

**Wellness Possibilities, Lisa H. Hjelmstad, MSW, LCSW, LMFT, LAC  
PROVIDER – PATIENT SERVICES AGREEMENT**

Welcome to my private practice, Wellness Possibilities. My formal education includes a Bachelor of Social Work from the University of Alaska, Anchorage (1995) and a Masters Degree of Social Work from Walla Walla College (2001). I am licensed by the State of Montana as a Licensed Clinical Social Worker, Marriage and Family Therapist and Addiction Counselor. I have worked in the helping field with a number of client populations for over 25 years. My areas of special training and expertise include survivors of trauma (post-traumatic stress), co-occurring substance abuse and mental illness, child victims of abuse and neglect, treatment of sexual offenders, social work in the criminal justice field, and interventions with youth and families. I am a member of the National Association of Social Workers (NASW), the National Association of Alcohol and Drug Addiction Counselors (NAADAC) and the Association for the Treatment of Sexual Abusers (ATSA).

I look forward to being of assistance as we enter into a therapeutic relationship. Therapy is a relationship between people which works in part because of clearly defined rights and responsibilities held by each person. As a client in therapy, you have certain rights and responsibilities that are important for you to know about because this is your therapy with an overall goal of restoring your well-being. This agreement contains important information about my professional services, responsibilities, and business policies. I am legally mandated to provide this disclosure statement. It also contains summary 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) used for the purpose of treatment, payment, and health care operations.

HIPAA requires I provide you a Notice of Privacy Practices which are available to you in the office each visit and you receive with this agreement, for the use and disclosure of PHI for treatment, payment and health care operations. The law requires that I obtain your signature acknowledging that I have provided you with this information at the end of the first session. Although these documents are long and sometimes complex, it is very important you read them carefully. We can discuss any questions you have about the procedures at any time. When you sign this document, it will also represent an agreement between us. You may revoke this Agreement at any time by providing written notice of the revocation. That revocation will be binding on me unless I have already 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.

**Behavioral Health Services**

Psychotherapy is not easily described in general statements. It varies depending on the personalities of the therapist, patient, and the particular needs you identify. There are many different methods I may use to deal with the problems you hope to address. These methods will be discussed with you as we move through our work together. Psychotherapy calls for a very active effort and a willingness on your part. In order for the therapy to be most successful, you will work on things during our sessions and at home.

I normally conduct an evaluation during the first session or two that we meet. 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. Before you begin treatment, it is important to understand that psychotherapy has both benefits and risks. While it has been shown to have benefits for people who invest in the process with commitment and realistic expectations, it also has risks that may include experiencing uncomfortable feelings or recalling unpleasant aspects of your history. These are common feelings when trying something new.

\_\_\_\_ Client Initials

Psychotherapy often leads to a reduction in feelings of distress, better relationships, and resolution of problems. However, I cannot guarantee any particular resolution to problems or a response to treatment. Open, honest and accurate reporting of dilemmas and concerns are vital to progress in therapy. Self-exploration, insight, exploring options for dealing with problematic behaviors, learning new skills, or venting difficult feelings / experiences are generally very useful; nevertheless some risks do exist. Please understand that throughout the course of therapy some individuals experience unwanted feelings, and that examining old issues may produce unhappiness, anger, guilt or frustration. These feelings are difficult, but a natural part of the psychotherapeutic process and often provide the basis for change.

Important decisions are often an outcome of counseling. These decisions, including changing behavior, exploring opportunities, substance abuse patterns, schooling, and relationships, are likely to produce new opportunities as well as unique challenges for each individual involved. Sometime a decision that seems positive for one family member will be viewed quite negatively by another. Do not be hesitant to discuss counseling goals, procedures or your impressions of the services being provided with your therapist. If you ever do not understand a suggestion or comment that has been made, please ask for clarification.

Therapy involves a commitment of time, money, and energy. I do my best to try to match you with a treatment plan that will be a good fit for you that can help you address your issues. If you decide to enter treatment, I will usually schedule one 45-50 minute session (one appointment hour of 45-50 minutes duration) per week at a time we agree on, although some sessions may be longer or more/less frequent. I may also recommend group psychotherapy, support or education groups, depending upon your needs.

