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**PUTTING FIRST RESPONDERS AND THEIR FAMILIES FIRST**

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## **OUTPATIENT SERVICES CONTRACT**

Welcome to my practice. I am a licensed psychologist in the state of California. I provide assessment and psychotherapy services to individuals, couples, families, adolescents and adults.

This document (the Agreement) 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 new federal law that provides new privacy protections and new client rights with regard to the use and disclosure of your Protected Health Information (PHI) used for the purpose of treatment, payment, and health care operations. HIPAA requires that I provide you with a Notice of Privacy Practices (the Notice) for use and disclosure of PHI for treatment, payment and health care operations. The Notice, which is attached to this Agreement, explains HIPAA and its application to your personal health information in greater detail. The law requires that I obtain your signature acknowledging that I have provided you with this information. Although these documents are long and sometimes complex, it is very important that you read them carefully. Please jot down any questions you have so that we can discuss them during our meeting. When you sign this document, it will represent an agreement between us. You may revoke this Agreement in writing at any time. That revocation will be binding on me 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**

I share my office space with two psychological assistants. I want you to know that I am completely independent in providing you with clinical services and I alone am fully responsible for those services. I do not provide fitness for duty statements or custody recommendations.

Unless you are referred for assessment, you will likely be meeting with me to obtain psychotherapy. Psychotherapy varies depending on the personalities of the psychologist and client, and the particular problems you are experiencing.

Psychotherapy has benefits and risks. Therapy often involves discussing unpleasant aspects of life and you may experience feelings of sadness, guilt, anger, frustration, loneliness, and helplessness. It can be uncomfortable to talk about the circumstances that you find yourself in or that have led up to your troubles. On the other hand, psychotherapy has been shown to be beneficial for many people and can lead to significant reductions in distress, better relationships, and solutions to specific problems. There are no guarantees of what you will experience.

Therapy involves a large commitment of time, money and energy. In taking this step to help yourself, it is important that you feel comfortable with the psychologist you choose. Our first one to two sessions will involve an evaluation of your needs. Depending on your situation, this may involve psychological testing. At the end of this initial evaluation, I will be able to offer you some first impressions of what our work will include. If you decide to work with me we will formulate a written treatment plan. If I feel that I am not the best person to assist you, I will refer you to your insurance or a professional or an agency to better serve your needs. Please remember that you are the consumer. You have a right to ask questions about treatment or to refuse to participate in anything you deem inappropriate. I am open to discussing my treatment approach with

you and encourage you to bring questions and concerns to my attention so we may discuss them, whenever they arise.

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**Professional Fees**

My hourly fee for individual therapy is \$125, \$160 for couples or family therapy. I will usually schedule one appointment hour of 50 minutes duration per week at a time that we agree on, although some sessions may be longer or more or less frequent. 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 an hour. Other services include report writing, telephone conversations lasting more than ten minutes, attendance at meetings with other professionals you have authorized, preparation of records or treatment summaries, and time spent on other agreed upon services. If you become involved in 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. Because of the complexity of legal involvement, I charge \$275 per hour for preparation, travel time, and attendance at any legal proceeding. In addition, this fee will need to be paid in advance.

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I require 24 hour advanced notice for any cancellation of a scheduled appointment. It is possible to call and leave a message 24 hours a day at (510) 797-4911. You will be charged \$75 for any cancellation made with less than 24 hours notice, unless we both agree that you were unable to attend due to circumstances beyond your control. **Late cancellations will be charged directly to you and not your insurance company.**

Initial \_\_\_\_\_

There will be a \$30 surcharge for checks returned due to non-sufficient funds.

Initial \_\_\_\_\_

If you choose to pay by PayPal, fees may apply. This charge goes directly to PayPal, not to me.

Initial \_\_\_\_\_

**Billing, Payments, and Insurance Reimbursement**

You are expected to pay for each session at the time it is held, unless we agree otherwise or unless I have a contract with your managed care insurance company. If I have a contract with your managed care company, the billing procedures of that company will be followed. If I am covered by your insurance plan, but do not have a contract with your insurance plan, or if I am not covered by your insurance plan, you will be responsible for paying for my services at the time they are provided. I will be happy to provide you with a receipt for you to submit to your insurance company and provide you with whatever assistance I can in helping you receive the benefits to which you are entitled; however, you (and not your insurance company) are responsible for full payment of my fees.

Initial only if no receipt is needed, and cashed check will be proof of payment.

Initial \_\_\_\_\_

If you have insurance, it is very important that you find out exactly what mental health services your insurance policy covers. You should carefully read the section in your insurance coverage booklet that describes mental health services. If you have questions about the coverage, call your plan administrator. Of course, I will provide you with whatever information I can based on my experience and will be happy to help

you in understanding the information you receive from your insurance company. If it is necessary to clear confusion, I will be willing to call the company on your behalf.

