M. Elicia Nademin, Ph.D.

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PSYCHOLOGIST-CLIENT AGREEMENT

Welcome to my practice! This document (the Agreement) contains important information about my professional services and policies. It is intended to help clients understand how my practice operates with respect to the psychologist-client relationship. Please read the information herein and ask me any questions you may have. Your signature on this document will represent an Agreement between us. You may revoke this Agreement in writing at any time, and that revocation will be binding unless a) I have taken action in reliance on it; b) your health insurer imposes obligations on me in order to process or substantiate claims made under your policy; or c) you fail to satisfy any financial obligations you have incurred.

Psychological Services

Psychotherapy, as I practice it, varies depending on the personalities of the psychologist and client, the therapist's training and treatment philosophy, and the client's specific needs. My approach to psychotherapy is generally characterized as cognitive-behavioral in nature. In the interest of individualizing optimal treatment, however, I integrate skills from various other approaches as well, including interpersonal therapies. Throughout treatment, I may ask you to work on things we talk about both during session and at home. Unlike a medical appointment, psychotherapy requires an active engagement on your part and offers few guarantees. It can have benefits and risks. Since therapy often involves discussion of unpleasant aspects of your life, you may experience uncomfortable feelings like sadness, anxiety, guilt, anger, frustration, loneliness, and helplessness as a result of sessions. On the other hand, therapy also offers hope of many benefits, leading to solutions to specific problems, self-awareness, significant reductions in feelings of distress, better relationships, and an improved quality of life. During our initial meeting, I will conduct a thorough assessment of your presenting concerns and symptoms, and we can decide together if I am the best person to provide the services needed to meet your treatment goals. If we agree to proceed, I will generally schedule weekly or biweekly 45-minute sessions (i.e., the "therapeutic hour"). Sessions may become less frequent as therapy and progress continue.

One of the most vital elements of psychotherapy is the therapeutic relationship. My hope is that you will feel comfortable working with me and safe disclosing to me; trust is crucial to our process. Therapy involves a significant commitment of time, money, and energy, so choosing a therapist who is a good fit is essential. If after we meet you have questions, doubts, or misgivings, I encourage you to communicate these to me as they arise, so that we may discuss them and make modifications to our plan, if fitting. At any time, I would be happy to offer you referral options for an alternative mental health professional, if desired.

Cancellations

Once an appointment is scheduled, you are responsible for full payment unless you provide at least 24 business hours advance notice of cancellation or rescheduling (or we both agree that you were unable to attend due to circumstances beyond your control). If you are running late to a session, please call me ASAP to let me know. If you arrive late, we will proceed with the session, though will end at our previously scheduled time; you are still responsible for payment of the full session fee. If *I* am late, I will extend our session time accordingly. **If you are over 15 minutes late and I do not hear from you, I will consider the session cancelled, and you will be charged the full session fee.** Please note that if you plan to submit claims for insurance reimbursement, insurance companies do not reimburse for cancelled sessions. If I am unable to reach you to discuss rescheduling, and four weeks lapse from the time of our last contact, I will assume you are no longer interested in services, and your chart will be closed. I will happily reopen your file to resume services at a later time, per your request. While you may discontinue therapy at any time, you will be responsible for payment in full of all services rendered; payment is due at time of each session.

Contacting Me

I regret that due to the limited nature of my private practice, I am often not immediately available by telephone, and I do NOT provide emergency services. Messages, which are generally monitored daily, can be left for me at 480.221.8816, and I will make every effort to return calls within 24 hours, barring extenuating circumstances. Please leave a callback number with all messages, as I do not readily access client files when away from the office. I can be reached by e-mail at eliciaphd@gmail.com for scheduling/administrative purposes. **Please note, however, that e-mail is not a confidential form of communication nor appropriate for urgent messages.** In an effort to protect your privacy, I encourage you to refrain from including sensitive clinical information over e-mail. If you feel you cannot wait for my return call, please contact your family physician or nearest emergency room. In a crisis, please call EMPACT 24-hour crisis hotline at 480-784-1500 and/or Magellan Crisis Lines at 602-222-9444 or 800-564-0546. In the event of an emergency, please call 9-1-1. If I will be unavailable for an extended period of time, I will provide you with a colleague's name to contact, if necessary.

