Abigail Fernandes, LICSW
Holistic Outpatient Therapy
617-285-2334

OUTPATIENT SERVICES CONTRACT

Welcome to my practice. This document contains important information about my professional services and business policies. Please read it carefully and jot down any questions you might have so that we can discuss them at our next meeting. When you sign this document, it will represent an agreement between us. Please note, although my office is located at 27 Congress Street, #203, Salem, I am not affiliated with Healing Creative, LLC.

MENTAL HEALTH SERVICES

Psychotherapy is not easily described in general statements. It varies depending on the personalities of the clinician and client, and the particular problems you bring forward. There are many different methods I may use to deal with the problems that you hope to address. Psychotherapy calls for a very active effort on your part. In order for the therapy to be most successful, you will have to work on things we talk about both during our sessions and at home. Psychotherapy can have benefits and risks. Since therapy often involves discussing unpleasant aspects of your life, you may experience uncomfortable feelings like sadness, guilt, anger, frustration, loneliness, and helplessness. On the other hand, psychotherapy has also been shown to have benefits for people who go through it. Therapy often leads to better relationships, solutions to specific problems, and significant reductions in feelings of distress. However, there are no guarantees of what you will experience.

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 first impressions of what our work will include and a treatment plan to follow, if you decide to continue with therapy. You should evaluate this information along with your own opinions of whether you feel comfortable working with me. Therapy involves a large commitment of time, money, and energy, so you should be very careful about the therapist you select. If you have questions about my procedures, we should discuss them whenever they arise. If your doubts persist, I will be happy to help you set up a meeting with another mental health professional for a second opinion.

MEETINGS

I normally conduct an evaluation that will last from 2 to 4 sessions. During this time, we can both decide if I am the best person to provide the services you need in order to meet your treatment goals. If psychotherapy is begun, appointments are generally 50 minutes in length. Since an appointment time is specifically set aside for you, I must ask that you provide me with a minimum of 24 hours notice if you will not be able to keep your appointment. This will give me the opportunity to then fill that appointment time. If you do not attend your appointment and have not notified me as stated above, you will be charged a $75 fee. Please be aware that your insurance carrier will not cover this charge. Since your time is as valuable as mine, I will do my best to contact you should I need to cancel and appointment due to inclement weather, illness, or other unexpected emergency.

PROFESSIONAL FEES

For the first session, a diagnostic evaluation, the fee is $125. Following that, my hourly fee is $100. In addition to weekly appointments, I charge this amount for other professional services you may need, though I will break down the hourly cost if I work for periods of less than one hour. Other services include report writing, telephone conversations lasting longer than 5 minutes, attendance at meetings with other professionals you have authorized, preparation of records or treatment summaries, and the time spent performing any other service you may request of me. If you become involved in legal proceedings that require my participation, you will be expected to pay for my professional time even if I am called to testify by another party.

BILLING AND PAYMENTS

You will be expected to pay for each session at the time it is held, unless we agree otherwise or unless you have insurance coverage which requires another arrangement. In circumstances of unusual financial hardship, I may be willing to negotiate a fee adjustment/sliding scale or payment installment plan. If you are choosing to use your health insurance, it is your responsibility to know the limits of your benefits under the "Outpatient Mental Health" provisions of your policy. Almost all insurers now require you to directly contact their case managers to pre-authorize your visits. Please make sure to contact your insurer for their specific procedures. Sessions that have not been pre-authorized by your insurer will become your financial responsibility.

If your account has not been paid for more than 60 days and arrangements for payment have not been agreed upon, I have the option of using legal means to secure the payment. This may involve hiring a collection agency or going through small claims court. If such legal action is necessary, its costs will be included in the claim. In most collection situations, the only information I release regarding a client's treatment is his/her name, the nature of services provided, and the amount due.

CONTACTING ME

I am often not immediately available by telephone. When I am unavailable, my telephone (617-285-2334) is answered by voice mail. 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 are difficult to reach, please inform me of some times when you will be available. If you are unable to reach me and feel that you can't wait for me to return your call, contact your primary care physician or the nearest emergency room or call 911. If I will be unavailable for an extended time, I will provide you with the name of a colleague to contact, if necessary.

