Fereshteh H. Darya, Ph.D.

Licensed Clinical Professional Counselor

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Counseling and Psychotherapy Services Agreement

And

Notice of Policies and Practices to Protect the Privacy of Your Health Information

Welcome! This document contains important information about my professional services and business policies. It also contains information about the policies and practices to protect the privacy of your health information. Please read it carefully and discuss any questions you may have with me. When you sign this document, you will be stating that I provided you with this information and it will represent an agreement between us.

I am in my private practice and I work in offices with other independently practicing professionals. While I share office space with them, I am completely independent of the other professionals in providing you with clinical services and I alone am responsible for the services I provide.

PSYCHOTHERAPY SERVICES: Psychotherapy varies depending on the therapist, the client and the client's particular situations and goals. There are many different methods I may use to deal with your particular situations and goals. In order for therapy to have the best outcome you will have to invest energy in the process and work actively on things we talk about both during and between our sessions. Psychotherapy can have benefits and risks. The risks may include experiencing uncomfortable feelings like sadness, guilt, anger, anxiety or frustration when discussing aspects of your life. There are also benefits in working through your issues in a therapeutic setting that can include building better relationships, finding solutions to specific problems, experiencing increased life satisfaction, improving physical health, and significantly reducing feelings of distress. However, there are no guarantees of what you will be experiencing. Our first few sessions will involve an evaluation of your situation and needs. We will also discuss goals you want to work towards and I will offer you some information about our work together. During this time, we can both decide if I am the best person to provide the services you need. Psychotherapy can involve a considerable investment of time, energy and money, so it is important that you select a therapist you are comfortable working with.

If at any time you have questions about any aspect of our work together, please discuss them with me. If you decide that you do not want to continue therapy with me, I can help you try to find another therapist or other appropriate resources.

SESSIONS: The assessment session takes one to one and half hours. The subsequent sessions are scheduled for 60 minutes usually once per week at a time we agree on. If you arrive late for an appointment, we will only be able to meet for the remaining time of our scheduled one hour. Sometimes I will meet more or less than once per week if that is consistent with a treatment plan we both agree to. If you ever need to cancel a scheduled therapy session, please do so at least 24 hours in advance. If you do not cancel a scheduled appointment with at least 24 hours notice or if you fail to attend a scheduled session, you will be expected to pay the full fee for that session, unless we both agree that you were unable to attend due to circumstances beyond your control. Insurance companies will not reimburse for canceled or missed appointments so you will be fully responsible for the charges for such sessions.

FEES: My fee is $200.00 for 60-minutes. Extended sessions and other services will be charged in 15-minute increments ($50). Travel time will be added for the out-of office services. Other services include report writing, telephone conversations lasting longer than 15 minutes, attendance at meetings or consultations with other professionals you have authorized, preparation of records or treatment summaries, and time spent performing any other professional service that you may request. If you become involved in legal proceedings that require my participation, you will be expected to pay for my professional time. Because of the complexity and difficulty of legal involvement, I charge $360 per hour for preparation and attendance at any legal proceeding. It is understood and agreed that my attorney's fee will be added to the account and the undersigned agree to pay all legal charges in full to this counselor.

BILLING AND PAYMENTS: You are expected to pay the full fee at the time of service. Payments can be made by check, cash, or credit card. Payment schedules for other professional services will be agreed to when they are requested. If you make a payment by check and your check does not clear due to insufficient funds or any other reason, you will be expected to pay in full for any related bank fees that I am charged as a result.

INSURANCE AND THIRD PARTY PAYMENTS: Payment is expected when services are rendered and you are ultimately responsible for payment of your therapy fees. I am a participating provider with **Aetna, BlueCross BlueShield, Cigna,** and **Medicaid.** My office will submit claims for you. It is a good idea to call your insurance company and check on the exact benefits that are covered.

