Psychotherapy Services Agreement with Aimee Lim-Miller, MSW, LICSW
Notice of Policies and Practices to Protect the Privacy of your Health Information

This document contains important information about my professional services and business policies. It also contains information about my policies and practices to protect the privacy of your health information. Please read it carefully and discuss any questions you may have with me. When you sign this document, you will be stating that I provided you with this information and it will represent an agreement between us.

PSYCHOTHERAPY SERVICES

Psychotherapy varies depending on the therapist, the client, and the client's life situation and goals. There are many different methods I may use to deal with your particular situations and goals. In order for therapy to have the best outcome, you will have to invest energy in the process and work actively on things we talk about both during and between our sessions. Psychotherapy can have benefits and risks. The risks may include experiencing uncomfortable feelings like sadness, guilt, anger, anxiety or frustration when discussing aspects of your life. Psychotherapy has been shown to have benefits that can include better relationships, solutions to specific problems, increased life satisfaction, improved physical health, improved understanding of yourself, enhanced coping skills and emotional intelligence and reductions in feelings of distress. However, it is impossible to predict or guarantee what you will experience.

Our first few sessions will involve an evaluation of your situation and needs and we will discuss goals you want to work towards. During this time, we can both decide if I am the best person to provide the services you need. Psychotherapy can involve a significant investment of time, energy and money, so it is important that you select a therapist you are comfortable working with. If at any time you have questions about some aspect of our work together, please discuss them with me. If you decide that you do not want to continue in therapy with me, please tell me. If you want me to help you find another therapist or other appropriate resources, I will do so.

SESSIONS

I schedule 60-minute initial consultation/ evaluation sessions and on-going 45-minute therapy sessions with clients usually once per week or every other week, at a time we agree on. If you arrive late for an appointment, we will only be able to meet for the remaining time of our scheduled 45 minutes or 60 minutes. Sometimes I will meet more or less than once per week if that is consistent with a treatment plan we both agree to.

- If you ever need to cancel a scheduled therapy session, please do so at least **24 hours** in advance.
- If you do not cancel a scheduled appointment with at least 24 hours notice, or if you fail to

attend a scheduled session, you will be expected to pay the full fee for that session, unless we both agree that you were unable to attend due to circumstances beyond your control.

PROFESSIONAL FEES

Initial consultation fee is $250 for our first 60-min session. $150 for each individual therapy 45-minute session and $200 for 60-minute sessions. In addition to our regular sessions, I charge $200 per hour for other professional services you may need. I will break down the hourly cost into 15-minute increments if I work for periods of less than one hour.

Other services are always agreed upon in advance and include report writing (reports that you may request), telephone conversations we may have lasting longer than 15 minutes, attendance at meetings or consultations with other professionals you have authorized, preparation of records or treatment summaries, and time spent performing any other professional service that you may request. We will handle these requests on an as-needed basis.

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. Because of the complexity and difficulty of legal involvement, I charge $200 per hour for preparation and attendance at any legal proceeding. If I have to consult an attorney during this process, the attorney's fees will be reimbursed by you. This type of scenario does not happen often.

BILLING AND PAYMENTS

You will be expected to pay your insurance co-pay or full-fee at time of service. Copayments and deductibles are established by your insurance company. Please review your insurance mental health benefits prior to our first meeting. If you have any questions regarding your insurance plan please contact your insurance provider in order to receive the most accurate information regarding your plan.

Two billable sessions (which may include a missed session that was not canceled in advance) of which payment is not made will result in postponement of therapeutic services. If payment arrangements are not made within five business days of receiving an invoice, your therapy time slot will not be reserved. I accept payments by check, cash or MC/Visa. Payment schedules for other professional services will be agreed to if/when you request them. If you make a payment by check and your check does not clear due to insufficient funds or any other reason, you will be expected to reimburse us in full for any related bank fees that we are charged as a result.