PROFESSIONAL RECORDS

The laws and standards of my profession require that I keep treatment records. You are entitled to receive a copy of the records unless I believe that seeing them would be emotionally damaging, in which case I will be happy to send them to a mental health professional of your choice. Since these are professional records, they can be misinterpreted and/or upsetting to untrained readers. I recommend that you review them in my presence so that we can discuss the contents. Clients will be charged an appropriate fee for any time spent in preparing information requests.

CONFIDENTIALITY

In general, the privacy of all communications between a client and a licensed mental health professional is protected by law, and I can only release information about our work to others with your written permission. But there are a few exceptions.

In most legal proceedings, you have the right to prevent me from providing any information about your treatment. In some proceedings involving child custody and those in which your emotional condition is an important issue, a judge may order my testimony if he/she determines that the issues demand it.

There are some situations in which I am legally obligated to take action to protect others from harm, even if I have to reveal some information about a client's treatment. For example, if I believe that a child, elderly person, or disabled person is being abused or neglected, I must file a report with the appropriate state agency.

If I believe that a client is threatening serious bodily harm to another, I am required to take protective actions. These actions may include notifying the potential victim, contacting the police, or seeking hospitalization for the client. If the client 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.

These situations have rarely occurred in my practice. If a similar situation occurs, I will make every effort to fully discuss it with you before taking any action.

I may occasionally find it helpful to consult other professionals about a case. During a consultation, I make every effort to avoid revealing the identity of my client. The consultant is also legally bound to keep the information 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.

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 at our next meeting. I will be happy to discuss these issues with you if you need specific advice, but formal legal advice may be needed because the laws governing confidentiality are quite complex, and I am not an attorney.

Your signature below indicates that you have read the information in this document and agree to abide by its terms during our professional relationship.

Print Name_____

Date_____

Signature_____

DOB:_____

Post Mail Address:

Abigail Fernandes, LICSW
27 Congress Street, Suite 203
Salem, MA 01970
617-285-2334

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW THIS NOTICE CAREFULLY

Your health record contains personal information about you and your health. This information about you that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services is referred to as Protected Health Information ("PHI"). This Notice of Privacy Practices describes how I may use and disclose your PHI in accordance with applicable law and the NASW Code of Ethics. It also describes your rights regarding how you may gain access to and control your PHI.

I am required by law to maintain the privacy of PHI and to provide you with notice of my legal duties and privacy practices with respect to PHI. I am required to abide by the terms of this Notice of Privacy Practices. I reserve the right to change the terms of my Notice of Privacy Practices at any time. Any new Notice of Privacy Practices will be effective for all PHI that I maintain at that time. I will provide you with a copy of the revised Notice of Privacy Practices.

HOW I MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

Without your Authorization: Applicable law and ethical standards permit me to disclose information about you without your authorization only in a limited number of situations. For each category of uses or disclosures I will explain what I mean and try to give some examples. Not every use or disclosure in a category will be listed. However, all the ways I am permitted to use and disclose information will fall within one of the following categories.

A. **For Treatment.** Your PHI may be used and disclosed to those who are involved in your care for the purpose of providing, coordinating, or managing your health care treatment and related services in my practice. For example, information obtained from a nurse, physician, or other member of your health care treatment team will be recorded in your record and used to determine the course of treatment for you. This includes consultation with clinical supervisors or other treatment team members. I may disclose PHI to any other consultant or health care provider only with your authorization.

B. **For Payment.** I may use and disclose PHI so that I can receive payment from you, an insurance company or a third party, for the services I have provided to you. For example, I may need to give your health plan information about treatment that you received from me so your health plan will pay me or reimburse you for the treatment. I may also tell your health plan about a treatment that you are going to receive in order to obtain prior approval for the service. The information disclosed would be limited to the nature of services provided, the dates of services, the amount due and other relevant financial information. If it becomes necessary to use collection processes due to lack of payment for services, I will only disclose the minimum amount of PHI necessary for purposes of collection.