Please bring your insurance card to your first session. If your plan requires a co-pay, you may pay cash, check, or by credit card (Visa/MasterCard). If you have another insurance provider, a monthly statement will be provided to you that can be submitted to the insurance company for reimbursement. At your request, I will provide relevant clinical information to the insurance

company for reimbursement purposes. You should be aware that most insurance companies require a clinical diagnosis, and some require additional clinical information that becomes part of their record. I assume no responsibility for the continuing confidentiality of the information once it is released to the insurance company.

CONTACTING ME: when I am in session with clients, I do not answer my phone and calls go to my voicemail. I check my messages regularly and will make every effort to return your call as soon as possible (usually within a few hours and almost always within 24 hours). If you are difficult to reach, please leave times you will be available. If you want me to use discretion when calling you or leaving a message for you, please let me know in advance. At times when I will be unavailable for an extended time, I will provide you with the name of a colleague to contact if necessary. In case of emergencies, please call 911 or go to the nearest hospital emergency room and tell them what is happening. In such situations, I will get back to you as soon as I possibly can, but I may not be able to get back to you immediately in all cases.

PROFESSIONAL RECORDS: The law protects the privacy of counseling records, except in the highly unusual circumstances like a court order or an emergency. No one can see your health or counseling record unless a written authorization is signed by you, your parent if you are a minor, or your legal guardian. Laws and standards of my profession require that I keep clinical records of each client in a safe and secure manner. You are entitled to examine and/or receive a copy of your records if you request it in writing. Because these are professional records, they can be misinterpreted or cause distress to people who are not mental health professionals. Therefore, if you want to see your records, I recommend that you review them with me so we can discuss the contents. We reserve the right to charge you for the costs of copying and sending your records if you request them.

PAST RECORDS: With your written authorization, I may ask to review your previous records (e.g., counseling, school, police, medical, military, etc.). When needed, such action can help the counselor to identify important patterns which the client may be unaware of or disinclined to discuss. Often a review of previous counseling records will indicate what types of treatment were attempted, what has been ineffective, and what has worked for the client. A counselor can gain increased clarity of the immediate concern based upon an improved understanding of previous stressors or transitions leading to the client's current condition.

CONFIDENTIALITY: In general, the law protects the privacy of all communication between a client and a psychologist. I can only release information about your treatment to others if you sign a written authorization form. You can revoke any such authorizations at any time in writing. However, in the following situations your authorization is not required for me to release information:

• If I believe that a client is in imminent danger of attempting serious physical harm to herself/himself, I have an obligation to intervene, which may include pursuing hospitalization

and/or contacting family members, friends or others who can help provide protection. If I believe that a client is likely to attempt serious physical harm to someone else, I have a duty to intervene, which may include contacting the police, warning the intended victim(s) and/or pursuing hospitalization.

• I am required to report any suspected physical or sexual abuse or neglect of a child under 18 to the Maryland's Child Protected Services as soon as it comes to my attention. Likewise, I am obligated to report any suspected elder abuse to the appropriate agency if the elderly person is not capable of reporting the abuse herself/himself. Once such reports are made, I may be required to provide additional information. For the situations described above regarding potential harm to self or others and suspected child or elder abuse or neglect, I will try to discuss it with you whenever possible before I take action and I will limit my disclosure to what is necessary.

• If you become involved in a court proceeding, in most cases you have the right to prevent me from providing any information about your treatment. However in some proceedings such as those involving child custody or those in which your emotional condition is an important issue, a judge may order my testimony with a court order if she/he determines that the issues require it.

• If you file a worker's compensation claim and I am providing treatment in accordance with the Maryland's law, I must, when appropriately requested, provide a copy of your record to your employer or their appropriate designee.

• I may be required to disclose information to a health oversight agency for oversight activities authorized by law such as licensure or disciplinary actions.

• If a client files a complaint or lawsuit against me, I may disclose relevant information regarding that client in order to defend myself.

• I occasionally find it helpful to consult with other professionals about a case. In these consultations I make every effort to avoid revealing the identity of the client and the consultant is legally bound to keep any information discussed 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 record. While I am not an attorney, please discuss any questions or concerns you have about confidentiality with me at any time. If you have specific legal questions about the laws regarding confidentiality, the exceptions, and how it may relate to your situation, please seek formal legal advice from an attorney.

