Agreement Purpose: This document describes essential elements of my professional services and business policies. It also contains information about the Health Insurance Portability and Accountability Act (HIPAA), a Federal law that provides privacy protections and patient rights with regard to the use and disclosure of your Protected Health Information (PHI) for the purpose of treatment, payment, and health care operations.

Office Hours: The office is usually open Monday-Friday, by scheduled appointment. If the office will be closed for other commitments, this will be stated in advance. If I am ill or in cases of inclement weather, I will call you directly to reschedule your appointment if at all possible.

Psychiatric Service Fee Schedule[1]**:** I offer the following psychiatric services at the following costs:

Initial Assessment and Extensive Medical Appointments	$250
Psychotherapy sessions with or without medication management	$150
Late Cancel	$50
Missed session	$100

Emergency/After-hours Support: If you are in need of emergency services, please use the crisis plan established during your initial consultation. If you have an urgent after hours issue which cannot wait until the next business day, please call my office at **615.293.0194**. This option is reserved for urgent issues and does not apply to refills requests scheduling issues. If you cannot wait for a return call, are unable to reach me, or do not feel safe, please call the local Crisis and Intervention Line, call 911, or proceed to the nearest emergency room.

In the unexpected event of my physically being unable to contact you (due to illness, injury, or death), terms of my Professional Will shall be implemented. This will include an administrative lead contacting you to facilitate coordination of care.

Patient Rights: My professional responsibilities and personal ethics are to provide you the best care I can and to support your patient rights. I respect that for most people, starting or continuing psychiatric care involves safe-guarding private thoughts and information. HIPAA provides you with rights with regard to your medical record and disclosures of protected health information (PHI). These rights include: requesting restrictions on PHI disclosed to others; requesting an accounting of disclosures of PHI that you have neither consented to nor authorized; determining the location to which PHI disclosures are sent; having any complaints you make about my policies and procedures recorded in your records, and the right to request a copy of this Service Agreement.

Confidentiality: Your privacy is very important to me. All protected health information will be kept confidential. By current state and federal law, I am required to disclose information in the following circumstance:

- I must report to the appropriate agencies all cases of physical and sexual abuse or neglect of minors (children under the age of 18), the disabled, and the elderly;
- I must report to the appropriate agencies all cases in which there exists a danger to you and/or others;
- When authorized by you, to support medical insurance claims and authorized payment of benefits;
- In the event that a you need emergency services and other medical personnel are needed;
- In response to court subpoena of information concerning your treatment.

[1] If you are submitting to insurance, appropriate CPT codes will be submitted for all encounters. Each code has an established cost due to complexity as defined by state and national standards; this results in a ranges of fees. I have a set fee for each service (discussed in advance and denoted in invoices) that may include psychotherapy, medication management (evaluation and management; EM I-V), crisis, and additional services.

Client initials _____

Considerations for Psychotherapy: My clinical practice prioritizes psychotherapy as the primary treatment for improvement in mood, thinking patterns, and specific behaviors (including sleep and substance ab/use). Medication and cognitive skill development supplement our own individual and mutual understanding of how your mind works and core conflicts in ways of fully relating to yourself and others. My intention is to create a strong enough support for you to become aware of familiar patterns of relating and coping without our working relationship. My practice polices regarding time commitments to each other, fee schedule, and additional factors are designed to support this deepening awareness for us both. During a successful psychotherapy, intense feelings emerge. Please let me know what you feel about yourself and/or me, especially when it might be difficult to discuss these feelings directly. If you are in an intensive psychotherapy, I may present my own understanding of clinical work to supervisors without sharing your identifying information. Peer and individual supervision helps deepen my understanding of what is going well; it offers specific opportunity to improve your clinical care. If you have questions or concerns about my approach to supervision including how I prioritize the protection of your anonymity during supervision, please ask.

Telepsychiatry consent: My clinical practice can include services by telemedicine. Confidentiality and all other terms in this agreement apply to telesessions. Potential risks include, but may not be limited to: information transmitted may not be sufficient (poor resolution of video); delays in medical evaluation and treatment due to deficiencies or failures of the equipment; security protocols can fail, causing a breach of privacy; and a lack of access to all the information available in a face to face visit may result in delays in clinical assessment or care. Each of us will assess whether tele sessions are meeting the minimum standard of effective care and both have the right to withdraw consent to the use of telepsychiatry during the course of care. You have a responsibility to establish a safe and reliable environment where no other person can see or hear any part of your session to ensure privacy and the potential limitations of free disclosure of essential information for your care. Neither you nor I can record sessions without mutual written consent.