Due to the rising costs of health care, insurance benefits have increasingly become more complex. It is sometimes difficult to determine exactly how much mental health coverage is available. “Managed Health Care” plans such as HMOs and PPOs often require authorization before they provide reimbursement for mental health services. These plans are often limited to short-term treatment approaches designed to work out specific problems that interfere with a person’s usual level of functioning. It may be necessary to seek approval for more therapy after a certain number of sessions. While much can be accomplished in short-term therapy, some clients feel that they need more services after insurance benefits end. [Some managed-care plans will not allow me to provide services to you once your benefits end. If this is the case, I will do my best to find another provider who will help you continue your psychotherapy.]

You should also be aware that your contract with your health insurance company requires that I provide it with information relevant to the services that I provide to you (and/or your child if applicable). I am required to provide a clinical diagnosis. Sometimes I am required to provide additional clinical information such as treatment plans or summaries, or copies of your entire Clinical Record. In such situations, I will make every effort to release only the minimum information about you and/or your child that is necessary for the purpose requested. This information will become part of the insurance company files and will probably be stored in a computer. Though all insurance companies claim to keep such information confidential, I have no control over what they do with it once it is in their hands. In some cases, they may share the information with a national medical information databank. I will provide you with a copy of any report I submit, if you request it. By signing this Agreement, you agree that I can provide requested information to your carrier.

Once we have all of the information about your insurance coverage, we will discuss what we can expect to accomplish with the benefits that are available and what will happen if they run out before you feel ready to end your sessions. It is important to remember that you always have the right to pay for my services yourself to avoid the problems described above [unless prohibited by contract].

**Initial** \_\_\_\_\_

If a reduced fee, delayed of fee or other entity will be paying your fee, this is pertinent information to note in our contract. Please outline the specific details below:

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I have received a copy of “Insurance Coverage: Some Helpful Hints”

**Initial** \_\_\_\_\_

## Contacting Me

Generally, I am in the office between 11:00 am and 2:00 pm. I am often not immediately available by telephone and not available typically on weekends and holidays. I will also not answer the phone when I am with a client. Calling me at **(510) 797-4911** is the easiest way to reach me and if I do not answer, you may leave me a private, confidential voice mail message. 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 cannot wait for me to return your call, contact your family physician, 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 and/or the number of a local crisis hotline.

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## Limits on Confidentiality

The law protects the privacy of all communications between a client and a psychologist. In most situations, I can only release information about your (and/or your child's) treatment to others if you sign a written Authorization form that meets certain legal requirements imposed by HIPAA. There are other situations that require only that you provide written, advance consent. **Your signature on this Agreement provides consent for those activities, as follows:**

- I may occasionally find it helpful to consult other health and mental health professionals about a case. During a consultation, I make every effort to avoid revealing the identity of my client. The other professionals are 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. I will note all consultations in your Clinical Record (which is called "PHI" in my Notice of Psychologist's Policies and Practices to Protect the Privacy of Your Health Information).
- I may employ administrative staff. In most cases, I need to share protected information with these individuals for both clinical and administrative purposes, such as scheduling, billing and quality assurance. All staff members have been given training about protecting your privacy and have agreed not to release any information outside of the practice without the permission of a professional staff member.
- As required by HIPAA, I have a formal business associate contract with certain business(es), in which it/they promise to maintain the confidentiality of this data except as specifically allowed in the contract or otherwise required by law. If you wish, I can provide you with the names of these organizations and/or a blank copy of this contract.
- Disclosures required by health insurers or to collect overdue fees are discussed elsewhere in this Agreement.
- If a 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.

There are some situations where I am permitted or required to disclose information without either your consent or Authorization:

- If you are involved in a court proceeding and a request is made for information concerning the professional services I provided you (and/or your child), such information is protected by the psychologist-client privilege law. I cannot provide any information without your or your legal

representative's written 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.

- If a government agency is requesting the information for health oversight activities, I may be required to provide it for them.
- If a client files a complaint or lawsuit against me, I may disclose relevant information regarding that client in order to defend myself.
- If a client files a worker's compensation claim, and I am providing services related to that claim, I must, upon appropriate request, provide appropriate reports to the Workers Compensation Commission or the insurer.

There are some situations in which I am legally obligated to take actions, which I believe are necessary to attempt to protect others from harm and I may have to reveal some information about a client's treatment. These situations are unusual in my practice.