Confidentiality Policy

Please see (and sign) separate forms, Exhibits B and C, on privacy practices**.**

Limits on Confidentiality

In general, the law protects the privacy of all communications between a client/patient and psychologist or other health care professional, and I can only share information about our work together to others with your written permission. To ensure the highest quality of care, I may sometimes consult other health professionals about your treatment. I make every effort to avoid revealing your identity; however, if potentially identifiable or more detailed information is necessary, I will only release information about you with a written and authorization form signed by you, consistent with legal requirements imposed by the Health Insurance Portability and Accountability Act (HIPAA). This legal "Authorization" for release/exchange of information will remain in effect for a period of time, as designated by you. You may revoke the authorization at any time, unless I have taken action in reliance on it. Please also note that I practice with other professionals who may also be privy to your Protected Health Information (PHI) for administrative purposes, such as scheduling, billing, and quality assurance. These persons along with professionals with whom I exchange information about you are likewise bound by the rules of confidentiality not to release any information about you without appropriate consents.

I may be permitted or required by law to contact appropriate agencies and disclose information without your consent or authorization if:

- Health insurance companies require treatment information to authorize payment for services or for collection of overdue fees, as discussed in this Agreement.
- You are involved in legal proceedings, and a request is made under a court order for information concerning professional services I provide you. My policy to try to reach you before releasing any information, if a subpoena is received. (Note: If you are involved in or contemplating litigation, you are advised to consult with your attorney to determine whether a court would be likely to order me to disclose information.)
- A government agency requests information for health oversight activities.
- You file a complaint or lawsuit against me, and I must disclose information about you to defend myself.
- If you file a worker's compensation claim, and I am providing services related to that claim. I must provide relevant reports to the Workers Compensation Commission or insurer upon appropriate request.

In some situations, I am legally obligated to take actions I believe necessary to protect others from harm. These situations may require me to reveal information about your treatment. While rare in my practice, these include:

- If I have knowledge or reason to suspect that an identifiable child under the age of 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 and follow-up, as necessary, with the appropriate governmental 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 a vulnerable and/or incapacitated adult has been the victim of mental, physical, or sexual abuse; neglect; or financial exploitation, the law requires that I file a report with the appropriate state official, usually a protective service worker.

- If you communicate an explicit threat of imminent and serious injury to self or another individual, or if I believe that you present as a substantial risk of such, I may be required to take protective actions, including notifying individuals who can protect you and/or others. Such actions may include initiating emergency hospitalization, contacting the police, and/or notifying the potential victim (in the event of threat to other).

If such situations arise, I will make every effort to discuss options with you before taking any action; I will limit disclosure(s) to the minimum necessary for reporting. It is important that we discuss any questions or concerns you may have about these limits to confidentiality. However, because the laws governing confidentiality can be quite complex and I am not an attorney, legal advice may be warranted when specific advice is desired.

Minors and Parents

Clients under the age of 18 who are not emancipated and their parents should be aware that the law may allow parents to examine their childrens' treatment records. Because privacy in psychotherapy is crucial to progress, I generally request verbal consent from parents to relinquish their access to their childrens' records. If they agree, I will provide them only with general information about the progress of their child's treatment and his/her attendance at scheduled sessions. I will provide parents with a verbal summary of their child's treatment periodically, as requested, and/or when treatment is complete. Any other communication will require the child's authorization, unless I feel that the child is in danger or a danger to someone else, in which case parents and/or proper authorities will be notified of my concern. Whenever disclosures are anticipated, I will discuss related matters with the child, if possible, and do my best to handle any objections he/she may have. Please review the additional consent for treatment with a minor.

Professional Records

The laws and standards of my profession require that I keep PHI about you in your Clinical Record for a minimum of six years after the last contact for adults and three years after a minor reaches age 18. Except in unusual circumstances that involve a substantial risk of imminent psychological impairment or imminent serious physical danger to yourself and others, you can have access to a copy of your record, if you request it in writing (copy fees may apply). I will notify you if anything is withheld. Because these are professional records, they can be misinterpreted and/or upsetting to untrained readers. For this reason, I recommend that you schedule an appointment to initially review them in my presence and copy what you may need at that time or have them forwarded to another mental health professional so you can discuss the contents.