OTHER CLIENT RIGHTS:

• You have the right to request and receive from me confidential communication of your protected health information by alternate means or at alternative locations. For example, you can request that I send any correspondences to an address other than your home address if you don't want a family member to know that you are in therapy with me.

• You have the right to request that I change information in your record. I require such requests in writing along with your reasons for your requested changes. I may deny your request.

• You generally have the right to receive an accounting of any disclosures I have made of your protected health information, which did not require your authorization. If you want, I will discuss with you more details about this process.

• If you are concerned that I have violated your privacy rights or you disagree with a decision I made about access to your records, I would like you to inform me as soon as possible so we can try to resolve your concerns. You can also use a grievance or complaint procedure by contacting the Department of Health and Mental Hygiene: 4201 Patterson Avenue, Baltimore, MD 21215, Telephone number: 410-764-4732 – Main Number: 410-764-4740.

CONCLUSION AND SIGNATURES: I reserve the right to change policies, practices and procedures described in this document. I will notify you in writing of any significant changes. By signing below you are indicating that you have received and read the information in this document, you have discussed the contents with me to your satisfaction, and you agree to abide by its terms during the course of our professional relationship. If you would like a copy of this document, please ask me for one.

_____	_____	_____
Client 1 - Print Name	Signature	Date
_____	_____	_____
Client 2 - Print Name	Signature	Date
Fereshteh H. Darya, Ph.D. , LCPC	_____	_____

CLIENT INFORMATION

Date _____

Name: _____

Phone: (Home) _____(Work) _____ (Cell) _____

Address:_____

City:_____ State: _____ Zip:_____

Social Security #:_____ Email: _____

Sex: Male _____ Female _____ Date of Birth: _____

Employer: _____ Occupation: _____

Education: (List highest level of education attained) _____

Primary Physician: _____ Phone: _____

List any significant health problems: _____
_____

List any medications you are taking and the dosage: _____
_____

Why are you seeking counseling at this time? _____

What have you tried in the past to help? _____

Have you seen a counselor or psychotherapist before? YES ____ NO ____
If yes, when and with whom? _____

Give a brief description of treatment: _____

How helpful was your experience?
___ Very Helpful ___ Somewhat Helpful ___ Neutral ___ Not Helpful

How were you referred to my office? _____

Name and phone number of nearest relative _____

PRIOR TO YOUR FIRST APPOINTMENTPLEASE COMPLETE AND FAX TO 240-390-2400

INSURANCE AUTHORIZATION

I _____ hereby authorize Dr. Darya's office to bill my insurance based on the information that I have provided. I acknowledge that the amount of payment from my insurance may not cover the entire obligation due and that I am responsible for any balance or co-pays.

Name of Insured: _____Date of Birth of Insured: _____

Name of Patient: _____ Date of Birth of Patient: _____

Insurance Company Name: _____

Member ID Number: _____ Group Number: _____

Employer: _____

Customer Service Phone Number: _____

Claim Address:
_____

I authorize the release of information from my medical records as requested by my insurance company or other reimbursement agency. I further expressly authorize the release of photocopies of any portion of my medical records to the reimbursement agency.

Name: _____ Relationship to Client: _____

Signature: _____ Date: _____

PRIOR TO YOUR FIRST APPOINTMENT
PLEASE COMPLETE AND FAX TO 240-390-2400

Credit Card Authorization

Please complete this form even if you will not be charging your sessions on a regular basis. Missed appointments and returned checks will automatically be charged to this credit account.

Client Name: _____

Name as it appears on the card: _____

Billing Address: _____

_____

Card Type: □Visa □MasterCard

Card Number: _____

Expiration Date: _____

CVV2 _____

*I authorize **Dr. Fereshteh Darya** to process my credit card for payment of services on a recurring basis for all scheduled appointments including missed appointments, late cancellations, and returned checks.*

_____ _____

Signature Date

Email Address (Optional): _____