C. **Judicial and Administrative Proceedings.** In any judicial or administrative proceeding, you have the right to refuse to authorize the disclosure of any communication between you and a social worker relating to your care and treatment. There are a few instances in which this privilege would not apply, and therefore, in which I could testify in the judicial or administrative proceeding. Specifically, I may disclose such communications during judicial or administrative proceedings, if (I) I determine that you need hospitalization or are a threat to yourself or to others; (ii) the communications were made in the course of a court-ordered psychiatric examination; (iii) you hire a party to a case and you have introduced your mental or emotional state as an element of a claim or defense; (iv) if the testimony is given in connection with a care and protection proceeding, or a petition to dispense with parental consent to adoption; (v) in connection with any malpractice action brought by you against me, where the disclosure is necessary for my defense; (vi) if the communications relate to your ability to provide care or custody in a child custody or adoption case; or (vii) if the communication were made in connection with and during an investigation of allegations of child abuse, when I have made a report that I have reasonable cause to believe that child abuse is occurring; or (viii) if I believe a child, a disabled person, or an elderly person your care is suffering abuse or neglect.

D. **In an Emergency.** I may disclose your PHI to a physician who requests such records in the treatment of a medical or psychiatric emergency. For example, if you are unconscious and the doctor treating you needs to know details regarding your medical history in order to decide on a course of treatment for you, I would disclose the PHI necessary for the doctor to treat you during the emergency. If it is not possible to obtain your consent to this disclosure, then notice of the disclosure will be provided to you as soon as possible.

E. **As Required by Law.** I may disclose your PHI as required by law, such as the mandatory reporting of child abuse or neglect or mandatory government agency audits or investigations.

F. **If Required by Court Order.** I may disclose your PHI in a judicial proceeding if required by Court order.

G. **If Necessary Because of Threat to Health or Safety.** I may disclose you PHI if necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. I may use or disclose you PHI to the extent which is necessary to protect your safety or the safety of others, if (1) you present a clear and present danger to yourself, or (2) you have communicated an explicit threat to kill or inflict serious bodily injury upon another person, and there is a basis for reasonable belief that the treat may be carried out. If information is disclosed to prevent or lessen a serious threat it will be disclosed to a person or persons reasonably able to prevent or lessen the threat, including the target of the threat.

H. **Business Associates.** Some services in my practice I obtain through contracts with business associates. For example, I may contract with outside companies to provide legal services, accounting services, or billing services. When I contract with a business associate, I may disclose health information to the business associate so her can do the job I've asked her to do. To protect your health information, I require the business associate to appropriately safeguard you health information.

With Authorization. Uses and disclosures not specifically permitted by applicable law will be made only with your written authorization.

Revocation of Authorization. If you provide me with permission to use or disclose PHI about you, you may revoke that permission, in writing, at any time. If you revoke your authorization, I will no longer use or disclose medical information about you for the purposes covered by the written authorization. However, I am unable to take back any disclosures that I have already made with your authorization.

YOUR RIGHTS REGARDING YOUR PHI

You, or your authorized representative, have the following rights regarding PHI that I maintain about you. To exercise any of these rights, please submit your request in writing to me.

Right of Access to Inspect and Copy. You have the right, which may be restricted only in exceptional circumstances, to inspect and copy PHI that may be used to make decisions about your care. Your right to inspect and copy PHI will be restricted only in those situations where there is compelling evidence that access would be reasonably likely to endanger the life or physical safety of you or another person. I may charge a reasonable, cost based fee for copies. I will act on your request within thirty days of receiving your request.

Right to Amend. If you feel that the PHI I have about you is incorrect or incomplete, you may ask me in writing to amend the information although I am not required to agree to the amendment.

Right to an Accounting of Disclosures. You have the right to request an accounting of the disclosures that I make of your PHI. This is a list of certain disclosures I have made of your PHI. To make this request, you should submit it in writing to me. I may charge you a reasonable fee if you request more than one accounting in any 12-month period.