If you have any questions about any your treatment, it is important to discuss them with me as they come about. You have the right to ask questions about anything that happens in therapy. I am always willing to discuss what we are doing in therapy or other alternatives. If you continue to have questions or are concerned you and I are not suitably matched, I will make a referral to an appropriate consultation with another mental professional who may assist you. Please know you are free to leave therapy at any time.

### **Office Hours and Emergency Contact**

I do not provide 24 hour crisis services or emergency services although I do my best to be available to clients in crisis. The office is open for appointments Monday through Saturday between the hours of 8:30 am to 8:30 pm. While I am usually in my office during stated business hours, I do not answer the phone when I am with a patient. My telephone may be answered by a staff member or a confidential voice mail that is monitored frequently. I will make every effort to return your call on the same day you make it, with the exception of holidays or planned vacations. If you are difficult to reach, please inform me of some times when you will be available so that I may return your call. If you are unable to reach me and feel that you can't wait for me to return your call, contact your family physician or the nearest emergency room and ask for the mental health provider on call. If I will be unavailable for an extended time, I will provide you with the name of a colleague to contact, if necessary.

### **Late Cancellation/Missed Appointments**

Your appointment reserves my time. Please help me serve you better by keeping scheduled appointments or calling **at least 24 hours** prior to your appointment time if you must cancel. **Once an appointment is scheduled, you are expected to pay for the session unless you provide 24 hours advance notice of cancellation. This applies to all sessions, including group sessions.** These charges cannot be billed to your insurance. The charge for a missed, late canceled, or no showed appointment is **\$50.00 for individual or family sessions and \$25.00 for group appointments.** After the first missed, canceled or late rescheduled appointment, I will have you sign a notice that you are aware of the charges and possible early termination from treatment if the pattern continues.

\_\_\_ Client Initials

## Confidentiality

### A. General

In order for therapy to be successful, it is often necessary to safely reveal private, sensitive information about yourself in the course of treatment. Ethically and legally, I am bound to keep all of this information strictly confidential. The law protects the privacy of all communications between a patient and a clinical provider. In most situations, I can only release information about your 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 find it helpful to consult other health and mental health professionals and colleagues to gain greater insight and feedback about my work on cases. During consultation, I make every effort to avoid revealing the identity of my patient. The other professionals I consult with 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 Policies and Practices to Protect the Privacy of Your Health Information*).

You should be aware that I may employ administrative or support staff or contractors at various times. I share protected information with these individuals for both clinical and administrative purposes, such as scheduling, billing and quality assurance. All staff members have training about protecting your privacy and have agreed not to release any information outside of the practice without the permission of a clinical provider. If you know someone I employ in a nonprofessional capacity, please inform me right away. Your treatment will not be discussed with, or in the presence of, that person.

There are certain conditions under which confidentiality may be breached:

- If a patient 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.
- If you disclose that a child or an elderly person is being sexually or physically abused, it must be reported to the proper authorities.
- If you are a danger to yourself or someone else, I must do whatever necessary to protect you and/or others. The other person would have to be warned and the police notified.
- In legal proceedings, the courts usually respect your rights to confidentiality in the therapeutic relationship, and I am ethically bound to protect that right when testifying in certain situations, such as a contested custody proceeding in a divorce and, under these circumstances, we must do so.
- If a government agency is requesting the information for health oversight activities, I may be required to provide it.
- If a patient files a lawsuit against me, I may disclose relevant information regarding the patient in order to defend myself.

It is my practice, whenever possible, to discuss any imminent breaches of confidentiality with you before taking any action and I will limit my disclosure to the **minimum necessary**.

\_\_\_\_ Client Initials

## B. Professional Records and Patient Rights

The laws and standards of my profession require that I keep Protected Health Information about you in your Clinical Record. HIPAA provides you with several new or expanded rights with regard to your Clinical Records and disclosures of protected health information. These rights include requesting that I amend your record; requesting restrictions on what information from your Clinical Records 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 records; and the right to a paper copy of this Agreement, the Notice form, and my privacy policies and procedures.