CONTACTING ME

I am often not immediately available by phone because I do not answer the phone when I am in sessions with clients. Calls go to my voicemail when I am unavailable, which I check regularly during weekdays. I will make every effort to return your call as soon as possible (usually within a few hours and almost always within 24 hours). If you are difficult to reach, please leave times you will be

available. If you want me to use discretion when calling you or leaving a message for you, please let me know in advance. At times when I will be unavailable for an extended time, I will provide you with the name of a colleague to contact if necessary. If you are in an emergency situation, call your local mental health emergency services at 988, or call or go to the nearest hospital emergency room and tell them what is happening. I will get back to you as soon as I possibly can in such situations, but I may not be able to get back to you immediately in all cases.

PROFESSIONAL RECORDS

The laws and standards of my profession require that I keep treatment records. You are entitled to examine and/or receive a copy of your records if you request it in writing unless I believe that seeing them would be emotionally damaging, in which case I will send them to a mental health professional of your choice. Because these are professional records, they can be misinterpreted and/ or be upsetting to people who are not mental health professionals. In order to see your records, we will need to discuss the contents together. I reserve the right to charge you for the costs of copying and sending your records if you request them.

CONFIDENTIALITY AND "PHI"

Your health records contain 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 service agreement and notice of privacy practices describes how I may use and disclose your PHI in accordance with applicable law; including the Health Insurance Portability and Accountability Act ("HIPAA"), regulations promulgated under HIPAA including the HIPAA Privacy and Security RUles. 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 private practices with respect to PHI.

HOW I MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

For treatment: Your PHI may be used and disclosed by those who are involved in your care for the purpose of providing, coordinating, or managing your health care treatment and related services. This includes consultation with clinical supervisors or other treatment team members. I may disclose PHI to any other consultant only with your authorization.

Medical Emergencies: I may use or disclose your PHI in a medical emergency situation to medical personnel only in order to prevent serious harm. I or a staff member will try to provide you a copy of this notice as soon as reasonably practicable after the resolution of the emergency.

Family Involvement in Care: I may disclose information to close family members or friends directly involved in your treatment based on your consent or as necessary to prevent serious harm.

Deceased Patients/Clients: I may disclose PHI regarding deceased patients as mandated by state law, or to a family member or friend that was involved in your care or payment for care prior to death, based on your prior consent. A release of information regarding deceased patients may be limited to an executor or administrator of a deceased person's estate or the person identified as next-of-kin. PHI of persons that have been deceased for more than fifty (50) years is not protected under HIPAA.

Child Abuse and Neglect:
Your mental health information is confidential; however therapists (social workers, psychologist, psychiatrist, LMHC) are mandated reporters which means that in certain circumstances, I am required by law to release information without your consent. These situations are described below. Please read these situations and feel free to ask any questions about them.

- If you make a specific threat to harm yourself or someone else (and the risk of danger is deemed imminent), I must take appropriate steps to protect you or warn the appropriate parties.
- If I suspect you have physically or sexually abused or neglected a child or vulnerable adult, I must make a report to the proper authorities. This includes some cases of domestic abuse when a child is exposed to weaponry or is physically threatened and/or used as a weapon.
- If you are pregnant and using a controlled substance, such as heroin, cocaine, phencyclidine, methamphetamine, or their derivatives.
- When there is a court order to release your records to the legal authorities.

While I am not an attorney, please discuss any questions or concerns you have about confidentiality with me at any time. If you have specific legal questions about the laws regarding confidentiality, the exceptions, and how it may relate to your situation, please seek formal legal advice from an attorney.