Payment and Billing Policy: Payment is due at the time of your appointment directly from you. I accept payment by credit card, cash or personal check. I offer payment online prior to session or payment at the end of the session depending on your preference. If requested, I will provide you a summary statement of medical expenses to be sent to your insurer in support of you receiving full fiscal support for my services as defined in your insurance policy.
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If you believe you cannot pay your bill, please let me know directly and as soon as possible. I am committed to establishing a temporary collaboratively plan if at all possible for you to continue treatment and make fair payments.

Cancellation and Late Policy: Your appointments are the foundation of my professional service to you and a primary aspect of the framework of psychotherapy. If you are late for your appointment, we will meet for the remainder of the time for your session and end on-time without a fee reduction. Once an appointment is scheduled, I expect you to provide at least two business days advance notice of cancellation. For example, an appointment for Monday needs to be rescheduled before your appointment time the previous Thursday. You will be charged the service fee for an appointment not cancelled with sufficient notice. Additionally, scheduled absences that do not correspond with my time away from the office are expected to be rescheduled. For example, if you cancel two appointments with advance notice, you may choose to reschedule both appointments OR accept these as missed appointments. I provide a list of office schedule closures for the year in January so that you can coordinate time away from the office if you like. As a courtesy, I can confirm upcoming initial appointments by phone or other message.

Telephone contact and additional nonclinical service fees: I prioritize psychotherapy that meets once or more each month. Frequent sessions can provide a means to clarify core conflicts and root causes of mood, behavioral, and additional symptoms. We may collaborative decide on a trial of phone calls is an iterative step towards more or less frequent sessions. I charge a fee ($50 for a 20 minute call) for established phone calls. I avail time at the same rate to attend to non-urgent and non-clinical telephone calls (such as to respond to legal queries or unplanned medication refill requests), with additional charges based on the amount of time spent. All paperwork, letters, or forms not specifically related to in-office care will also be subject to a fee based on the time it takes to complete the documentation ($25 for 15 min or less, $50 for 16-30 min, $75 for 31-45 min, etc.).

Client initials _____

Medication Refill Policy: If medication is a part of your treatment, it is our shared responsibility to coordinate medication refills. I provide electronic authorization of prescription refills. My practice is to authorize 1 month of medicine during active medication changes towards a stable, nonreactive medication plan. At times,I may do 3 month authorizations once psychopharmocologic stability is reached. Refill requests should be addressed in session, and I rely on you to ensure that you are not in the uncomfortable circumstance of not having your medication available by coordinating in advance with your pharmacy.

Professional Records: My professional ethics, state and national laws, and standards of medical practice require that I keep protected health information (PHI) about you in a medical record. Except in unusual circumstances that involve danger to yourself and/or others, you may receive a copy of your medical record. Please make your request in writing so that I can include it in your record. I document therapeutic assessments and plans in medical records. Clinical documentation is different from an evaluation to prove disability or substantiate medical or other procedures. I provide independent consultation (usually 2-4 sessions) for disability and others evaluation and refer established or former clients to a trusted provider for an objective evaluation if this need emerges during or after treatment. I am allowed to charge a copying fee for legal and other types of requests in addition to resolution of your current bill for services. Following our discussion of your request (or written request if you choose not to discuss your request), a summary of your records will be sent to you or someone you identify as soon as possible and no later than five (5) business days.

Your contract with your health insurance company may require that I provide them information relevant to your services. This may include a clinical diagnosis, treatment plans, or a copy of part or all of your medical record. I release the minimum information necessary for the purpose requested. If your insurance or demographic information changes, please let me know as soon as possible.

Treatment of Minors: In addition to the terms defined in our psychiatric service agreement, specific additional considerations are made to ensure legal and other protections for people non-emancipated minors. Treatment of patients under the age of 18 is contingent upon consent of the parent or legal guardian and he/she will not be seen initially without his/her legal guardian present. In cases of divorce, a copy of the custody agreement must be provided, and by signing the consent form on below, the client acknowledges that he or she is the legal guardian. Records will be released per instructions of your custody agreement. Patients under 18 years of age (who are not emancipated) should be aware that the law allows parents to examine their child's treatment records. Before giving parents any information, I discuss the matter with the child, if possible, and do my best to handle any objections he/she/they may have.

Intentions: My intention is to define aspects of your care in this annual agreement that can serve as the essential policy and procedures of your effective psychiatric treatment. This is not an exhaustive definition of our work. I will help define and establish a tenable plan for additional needs if they emerge during treatment. Your signature below indicates that you have read and commit to fulfill terms of this agreement during and after your care. You may revoke this professional service contract in writing at any time. Please discuss questions or concerns at your next appointment.

I confirm that I have fully read this contract and am responsible for the information in each section:

Patient's Printed Name _____ Signature_____ Date:_____

Legal Guardian's Name (if applicable): _____ Signature (if applicable)_____

I confirm that I have fully read this contract and am responsible for the information in each section

Lauren Hansen, DNP, WHNP-BC _____ Date:_____

Thank you for the opportunity to be a part of your clinical care.