Professional Fees, Payment Policies, and Terms

My fees range from $225-260 for the initial (diagnostic) session. Fees for 45-minute psychotherapy and/or behavioral weight management sessions are $175 per session, *paid by cash or check*. In addition to scheduled appointments, I charge a prorated fraction of this fee for other professional services, including but not limited to report-writing, telephone conversations lasting longer than 10 minutes, consultation with other professionals with your consent, and preparation of records or treatment summaries. A $25.00 fee will be charged for any returned check. The client agrees to pay all charges in accordance with the Payment Policy outlined herein. Please be reminded that the process of psychotherapy is different for everyone, and progress is strongly reliant upon the client's active participation and compliance. All payments are non-refundable and due at or in advance of the time of each service. Failure to keep current with appointments and payments may result in an interruption of therapy. Such will be discussed with you in advance of any action being taken. I can use legal means to secure the payment, which may involve running your credit card (when applicable), hiring a collection agency, or going through small claims court, which may require me to disclose otherwise confidential information. In most collection situations, the only information released regarding a client's treatment is his/her name, the nature of services provided, and the amount due. If such legal action is necessary, its costs will be included in the claim.

If you become involved in legal proceedings that require my participation, you will be responsible for payment of my professional time, even if I am called to testify by another party. Because of the difficulty of legal involvement, my fees are doubled per hour for preparation, transportation, and attendance. Should I incur

collection charges or legal fees related to your care, you also agree to pay these in full. Please note that I reserve the right to decline client's seeking reports for third party opinions, as well as disability and divorce cases. The practice is focused on treatment and cannot sustain the amounts of additional report writing these cases require.

Health 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. Health insurance policies usually provide some coverage for mental health treatment, though benefits have become increasingly more complex due to the rising costs of health care. I elect NOT to participate in-network with any health insurance plans or policies at this time, and all visits are strictly fee for service. On occasion, I will assist with claim filing and/or pre-authorization/certification courtesies, though ultimately you (not your insurance company) are responsible for full payment of my fees. If you plan to file for insurance reimbursement, you are advised to call your insurance plan administrator to assess the out-of-network outpatient mental health benefits of your policy, or I am happy to call on your behalf. If you elect to file claims independently, I am happy to provide you with a Super Bill/receipt at the time of each visit, providing the appropriate mechanism by which you may file a claim with your insurance. Insurance plans will often request information including diagnostic impressions, treatment plan, reason for treatment, prognosis, or other material, which I am happy to provide with your consent. In such situations, I will make every effort to release the minimum information about you that is necessary for the purpose requested. Nevertheless, the released information may become part of the insurance company files and will likely be stored in a computer network. Though 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 fact, records are often forwarded by a client's insurance plan to the ***Medical Information Bureau*** (MIB), at which time the client's health history becomes available to other insurance companies without the client's knowledge or consent. As such, I want clients to be informed that the release of any medical or diagnostic information through the claims filing process may present a potential risk that could be personally damaging to unknowing clients should an inappropriate party have access to the MIB national database.

> ***Medicare Part B Entitlement Policy:*** I gladly treat clients over the age of 65, but I do not participate in the Medicare Part B program. Medicare--eligible clients must sign a Waiver of Medicare Part B Entitlement, indicating that my services will not be claimed against the Medicare Part B Program but are instead the client's financial responsibility. Current laws require that both the client and provider sign this waiver.

Protocol for Secure Storage, Transfer, and Access to Client Records on Termination of the Practice

In the event that I terminate my practice, I will notify active clients by letter and/or direct verbal communication and provide them with a phone number by which they may contact me. For reasons of personal privacy, I will only provide direct access and personal contact information to current or recent (six months) clients. Clients may also contact the Arizona Psychological Association to convey a request for current contact information. I will maintain records for the required period of time, and I will respond to client requests for access to their medical records in a timely manner (i.e., within 30 days or other legally or ethically responsible requirements, unless prohibited by illness or temporary travel unavailability). I will dispose of unclaimed records after the current legal and/or legally specified time requirements by destroying them, so that no confidential information remains in usable form. In the event that circumstances require, I will forward record access and responsibility to another professional who will respond to record requests in accordance with legal and professional standards. Records are currently located at 3040 E. Cactus Rd., Phoenix, Az 85032.

Client Responsibilities

Each client is responsible for providing accurate contact and billing information. If telephone numbers and/or addresses change, please inform me immediately.

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CONSENT FOR PSYCHOLOGICAL SERVICES, PAYMENT AGREEMENT, AND PRIVACY PRACTICES

I have read, understand, and accept the provisions of this Agreement and have had any and all questions answered to my satisfaction regarding the policies outlined herein. I agree to abide by all of the terms herein and understand that if I violate any provisions of this agreement, my treatment may be terminated. I also understand that this Agreement is binding in the State of Arizona and that the stated provisions are for my protection and that of Dr. Nademin. I have informed Dr. Nademin of any ongoing or pending legal proceedings I am (or could be) involved in. The original copy of this agreement will become a part of my private medical record.

