# Elizabeth H. Pilson, LCSW-C

5124 Dorsey Hall Drive
Ellicott City, MD 21042
Tel. 410-868-7431


## Outpatient Services Contract

Welcome to my Practice. This document contains important information about my professional services and business policies. It also contains summary information about the Health Insurance Portability Accountability Act (HIPAA) and/or Maryland law. HIPAA is a new federal law that provides new privacy protections and new patient rights regarding the use and disclosure of your Protected Health Information (PHI) used for the purpose of treatment, payment and health care operations. Please read this information carefully and ask about any information that you do not fully understand. Once you sign this document it is a binding agreement between us. You may revoke this Agreement in writing at any time. That revocation will be binding on us 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.

### **Psychological Services**:

Psychotherapy requires a very active effort on your part. In order to be most successful, you will have to work both during our sessions and at home. Psychotherapy has both benefits and risks. Often it requires recalling unpleasant aspects of your life. However, many discover that therapy often leads to a significant reduction in feelings of distress, improvements in relationships, and problem-resolution. Ultimately, these are not guaranteed outcomes in the therapeutic process, and I encourage patient participation around treatment goals, procedures and mutual feedback during the time you are in treatment.

By the end of the evaluation, I will be able to offer you some initial impressions of what our work will include and an initial treatment plan. If you decide to continue you should evaluate this information along with your assessment about whether you feel comfortable working with me. Therapy involves a commitment of time, money, and energy, so you should be very careful about the therapist you select. If you have any questions about the procedures, we should discuss them whenever they arise. If your doubts persist, I will be happy to help you secure an appropriate consultation with another mental health professional.

### **Limits on Confidentiality:**

A patient's confidentiality is of primary importance and is legally protected. In most cases your confidentiality will be strictly guarded, however, special circumstances may arise which may place limitations on a patient's right or ability to maintain confidential communications. Confidentiality must be broken if 1) I believe that you are in immediate danger of hurting or killing yourself; 2) I believe that you are going to hurt or kill another person; 3) I have reason to believe that a child or vulnerable adult has been subjected to abuse or neglect or that a vulnerable adult has been subjected to self-neglect, or exploitation. In those cases, the law requires that I file a report with the appropriate government agency, usually the local office of the Department of Social Services.
4) I have been ordered to testify or relinquish records by the court.

All precautions will be taken to keep records strictly confidential and in a locked office. Patient records may be released with your consent only, by signing a written **Release of Information** form. For insurance reimbursement, both for the patient submitting on their own, as well as for my own ability to receive reimbursements from insurance companies, I will provide patient information that is confidential, but necessary for reimbursement purposes. In accepting the terms of this patient-therapist contract, the patient agrees to release such information for the purpose of receiving reimbursements directly from their insurance company and will be submitted along with their claims.

## Cancellation Policy:

If you cancel an appointment, please give a minimum of 24 hours advanced notice. If you cancel an appointment without giving at least 24 hours notice or you do not show, you will be charged $75 for the missed appointment which will be due along with your regular payment for services at the beginning of your next appointment. Please be advised that insurance companies do not cover this charge. The charge will not apply under conditions of an unavoidable emergency.

## Services, Payment, and Fees:

Out of pocket fees are based on the time spent in the therapy session. The following units of time and fees are set for these therapy sessions:

| | |
|---|---|
| Initial Evaluation Session 60 mins | $160 |
| Individual Psychotherapy 45-53 mins | $140 |
| Individual Psychotherapy 54-60 mins | $160 |
| No Show/Late Cancellation | $ 75 |
| Phone Session 30min (Not covered by insurance) | $ 80 |
| Letter Writing/Report 60 mins | $200 |

I am not able to accept credit cards at this time. Checks are accepted, however, if the check is returned, **I will require a reimbursement fee of $30 for the returned check processing.**

## Services Associated With Legal Issues:

Please know that I do not testify in legal proceedings on behalf of my clients because doing so can adversely affect our treatment relationship. By signing this informed consent, you agree that should there be a legal proceeding (such as, but not limited to, a divorce and custody dispute, injuries, lawsuits, etc.) neither you, nor your attorney, nor anyone else acting on your behalf, will call me to testify in such proceeding, nor will a disclosure of the psychotherapy records be requested unless otherwise agreed upon. I prefer that therapy remain a voluntary endeavor strictly for the purpose of working toward improving certain aspects of your life.

Fees & Payment: In the event that I am ordered to court on your behalf by a judge, consultation with lawyers including telephone, written responses and email will incur a fee of $500 per hour per 15 minute increments or any part thereof. The fee for court appearances, responding to subpoenas, depositions and case preparation, is $500 per hour plus expenses. Charges are billed based on ½ hour increments, pro-rated with a minimum of 2 hours. Travel time to and from court appearances and depositions will also be billed at the aforementioned hourly rate. I understand and agree that I accept financial responsibility for such activity and will give at least 48 hours advance notice of change or cancellation, to not incur the two-hour minimum fee. Payment is due one week prior to the scheduled appearance or deposition/consultation. If you have been seen as a couple and records are subpoenaed, both partners need to sign the authorization for release of records unless court ordered.

## Insurance Billing:

If we are billing your health insurance company for any portion of our fee, please be aware that you are ultimately responsible for payment of the fee when your insurance company does not pay. We require co-payments to be paid at the time of service. We require that you call your insurance company to request authorization, if required by your carrier. <u>If you do not obtain authorization by your insurance carrier in a timely manner, you will be responsible for the full payment.</u>

## 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 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 any one, including reports to your insurance carrier. Except in unusual circumstance that disclosure is reasonably likely to endanger the life or physical safety of you or another 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 our presence or have the forwarded to another mental health professional so you can discuss the contents. In most circumstances, I am allowed to charge a copying fee (and other expenses). I retain your clinical record for up to 6 years after termination of services.

## Contacting Me:

Since my work schedule is often set to accommodate patients' needs, I may not always be reachable directly. I have a phone with a private and confidential voicemail that I monitor for incoming messages. Please fee free to leave any scheduling, routine or urgent messages on this voicemail and I will respond as promptly as possible. If you have a life-threatening emergency or psychiatric emergency, please call 911 or go to the nearest hospital emergency room.

## Authorization/Agreement:

By signing this Outpatient Service Contract, you agree that you have reviewed this information and agree to the terms.

_____

Signature of Patient Date

Printed Name of Patient

Elizabeth H. Pilson, LCSW-C is not affiliated, owned, owner-associated, a partner, joint venturer, or in any way connected to Martin Counseling and Associates, LLC (otherwise known as MCA), its Members, agents, employees, partners, successors or assigns. The services provided to you are provided strictly, absolutely and solely by Elizabeth H. Pilson, LCSW-C. MCA, its Members, agents, employees, partners, successors and assigns are not in any way liable or responsible and will not be liable or responsible for services provided to you by Elizabeth H. Pilson, LCSW-C, its Members, agents, employees, partners, successors and assigns does not advocate, recommend, review, control, manage, monitor, approve or in any way promote, warrant, covenant, insure or underwriter the activities and services of Elizabeth H. Pilson, LCSW-C. Any claim for damages, harm, malpractice, omission or the like is the sole and exclusive responsibility of Elizabeth H. Pilson, LCSW-C.

_____

Signature of Patient

_____

Printed Name of Patient

_____

Date