attempt to protect others from harm and I may have to reveal some information about a patient's treatment. These situations are unusual in my practice:

1. If I have reason to believe that a child has been abused, the law requires that I file a report with the appropriate governmental agency, usually the Department of Human Resources. Once such a report is filed, I may be required to provide additional information.
2. If I have reasonable cause to believe that a disabled adult or elder person has had a physical injury or injuries inflicted upon them, other than by accidental means, or has been neglected or exploited, I must report to an agency designated by the Department of Human Resources. Once such a report is filed, I may be required to provide additional information.
3. If I determine that a patient presents a serious danger of violence to another, I may be required to take protective actions. These actions may include notifying the potential victim, and/or contacting the police, and/or seeking hospitalization for the patient.

If any of these situations arise, 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.

Professional Records

The laws and standards of my profession require that I keep Protected Health Information about you in your Clinical Record. You may examine and/or receive a copy of your clinical record with a written request with the following exceptions; in unusual circumstances that involve danger to yourself and others, or makes reference to another person and I believe that access is reasonably likely to cause substantial harm to such other person, or where information has been supplied to me confidentially by others. 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 your presence, or have them forwarded to another mental health professional so you can discuss contents. In most situations, I am allowed to charge a copying fee of \$50 per record. If I refuse your request for access to your records, you have a right of review (except of information provided to me confidentially by others), which I will discuss with you upon request.

In addition, I may also keep a set of Psychotherapy Notes. These Notes are for my own use and are designed to assist me in providing you with the best treatment. While the contents of Psychotherapy Notes vary from client to client, they can include the contents of our conversations, my analysis of those conversations, and how they impact on your therapy. They also contain particularly sensitive information that you may reveal to me that is not required to be included in your Clinical Record (and information supplied to me confidentially by others). These Psychotherapy Notes are kept separate from your Clinical Record. They are not available to you and cannot be sent to anyone else, including insurance companies without your written, signed Authorization. Insurance companies cannot require your authorization as a condition of coverage nor penalize you in any way for your refusal to provide it.

Patient Rights

HIPPA 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 I 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 authorize; 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, that attached Notice form, and my privacy policies and procedures. I am happy to discuss any of these rights with you.

Minors and Parents

For patient's under 18 years of age who are not emancipated, their parents are allowed by law to examine their child's treatment records unless I believe that doing so would endanger the child or we agree otherwise. However, because privacy in psychotherapy is often crucial to successful programs, particularly with teenagers, it is often my policy to have an agreement with parents that they consent to not seek access to their child's records. If they agree, during treatment, I will provide them with general information about the progress of the child's treatment, and his/her attendance at scheduled sessions. I will also provide parents with a summary of their child's treatment, and his/her attendance at scheduled session. I will also provide parents with a summary of their child's treatment when it is complete. If at any point during treatment I feel that the child is in danger or is a danger to someone else, I will notify the parents of my concern.

Payment and Insurance Reimbursement Policy

Patients are required to pay all fees in full at the time service is rendered unless Dr. Rudnicki has made other arrangements. A completed insurance form can be provided to you so that you may file a claim for direct reimbursement from your insurance company. If you are covered by a managed care company, and authorized for visits, please provide a copy of your insurance card to Dr. Rudnicki. You will also be required to sign the assignment of benefits statement below and pay your co-payment at each visit. If you have an unmet deductible, you will be required to pay for the services rendered in full until the deductible has been met. Documentation can be provided for patients wishing to file claims with their secondary insurers.

Insurance policies are quite varied, and it is your responsibility to familiarize yourself with your insurance benefits, including obtaining any pre-authorizations required and verifying coverage. It is important to realize that, regardless of your insurance coverage, it is the patient (or their adult parent/guardian) who is ultimately responsible for payment of services. I will attempt to accommodate your insurance needs. However, if payment is denied, you will be held responsible for the charges you incurred.

Payments are generally accepted in the form of cash, check, or major credit cards. Please make all checks payable to Dr. Rudnicki. For any returned checks, the patient will be charged a \$35.00 fee. In the event of default of payment, your account may be turned over to a collection agency, which may require disclosure of confidential information. In most collection situations, the only information released is a patient's name, identifying date, nature of services provided, and amount due. If your account is delinquent beyond 90 days, you may be assessed a delinquency fee of 30% of the balance.

Insurance Reimbursement and Confidentiality

You should also be aware that your contract with your health insurance company requires that I provide it 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. 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 a computer. Though all insurance companies claim to keep such information confidential, I have no control over what they do with it once it is in their hands. In some cases, they may share the information with national medical information databank. I will provide you with a copy of any report I submit, if you request it.

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 problems described above, unless prohibited by contract with your insurance company directly.

Assignment of Benefits

I authorize release of any treatment or patient information necessary to process insurance claims. I also authorize payment of insurance benefits to be made to _____ for services provided by Dr. Rudnicki.

Signature_____

Date_____

Relationship to patient: Self/Parent/Guardian_____

Our Agreement

I, the client (or his/her parent or guardian), understand I have the right not to sign this form. My signature below indicates that I have read and discussed this agreement; it does not indicate that I am waiving any of my rights. I understand I can choose to discuss my concerns with you, my psychologist, before I initiate (or the client initiates) any psychological services. I also understand that any of the

points mentioned above can be discussed again and may be open to change. If at any time during treatment I have questions about any of the subjects discussed in this document, I can talk with you about them, and you will do your best to answer them.

I understand that after psychological treatment begins I have the right to withdraw my consent to therapy at any time for any reason. However, I will make every effort to discuss my concerns about my progress with you before ending therapy with you.

I understand that no specific promises have been made to me by you, my psychologist, about the results of any psychological evaluation or treatment, the effectiveness of procedures used, or the number of sessions necessary for therapy to be effective.

I have read, or have had read to me, the information included in this document. I have discussed those points I did not understand, and have had my questions, if any, fully answered. I agree to act according to the points covered here. I hereby agree to enter into psychological services with you (or to have the client enter psychological services with you), to pay for services under the conditions and specifications set forth above, and to cooperate fully and to the best of my ability, as shown by my signature here.

Signature of Client or Legal Guardian of minor: _____

Printed name: _____

Date: _____

Minor's name: _____

Relationship to client:

- Self Parent Legal guardian
 Health care custodial parent of a minor (less than 14 years of age)
 Other person authorized to act on behalf of the client

I, the psychologist, have met with this client (and/or his/her parent or guardian) for a suitable period of time, and have informed him/her of the issues and points raised in this document. I have responded to all of his or her questions. I believe this person fully understands the issues, and I find no reason to believe this person is not fully competent to give informed consent to treatment. I agree to provide the agreed upon psychological services with the client, as shown by my signature here.

Signature of psychological service provider: _____

Date: _____

I truly appreciate the opportunity you have given me to be of professional service to you, and I look forward to having a successful relationship with you. If you are satisfied with my services as we proceed, I (like any other professional) would appreciate you referring other people to me who might also be able to make use of my services.

_____ Copy accepted by client

_____ Copy kept by psychologist