- If I have reason to believe that a child under 18 is or has been the victim of injury, sexual abuse, neglect or deprivation of necessary medical treatment, the law requires that I file a report with the appropriate government agency, usually the Office of Child Protective Services. Once such a report is filed, I may be required to provide additional information.
- If I have reason to believe that any adult client who is either vulnerable and/or incapacitated and who has been the victim of abuse, neglect or financial exploitation, the law requires that I file a report with the appropriate state official, usually a protective services worker. Once such a report is filed, I may be required to provide additional information.
- If a client communicates an explicit threat of imminent serious physical harm to a clearly identified or identifiable victim, and I believe that the client has the intent and ability to carry out such threat, I must take protective actions that may include notifying the potential victim, contacting the police, or seeking hospitalization for the client.

If such a situation arises, I will make every effort to fully discuss it with you before taking any action and I will limit my disclosure to what is necessary.

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 now or in the future. The laws governing confidentiality can be quite complex, and I am not an attorney. In situations where specific advice is required, formal legal advice may be needed.

**Initial** \_\_\_\_\_

### **Professional Records**

The laws and standards of my profession require that I keep Protected Health Information about you and/or your child in your/your child's Clinical Record. Except in unusual circumstances that involve danger to yourself/your child and/or others or where information has been supplied to me confidentially by others, you may examine and/or receive a copy of your/your child's 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 my presence, or have them forwarded to another mental health professional so you can discuss the contents. [I am sometimes willing to conduct this review meeting

without charge.] In most situations, I am allowed to charge a copying fee of 25 cents per page (and for certain other expenses). If I refuse your request for access to your records, you have a right of review, which I will discuss with you upon request. You will be charged an appropriate fee for any professional time spent in responding to information requests, although I am sometimes willing to conduct a review meeting without charge.

**Initial** \_\_\_\_\_

If you are seeing me as a member of a couple or family, the couple or family *as a whole* is my client. I will not release records without the written consent of *all* applicable parties.

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In addition, I also may keep a set of Psychotherapy Process Notes. These notes are for my own use and are designed to assist me in providing you with the best treatment. While the contents of the Psychotherapy Process Notes vary, they can include the contents of our conversations, my analysis of those conversations and how they may impact on your therapy. They also may contain sensitive information that you reveal to me that is not required to be in your clinical client record/PHI. While insurance companies can request and receive a copy of your clinical client record/PHI, they cannot receive a copy of your Psychotherapy Process Notes without your written, signed authorization. Insurance companies cannot require your authorization as a condition of coverage nor penalize you in any way for your refusal. Examination of your Psychotherapy Process Notes is at my discretion.

**Initial** \_\_\_\_\_

### **Client Rights**

HIPAA provides you with several new or expanded rights with regard to your/your child's Clinical Record and disclosures of protected health information. These rights include requesting that I amend your/your child's record; requesting restrictions on what information from your/your child's Clinical Record 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/your child's records; and the right to a paper copy of this Agreement, the attached Notice form, and my privacy policies and procedures. I am happy to discuss any of these rights with you.

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### **Minors & Parents**

Clients under 18 years of age who are not emancipated and their parents should be aware that the law may allow parents to examine their child's treatment records. If they agree, during treatment, I will provide them only with general information about the progress of the child's treatment, and his/her attendance at scheduled sessions. I will also provide parents with a summary of their child's treatment when it is complete. Any other communication will require the child's Authorization, unless I feel that the child is in danger or is a danger to someone else, in which case, I will notify the parents of my concern. Before giving parents any information, I will discuss the matter with the child, if possible, and do my best to handle any objections he/she may have. I do not make child custody recommendations.

**Initial** \_\_\_\_\_

With my signature, I acknowledge that I have read the above information, or it has been read to me. I acknowledge that I have received answers to my questions I may have had and that I understand the content of the information above and agree to abide by its terms during our professional relationship. I hereby authorize the release of any medical information necessary to process medical claims on my/my child's behalf. I also authorize the payment of any governmental or private insurance benefits directly to Anne Bisek, Psy.D. I acknowledge that I am responsible for all services rendered to me, my child and/or members of my family. I also understand that I am obligated to pay for all services should my insurance eligibility be denied.

YOUR SIGNATURE BELOW INDICATES THAT YOU HAVE READ THIS AGREEMENT AND AGREE TO ITS TERMS AND ALSO SERVES AS AN ACKNOWLEDGEMENT THAT YOU HAVE RECEIVED THE HIPAA NOTICE FORM DESCRIBED ABOVE.

Printed Name of Adult Client(s):

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Printed Name of Child / Adolescent Client(s):

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(1) Signature of Client or Custodial Parent / Legal Guardian

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Date

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(2) Signature of Client or Custodial Parent / Legal Guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Anne Bisek, Psy.D.

\_\_\_\_\_  
Date