TELEHEALTH
Telehealth is a mode of delivering health care services, including psychotherapy, via communication technologies (e.g. Internet or phone) to facilitate diagnosis, consultation, treatment, education, care management, and self-management of a patient's health care. By signing this form, I understand and agree to the following:

1. I have a right to confidentiality with regard to my treatment and related communications via Telehealth under the same laws that protect the confidentiality of my treatment information during in-person psychotherapy. The same mandatory and permissive exceptions to confidentiality outlined in the [Informed Consent Form or Statement of Disclosures] I received from my therapist also apply to my Telehealth services.
2. I understand that there are risks associated with participating in Telehealth including, but not limited to, the possibility, despite reasonable efforts and safeguards on the part of my

therapist, that my psychotherapy sessions and transmission of my treatment information could be disrupted or distorted by technical failures and/or interrupted or accessed by unauthorized persons, and that the electronic storage of my treatment information could be accessed by unauthorized persons.

3. I understand that miscommunication between myself and my therapist may occur via Telehealth.
4. I understand that there is a risk of being overheard by persons near me and that I am responsible for using a location that is private and free from distractions or intrusions.
5. I understand that at the beginning of each Telehealth session my therapist is required to verify my full name and current location.
6. I understand that in some instances Telehealth may not be as effective or provide the same results as in-person therapy. I understand that if my therapist believes I would be better served by in-person therapy, my therapist will discuss this with me and refer me to in-person services as needed. If such services are not possible because of distance or hardship, I will be referred to other therapists who can provide such services.
7. I understand that while Telehealth has been found to be effective in treating a wide range of mental and emotional issues, there is no guarantee that Telehealth is effective for all individuals. Therefore, I understand that while I may benefit from Telehealth, results cannot be guaranteed or assured.
8. I understand that some Telehealth platforms allow for video or audio recordings and that neither I nor my therapist may record the sessions without the other party's written permission.
9. I have discussed the fees charged for Telehealth with my therapist and agree to them [or for insurance patients: I have discussed with my therapist and agree that my therapist will bill my insurance plan for Telehealth and that I will be billed for any portion that is the patient's responsibility (e.g. co-payments).
10. I understand that my therapist will make reasonable efforts to ascertain and provide me with emergency resources in my geographic area. I further understand that my therapist may not be able to assist me in an emergency situation. If I require emergency care, I understand that I may call 988 or proceed to the nearest hospital emergency room for immediate assistance.

INSURANCE CONTACT

For clients using their private insurance to pay for psychotherapy service/ telehealth services, you will need to sign a consent form for me to contact your insurance provider. Disclosure of HPI, clinical diagnosis, and treatment plans may be requested in order to process your insurance claim.

OTHER CLIENT RIGHTS

If you want, I will discuss with you more details about any of the following:

You have the right to request and receive from me confidential communication of your protected health information (PHI) by alternate means or at alternative locations. For example,

Aimée Lim-Miller, MSW, LICSW
t|617.800.9222| e|aimeeLICSW@gmail.com
www.balancingwell.com

you can request that I send any correspondences to an address other than your home address if you don't want a family member to know that you are in therapy with me. You have the right to request that I change information in your record. I require such requests in writing along with your reasons for your requested changes. I may deny your request.

You generally have the right to receive an accounting of any disclosures I have made of your protected health information, which did not require your authorization. If you want, I will discuss with you more details about this process.

CONCLUSION

I reserve the right to change the policies, practices and procedures described in this document. I will notify you in writing of any significant changes. By signing the attached form you are indicating that you have received and read the information in this document, you have discussed the contents with me to your satisfaction, and you agree to abide by its terms during the course of our professional relationship.

Therapist Copy

My signature below indicates that I have read and am in agreement with Aimee Lim-MIller, MSW, LICSW - Psychotherapist and the "Psychotherapy Services Agreement."

____ _________________
Client Signature Date

____
Client's Printed Name

____ _________________
Parent/Guardian (if client is a minor) Date

For clients using third party insurance, please sign below:

The signature below authorizes Aimee Lim-Miller, MSW, LICSW, to submit the required information regarding your mental health services to your health insurance carrier for payment. I authorize the release of information necessary to process this claim, including diagnosis code and at times treatment plans.

____ _________________
Client Signature Date

____
Client's Printed Name