Right to Request Restrictions. You have the right to request a restriction or limitation on the medical information I use or disclose about you for treatment, payment, or health care operations. For example you might request that particularly sensitive information (such as the existence of drug dependence) not be disclosed for any purpose. I am not required to agree to your request. To request restriction, you must submit your request in writing to me. In your request, you must tell me (1) what information you want to limit, (2) whether you want to limit the use, disclosure, or both, and (3) to whom you want the limits to apply (for example, disclosures to your insurance carrier.)

Right to Request Confidential Communication. You have the right to request that I communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that I only contact you at work or by mail.

Right to a Copy of this Notice. You have the right to a paper copy of this notice. You may ask me to give you a copy of this notice at any time.

COMPLAINTS

If you believe I have violated your privacy rights, you have the right to file a complaint in writing with me or with the Office for Civil Rights, U.S. Department of Health and Human Services, Government Center, J.F. Kennedy Federal Building—Room 1875, Boston, MA 02203. Voice phone 617) 565-1340. FAX (617) 565-3809. TDD (617) 565-1343.

The effective date of this Notice is February 15, 2017.

I, _____ have received a copy of and understand this Notice of Privacy Practices.

_____ _____

Signature Date

Abigail Fernandes, LICSW

Authorization to Bill and Release Information to Insurance Company

I, _____, authorize the release of information including my child's (name of child: _____); DOB: _____, diagnosis and/or treatment related to substance abuse, mental health to my managed care or health insurance carrier.

The purpose of this authorization is to allow the managed care and/or health insurance company to carry out utilization review and quality assurance activities, to determine eligibility for covered benefits, and to make payment on claims filed by Abigail Reynolds, LICSW. This however does NOT include the release of any HIV/AIDS related confidential information.

I do assign benefits otherwise payable to Abigail Fernandes, LICSW on the claim.

I understand I am financially responsible for any balance not covered by my insurance carrier. I also understand that if I do not make payments when due, Abigail Reynolds, LICSW has the right to end all services and take whatever actions necessary to recover overdue payments.

A copy of this signature is as valid as the original. I may cancel this authorization at any time. If not canceled, this authorization expires181 days after the last date of service provided by Abigail Reynolds, LICSW.

_____ _____

Signature of Responsible Person Date

_____ _____

Signature of Witness Date

Authorization for Electronic Communication

As a convenience to me, I hereby request that Abigail Fernandes, LICSW, communicate with me regarding my treatment by Abigail Fernandes, LICSW via electronic communications (e-mail or text message). I understand that this means Abigail Fernandes, LICSW and/or my treating providers will transmit my protected health information such as information about my appointments, diagnosis, medications, progress and other individually identifiable information about my treatment to me via electronic communications.

I understand there are risks inherent in the electronic transmission of information by e-mail, on the internet, via text message, or otherwise, and that such communications may be lost, delayed, intercepted, corrupted or otherwise altered, rendered incomplete or fail to be delivered. I further understand that any protected health information transmitted via electronic communications pursuant to this authorization will not be encrypted. As the electronic transmission of information cannot be guaranteed to be secure or error-free and its confidentiality may be vulnerable to access by unauthorized third parties, Abigail Fernandes, LICSW shall not have any responsibility or liability with respect to any error, omission, claim or loss arising from or in connection with the electronic communication of information by Abigail Fernandes, LICSW to me.

After being provided notice of the risks inherent in use of electronic communications, I hereby expressly authorize Abigail Fernandes, LICSW to communicate electronically with me, which will include the transmission of my protected health information electronically. I understand that in the event I no longer wish to receive electronic communications from Abigail Fernandes, LICSW, I may revoke this authorization by providing written notice to Abigail Fernandes, LICSW at 27 Congress Street, Suite 203, Salem, MA 01970.

I agree that Abigail Fernandes, LICSW may communicate with me electronically unless and until I revoke this authorization by submitting notice to Abigail Fernandes, LICSW in writing. This authorization does not allow for electronic transmission of my protected health information to third parties and I understand I must execute a separate authorization for my protected health information to be disclosed to third parties.

I hereby authorize the transmission of my protected health information electronically as described above.

_____

Patient Name

_____ _____

Signature of Patient Date

Email: _____ Cell: _____