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CONSENT TO TREATMENT

This document contains important information about my practice and about the new Health Insurance Portability and Accountability Act (HIPAA). HIPAA requires that I provide you with a Notice of Privacy Practices for use and disclosure of specific health care information.

PSYCHOLOGICAL SERVICES

Psychotherapy is not easily described in general statements. It varies depending on the personalities of the psychologist and client, 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. Participating in psychotherapy can result in a number of benefits to you, including developing insight, reducing emotional distress, and resolving specific concerns. Benefits may also include increased comfort in social, work and family settings, increased capacity for intimacy, decreased negative thinking and behavior, and improved ability to seek and achieve personal goals. Psychotherapy can have risks as well. During the course of therapy you may experience uncomfortable feelings such as sadness, guilt, anger, frustration, loneliness or helplessness, or you may experience other unintended consequences. Psychotherapy requires your active involvement. In order for therapy to be most successful, you will have to work on things we talk about both during our sessions and during the week. You are encouraged to give feedback and input about the course of your therapy as it proceeds. While success cannot be guaranteed, you and I join together to work toward meeting your goals.

CONFIDENTIALITY

The patient/therapist relationship is held in the strictest confidence, and any information disclosed within this relationship, as well as the written records pertaining to your treatment, may not be revealed without your written authorization, except where disclosure is required by law. Disclosure without your consent may be required in the following circumstances:

- when the therapist suspects or has been informed that child abuse or abuse of an incapacitated adult has occurred
- when the therapist believes the patient to be an imminent danger to himself/herself or others

--if the therapist receives a court order or subpoena to testify in or release documents to a court of law about a patient and the subpoena cannot be quashed
--if a government agency is requesting the information for health oversight activities
--if a patient files a worker's compensation claim and a mental health report is requested.

The HIPAA Privacy Rule allows for the release of Protected Health Information (PHI) for treatment, payment and health care operations with your written general consent in advance. PHI consists of treatment dates, modalities, results of tests, diagnoses, symptoms, treatment plans, prognosis and progress. PHI does not include Psychotherapy Notes, which are optional, and may or may not be used with a particular patient. Psychotherapy Notes are different from routine progress notes, and may include the content of conversations and the therapist's analysis of these conversations. These notes are the possession of the therapist, are kept separately from the primary record, and cannot be released without your specific written authorization.

Situations in which PHI can be released based on your general advance consent include disclosures required by health insurers, the use of a collection agency (only billing information will be provided to a collection agency), and consultation with other professionals. Occasionally I consult with other professionals regarding the treatment of my patients in order to increase the effectiveness of services. Patient names and other identifying information are never mentioned in order to protect confidentiality.

Your signature on the final page of this document serves as your consent to my releasing PHI according to the HIPAA guidelines. **However, professional and ethical guidelines for psychologists are stricter than the HIPAA guidelines, and in most instances (the exceptions are described above) I am required to obtain your specific written permission to release any identifiable information about you.**

SESSIONS

Over the first few sessions a specific treatment plan, including appropriate goals, techniques and frequency of visits, will be discussed with you. You may also ask about any alternative treatments for your condition. If you have questions about my procedures or your therapy, we should discuss them whenever they arise. If at any point I believe I am not able to help you reach your therapeutic goals, I will discuss this with you, and, if appropriate, will develop a plan for termination and referral to another provider. You have the right to terminate your therapy at any time. Therapy never involves social, sexual or business relationships or any dual relationship that may impair the effectiveness of treatment.

Sessions are scheduled for 45 minutes once a week, unless a more or less frequent schedule is agreed upon. When an appointment is cancelled with less than 24 hours notice, regardless of the reason, there will be a charge of the full fee for that session. Please be aware that most insurance companies will not cover charges for missed appointments.

BILLING

My fee per 45-minute session is \$. Patients will be billed on a monthly basis and can make arrangements to pay for sessions either weekly or after receiving the bill. Report writing, court testimony and copying of records will also be billed unless otherwise agreed. Non-payment of fees may result in fee collection procedures.

Insurance carriers are legally required to provide coverage for mental health services. You should contact your provider to determine the details of your policy. I am not a preferred or participating provider for any insurance plans, but many plans offer out-of-network benefits which cover therapy with a clinical psychologist. It is your responsibility to obtain and file the appropriate claim forms. The necessary diagnostic, procedure and provider codes are included on your monthly statement. I will be happy to provide additional information if required by your insurance carrier.

AVAILABILITY AND EMERGENCY PROCEDURES

Please call 703-556-8482 to contact me by phone. I check my messages regularly Monday through Friday from 9:00 AM to 5:00 PM and will return your call as soon as possible. I also check my messages evenings and weekends (with somewhat less frequency) and will return your call by the next business day unless it is urgent. In the event of a clinical emergency and you do not receive a prompt response from me, you should call your local mental health hotline, or the police (911) or go to the Emergency Room of your nearest hospital.

PATIENT RIGHTS

HIPAA provides you with various rights with regard to your Private Health Information record and disclosures of your health information. These rights include: requests that I amend your record; restriction on what PHI information is disclosed to others; requests of an accounting of disclosures that have not required your consent; determining the location to which the PHI is sent; having complaints you may make about my policies and procedures recorded in your record; and requests for copies of this agreement and HIPAA Notice Form. You may also have the right to review your mental health record, except in limited legal and emergency situations, including situations where releasing that information might be harmful to you. In such a case, if your treatment has terminated, I may provide records to an appropriate mental health professional of your choice to review with you.

MINORS AND PARENTS

The area of patient rights and confidentiality for minors receiving mental health treatment is somewhat complicated. There is case law establishing the rights of minors to seek and obtain treatment without parental consent, but it is not absolutely clear that parents, as their children's legal guardian, are not also entitled to information about treatment. Apart from legal concerns, effective psychotherapy with children requires **both** that the child trust that confidences will be kept, and that parents be involved in treatment, especially

where younger children are concerned. It is my policy not to share specific information revealed by a child without that child's consent. However, I will meet with parents regularly (frequency will depend on the child's age and the needs of the family) and inform them about general themes of the child's work in therapy and the child's progress. I will also encourage children to tell their parents, or to allow me to tell their parents, about any important issue that needs to be discussed promptly. Of course, the same exceptions to confidentiality described earlier in this agreement apply to minors—suspected child abuse or neglect and imminent danger to self or others—and in these instances, when appropriate, I will make every effort to discuss the matter with the child before contacting the appropriate agency and/or the parents.

ACKNOWLEDGMENT

I have received a copy of the HIPAA Notice of Privacy Practices.

Signature of Patient or Patient's
Legal Representative

Date

I have read and agree to the statement of policies described in Dr. Miller's Consent to Treatment. I understand that this agreement can be discussed and reviewed at any time.

Signature of Patient or Patient's
Legal Representative

Date

Signature of Minor Patient
(if required)

Date