Kelly K. Anthony, PhD, PLLC
Independent Practice Within the
Triangle Center for Behavioral Health

PRACTICE AGREEMENT
Effective Date 08/01/2017

Welcome to my practice. I am a Ph.D. level clinical psychologist offering state-of-the-art, evidenced-based evaluation and treatment services for children, adolescents, families, and adults. In doing so, I strive to tailor evaluations and treatments to the unique needs of each individual with the overall goal of helping individuals and families gain optimal behavioral and emotional health. This document 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 federal law that provides privacy protection and patient rights regarding 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 (please see the separate document) for use and disclosure of PHI for treatment, payment, and health care operations. The law requires that I obtain your signature acknowledging that I have provided you with this information at the beginning of your treatment. Although it is a long document, it is important that you please read it carefully and make note of any questions you may have. We can discuss any questions you have during your appointment. When you sign this document, it will represent an agreement between us and that you consent to this Practice Agreement. You have the right to refuse treatment and you may also revoke your consent in writing at any time.

PSYCHOLOGICAL SERVICES

My evaluation and treatment services vary depending on your individual needs. There are many available methods used to help us reach your 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 impression of what your treatment will include and a plan to follow, if we decide to continue. You can request a copy of written treatment/service plan at any time. Treatment modalities offered include individual and family psychotherapy and often involve Cognitive-Behavioral interventions. It should be noted that psychotherapy calls for an active effort on the part of the client. In order for psychotherapy to be effective, you and/or your/child may need to work on things both during your sessions and at home. Psychological services can have both benefits and risks. Since psychotherapy often involves discussing unpleasant aspects of life, you and/or your child may experience uncomfortable feelings at times during the treatment process (e.g., sadness, guilt, worry, anger). On the other hand, the benefits of psychological services can include reductions in feelings of distress, generation of solutions to specific problems, and better relationships. There are, however, no guarantees on what you will experience. If you have questions about procedures, at any time in the process, they should be discussed with me whenever they arise.

APPOINTMENTS AND CANCELLATION POLICY

Your appointment time is reserved exclusively for you. Once this appointment hour is scheduled, you will be expected to pay for it unless you provide 24 hours advance notice of cancellation. I have a 24- hour voicemail service for your convenience. Simply call (919) 794-5501 and leave a confidential voice message. It is important to note that insurance companies do not provide reimbursement for cancelled

sessions. In the event of inclement weather, contact me directly for the day's schedule. I also reserve the right to reschedule your appointment if you arrive late, depending on my schedule for that day.

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 an insurance policy, it will usually provide some coverage for behavioral health treatment. I am currently an in-network provider for Blue Cross Blue Shield PPO and Indemnity Plans. I am also currently an authorized Medicaid and NC Health Choice provider for many, but not all of the counties in North Carolina. These counties include Durham, Wake, Cumberland, Johnston, Orange, Person, and Chatham. I will file claims directly with these entities. You are still responsible for paying any co-pay specified by your insurance plan and/or costs related to your plan's deductible. I am an out-of-network provider for all other private insurance companies. Therefore, I strongly encourage you to contact your insurance company prior to services to determine your out-of network benefits.

I use MEDICAL BILLING SOLUTIONS to process all insurance claims. By signing this form, you understand that your/your child's demographic information, insurance information, and diagnosis will be given to MEDICAL BILLING SOLUTIONS for processing. MEDICAL BILLING SOLUTIONS follows all policies outlined by the HIPPA Privacy Rules. If you do not want your/your child's protected health information released to MEDICAL BILLING SOLUTIONS, you will be responsible for filing your own insurance claim. In either instance, out-of-network claims will be submitted to your insurance company for direct reimbursement to you. In I am an out of-network provider for your insurance policy, you will still be responsible for paying for each session at the time it is held.

You should also be aware that if your insurance claims are filed by MEDICAL BILLING SOLUTIONS or you for 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 information such as treatment plans or summaries or copies of your entire Clinical Record. In such situations, I make every effort to release only the minimum information that is necessary for the purpose requested.
Although all insurance companies claim to keep information confidential, I cannot control what they do with the information once they have it. By signing this Agreement, you agree that I can provide requested information to your insurance carrier so that MEDICAL BILLING SOLUTIONS can submit claims forms to them for reimbursement.

BILLING AND PAYMENTS

You will be expected to pay for each session at the time it is held, unless we agree otherwise. I accept the following methods of payment: credit card, check, and cash. Checks need to be made out to Kelly K. Anthony, PhD, 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 patient'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.) Please note that if you become involved in any legal proceedings that require my participation, you will be expected to pay for all of my professional time,

including preparation and transportation costs, even if I am called to testify by another party. Due to the difficulty of legal involvement, my fee is $400 per hour for preparation and attendance at any legal proceeding.