_____ _____
(Printed Name) *(Date)*

_____ _____
(Signature) *(Date of Birth)*

I understand that all payments are due at the time of service. Dr. Nademin will provide me with a "Super Bill," if requested, which is a receipt that functions as a claim that can be submitted to my insurance company for possible reimbursement. I understand that there is a 24-hour cancellation/rescheduling policy and that I will be charged $100.00 if a scheduled appointment is not cancelled with a minimum of 24 hours notice. Finally, I understand that due to scheduling needs of other patients, Dr. Nademin is not able to extend my session time if I arrive late to an appointment and that in such cases or in cases when I miss a session without advanced notice, I will be responsible for payment of the full session fee, $175.00.

_____ _____
(Printed Name) *(Date)*

_____
(Signature)

Exhibit B: Notice of Protected Health Information Practices (Privacy Policy)

I understand that I am to read Dr. Nademin's privacy policy, which can be found under *New Client Paperwork* at www.aztherapeutic.com or at Dr. Nademin's office: 3040 E. Cactus Rd. Phoenix, Az 85032.

The privacy policy describes how psychiatric and medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Exhibit C - Acknowledgement of Receipt of Privacy Notice of Psychologist's Policies and Practices to Protect the Privacy of Your Health Information

Purpose of this Acknowledgement

This Acknowledgement, which allows the Practice to use and/or disclosure personally identifiable health information for treatment, payment or healthcare operations, is made pursuant to the requirements of 45 CFR §164.520(c)(2)(ii), part of the federal privacy regulations for the Health Insurance Privacy and Accountability Act of 1996 (the "Privacy Regulations").

Please read the following information carefully:

1. I understand and acknowledge that I am consenting to the use and/or disclosure of personally identifiable health information about me by M. Elicia Nademin, Ph.D., LLC (the "Practice") for the purposes of treating me, obtaining payment for treatment of me, and as necessary in order to carry out any healthcare operations that are permitted in the Privacy Regulations.

2. I am aware that the Practice maintains a Privacy Notice which sets forth the types of uses and disclosures that the Practice is permitted to make under the Privacy Regulations and sets forth in detail the way in which the Practice will make such use or disclosure. By signing this Acknowledgement, I understand and acknowledge that I have received a copy of the Privacy Notice.

3. I understand and acknowledge that in its Privacy Notice, the Practice has reserved the right to change its Privacy Notice as it sees fit from time to time. If I wish to obtain a revised Privacy Notice, I need to send a written request for a revised Privacy Notice to the office of the Practice at the following address:
3040 E. Cactus Rd. Phoenix, Az 85032, Attention: M. Elicia Nademin, Ph.D., Compliance Officer

4. I understand and acknowledge that I have the right to request that the Practice restrict how my information is used or disclosed to carry out treatment, payment or healthcare operations. I understand and acknowledge that the Practice is not required to agree to restrictions requested by me except in very limited circumstances as described in the Privacy Notice, but if the Practice agrees to such a requested restriction it will be bound by that restriction until I notify it otherwise in writing.

I request the following restrictions be placed on the Practice's use and/or disclosure of my health information (*leave blank if no restrictions*): _____.

I understand the foregoing provisions, and I wish to sign this Acknowledgement authorizing the use of my personally identifiable health information for the purposes of treatment, payment for treatment and healthcare operations.

BY SIGNING THIS FORM, I ACKNOWLEDGE THAT I HAVE REVIEWED AN EXECUTED COPY OF THIS ACKNOWLEDGEMENT AND A COPY OF THE PRACTICE'S POLICY NOTICE AND AGREE TO THE PRACTICE'S USE AND DISCLOSURE OF MY PROTECTED HEALTH INFORMATION FOR TREATMENT, PAYMENT & HEALTH CARE OPERATIONS.

_____ _____
Signature of Patient or Representative **Date**

_____ _____
Patient's Name **Date of Birth**

_____
Social Security Number

_____ _____
Name of Personal Representative (if applicable) **Relationship to Patient**

To Be Completed by the Practice

The requested restrictions on the use and/or disclosure of the patient's health information set forth above are:

_____ **Accepted** _____ **Denied** _____ **Not Applicable**

_____ **Other (explain)** _____

Signature of Authorized Practice Representative _____ **Date** _____