PROFESSIONAL FEE SCHEDULE
(for out-of-network services)

	Length of Session	**Rates**
Intake Appointments	60-90 minutes	$250.00
Individual and Family Therapy	45 minutes	$130.00
	60 minutes	$150.00
	30 minutes (pre-arranged)	$100.00
	90 minutes	$215.00
Consultation	120 minutes	$300.00
Other Fees		
Legal Proceedings	per hour	$400.00
Communications (email, phone)	15 minutes	$35.00
Form preparation	15 minutes	$35.00
No shows, late cancellations		$75.00
Psychological Testing	Varies	$280.00/hour

Following an intake session, the rate for psychological testing covers 1 hour of face-to-face testing and 1 hour for clinician's scoring, interpretation, and report writing. The total cost of testing varies, depending on the total amount of time required to complete the evaluation. I will provide you with an estimate of the amount of time required when giving you a breakdown of the different testing procedures involved.

**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.

CONTACTING ME AND EMERGENCY AVAILABILITY

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 hours for routine clinical matters. 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. In the event of a behavioral health crisis, please leave a voicemail or contact me by email. Every effort will be made to return your call within 2 hours and if necessary, an appointment will be scheduled within 24 hours of your contact. If the crisis is not de-escalated or stabilized after this appointment, you will be assisted in contacting other agencies that are able to provide more comprehensive care. This could include calling 911, going to the nearest emergency department, or contacting local Crisis and Assessment Centers. In any event, 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 or I am unable to communicate with you during a clinical emergency, Dr. Rebecca Dingfelder will oversee the short-term clinical operations of my practice. My voicemail will be updated with her contact information at the time of my absence. By signing this Agreement, you are consenting to allow Dr. Dingfelder access to your Clinical Record in order to contact you regarding my status and to assist with you with seeking alternative clinical services as needed. If ever I am unable to access your Clinical Record to communicate with you during a clinical emergency or behavioral health crisis, I will ask Dr. Dingfelder to access your Clinical Record to assist you with accessing emergency services. If necessary, an appointment will be scheduled within 24 hours of your contact. If the crisis is not de-escalated or stabilized after this appointment, Dr. Dingfelder will assisted you in contacting other agencies that are able to provide more comprehensive care. This could include calling 911, going to the nearest emergency department, or contacting local Crisis and Assessment Centers.

EMAIL

Should you decide to contact me via email, please note that email 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. By signing this agreement, you are providing me with permission to send protected health information in unencrypted emails. Please note that I will take every precaution to guard the privacy and security of personal health-related information, consistent with federal HIPAA standards. These precautions include use of an electronic mail account established on a separate server and use of an electronic signature to ensure that communications are in fact sent by me.

Please recognize that despite these precautions and the fact that they increase the security of email communications between us, your privacy could be breached. If there is a breach of your PHI, I will immediately inform you of the nature and extent of the information involved, the person who obtained the unauthorized access and whether that person has an independent obligation to protect the confidentiality of the information, and the extent to which the risk has been mitigated, such as by obtaining a signed confidentiality agreement from the recipient.

PRIVACY AND STORAGE OF RECORDS

My practice maintains its own records, stored separately from those of the other providers at Triangle Center for Behavioral Health. Your PHI may not be accessed by others without your authorization. However, in the event of my death or incapacitation, my colleague, Dr. Rebecca Dingfelder, will oversee the short-term clinical operations of my practice. By signing this Agreement, you are consenting to allow Dr. Dingfelder access to your Clinical Record in order to contact you regarding my status and to assist with you with seeking alternative clinical services as needed. If ever I am unable to access your Clinical Record to communicate with you during a clinical emergency, I will ask Dr. Dingfelder to access your Clinical Record during an emergency to assist you with accessing emergency services as well as to contact other parties involved, including law enforcement, to ensure your safety and that of others. Dr. Dingfelder follows the same rules of confidentiality expected of all psychologists. She will protect your privacy and will not further release your PHI without your Authorization. A written policy on my policies and procedures for privacy and security records is available upon request.

LIMITS ON CONFIDENTIALITY

In general, the law protects the privacy of all communication 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. However, I must also release information without consent in the following situations:

- 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.

- 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.

- I may also be required to disclose confidential information if there is reason to believe that there is a likelihood that the client will commit a felony or violent misdemeanor.

- If determined to be in the best interest of my client, I may disclose confidential information about my client for purposes of filing a petition for involuntary commitment or for the adjudication of the incompetency of the client and the appointment of a guardian or an interim guardian under Chapter 35A of the General Statutes.
- I may exchange confidential information with a physician or other health care provider who is providing emergency medical services to my client. Disclosure of the information is limited to what I determine is necessary to meet the emergency.

- I may disclose an advance instruction for mental health treatment or confidential information from an advance instruction to a physician, psychologist, or other qualified professional when the responsible professional determines that disclosure is necessary to give effect to or provide treatment in accordance with the advance instruction.

- If an individual is a defendant in a criminal case and I have been ordered by the court to provide a mental examination of the defendant (as provided in G.S. 15A-1002), I will be required to send the results or the report of this mental examination to the clerk of court, to the district attorney or prosecuting officer, and to the attorney of record for the defendant.

- If my client has been voluntarily admitted or involuntarily committed and is facing district court hearings and rehearings, I will be required to furnish certified copies of written results of examinations and records to the client's counsel, the attorney representing the State's interest, and the court.

- I may disclose confidential information about a client to staff attorneys of the Attorney General's office whenever the information is necessary to the performance of the statutory responsibilities of the Attorney General's office.

- I may be required to share confidential information regarding my client with the Community Care of North Carolina Program, or other primary care case management programs that contract with the Department of Health and Human Services to provide a primary care case management program for recipients of publicly funded health and related services. In turn, these programs may share confidential information regarding my client when necessary to conduct quality assessment and improvement activities or to coordinate appropriate and effective care, treatment or habilitation of the client.

- Whenever there is reason to believe that my client is eligible for benefits through a state-funded program, I may share confidential information regarding my client with the program, and the program may share confidential information regarding my client with an area facility or State facility or the psychiatric services of the University of North Carolina Hospitals at Chapel Hill. Disclosure is limited to that information necessary to establish initial eligibility for benefits, determine continued eligibility over time, and obtain reimbursement for the costs of services provided to the client.

- I may share confidential information regarding my client with the area authority or county program, when the area authority or county program determines the disclosure is necessary to develop, manage, monitor, or evaluate the area authority's or county program's network of qualified providers.

- I may be required to furnish confidential information about a client to the Division of Adult Correction of the Department of Public Safety when requested by that department when the inmate has been determined by the Division of Adult Correction of the Department of Public Safety to be in need of treatment for mental illness, developmental disabilities, or substance abuse.

- Whenever there is reason to believe that my client is eligible for educational services through a governmental agency, I may disclose client identifying information to the Department of Public Instruction. Disclosure is limited to that information necessary to establish, coordinate, or maintain educational services.

- If a patient files a complaint or law suit against me, I may disclose relevant information regarding the patient in order to defend myself.

- If I believe it is in the best interest of a client, I may disclose to the client’s next of kin the fact that the client has been admitted to or discharged from my professional services.

- Upon request of the next of kin or other family member who has a legitimate role in the therapeutic services offered, or other person designated by the client or his legally responsible person, I may be required to provide the next of kin, or family member, or the designee, notification of the client's admission to my services, transfer to another facility, decision to leave the facility against medical advice, discharge from the facility, and referrals and appointment information for treatment after discharge, after notification to the client that this information has been requested.

- The Community Care of North Carolina Program, or other primary care case management programs that contract with the Department of Health and Human Services to provide a primary care case management program for recipients of publicly funded health and related services may have access to confidential

information from private or public agencies or agents for purposes of research and evaluation in the areas of mental health, developmental disabilities, and substance abuse.

- I may be required to may disclose confidential information to persons responsible for conducting general research or clinical, financial, or administrative audits if there is a justifiable documented need for this information. A person receiving the information may not directly or indirectly identify any client in any report of the research or audit or otherwise disclose client identity in any way.

If such a situation arises in which confidential information needs to be released, I will make every effort to fully discuss it with you before taking any action, and I will limit my disclosure to only information that is necessary.

It is important for you to know that 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-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.

MINORS AND PARENTS

Parental involvement is essential to successful treatment and therefore some private information should be shared with parents. It is my policy only to share information that is considered necessary with a minor patient's parents, such as general information about the progress of the child's treatment and his/her attendance at scheduled sessions. Before giving parents any information, I will discuss this information 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 also 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 patient's agreement.

PATIENT RIGHTS

You have the right to treatment, including access medical care and habilitation for you or your child, regardless of age or the degree of the mental health disability, intellectual disability or developmental delay, or substance abuse disability. You also have the right to obtain a copy of your or your child's treatment plan. To obtain this copy, you should contact me directly at (919) 794-5501 or in person and request a copy verbally or in writing. I will be happy to discuss any of these rights with you.

HIPAA also 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. Some of these rights are explained further in the Privacy Notice.

CONSENT

By signing below I,_____, acknowledge that I
(Print) Your Full Name

understand and accept all the terms in the above agreement for services provided by my clinician, Dr. Kelly Anthony. With my signature, I also consent to treatment for myself or my child,

_____.
(Print) Your Child's Full Name if Applicable

I understand that I may withdraw my consent at any time, and that the refusal of consent cannot be used by the clinician as the sole grounds for termination or the threat of termination of services unless the services the clinician is offering are the only viable treatment option with her practice. I also acknowledge that I have received, read, and understand the Notice of Privacy Policies described above and my client rights have been explained.

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

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