You may examine and/or receive a copy of your Clinical Record or PHI if requested in writing, unless it is my private therapy notes, it is part of a legal case, or if I determine it would be harmful for you to see the information. Because the Clinical Records 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. Most of the time you can receive a copy as requested although you will be charged a small amount for the copying costs. The copying fee is **\$15.00 up to the first 30 pages and \$.50 a page thereafter.**

If you think some of the information is wrong in your Clinical Record or PHI, you may request, in writing, that it be changed or new information be added. You may ask the changes be sent to others who have received your PHI. You can request and receive a list showing where your medical information has been sent, unless it was sent as part of your provider's care, to assure that you received quality care or to make sure the laws are being followed.

## C. Minors

In cases of therapy with minors, parents or legal guardians have rights to information regarding treatment. However, in order for therapy to be effective, the child must have an assurance of confidentiality. Because of this, it is my policy to ask parents to agree that information will be shared only with the child's permission, except in situations where the child's safety is acutely at stake. Parents are encouraged to ask me about the therapy and **together** your child and I will talk with you about your concerns and will share information that is clinically optimal for the child to share as determined by the child and me. Consent for treatment from **both parents** and/or **legal custodian** is required in order for treatment to occur. If there is a legal custodian, rather than parents responsible for a child's care, please bring with you a copy of the Court order assigning custody to you. When a child turns 18, the control of his/her treatment and his/her treatment record reverts to the child. If this is a concern, please discuss it with me **before** starting treatment.

## D. Couples and Families

When there is more than one person involved in treatment, such as in couples and family therapy, confidentiality is more complicated. In these cases, the unit is defined as the couple, or the family. Usually, and unless otherwise specified, information that is shared by a member of the unit within the context of that therapy cannot be considered confidential from the other parties involved in the therapy. To ask me to keep secrets from other members of the therapy can disrupt the trust necessary for an effective treatment. Also, to release information to third parties under such circumstances, **all** persons age 18 and over involved in treatment must consent in writing to that release.

\_\_\_\_\_ Client Initials

## E. Group Therapy, Education and Support Groups

In group therapy, any and all information shared within group sessions by a group member must be kept confidential consistent with limits to confidentiality listed previously. A person engaged in group therapy who violates another person's right to privacy by violating confidentiality may be immediately terminated from group therapy and may civil or criminal penalties depending on the nature of the disclosure.

## F. Office Policies

### **All administrative and office staff are bound to confidentiality and cannot disclose any information.**

This becomes especially sensitive when relatives call the office requesting even simple information, such as an appointment time for their spouse. Even under these simplest of situations, office personnel cannot acknowledge they even know the person, nor can they disclose any information. If ongoing contact is to occur with a relative, regarding billing for example, a release of information can be signed, specifying the information you permit to be exchanged. All requests for records must be accompanied by a release of information. It is my policy to keep records for 8 years from when the record becomes inactive.

### **Safety**

Although I wish to be sensitive to family needs, there is no child care services provided at this facility. **Children are welcome if they are a patient** being seen for counseling. While waiting to be seen, all children must be accompanied always by a responsible adult. It is important you and your children exercise appropriate caution, control and safe behavior on the premises. This includes no running in the hallways, staircases, sidewalks, etc..... I, Lisa H. Hjelmstad, LCSW and Wellness Possibilities, are not responsible for injuries occurring on premises due to failure to exercise due care, control, or supervision. If a child is under 16 years old and is attending individual or play therapy sessions, one parent or guardian must remain available to the child and therapist for the duration of the session, either by phone or in person. If the parent of a child leaves the premises for the duration of the session, he or she must arrive back to the premises prior to fifteen (15) minutes before the end of the session.

### **Staff and Client Treatment**

You have the responsibility to treat staff and clients with dignity and respect. You are also expected to protect the confidentiality of the people served by Wellness Possibilities and Lisa H. Hjelmstad, LCSW. I reserve the right to right to not begin or to terminate a session with a client believed to be under the influence of drugs and or alcohol. You will be required to find a safe method of transportation to leave if you arrive at a session and are believed to be under the influence of drugs and or alcohol or otherwise believed to be incapacitated.

### **Interns, Employees, or Counselors in Training**

There may be times employees, interns or volunteers are assigned to work with your care and treatment. Prior to this occurring, the possibility will be discussed and your consent obtained. The treatment you receive is governed by this agreement in all cases, regardless of who provides treatment. Generally, fees for therapeutic services provided by an intern or counselor in training are not billable to third party payors unless a licensed clinician is present or directly supervising. Services such court ordered group or self-paid and initiated services not billable to a third party may be provided by an intern, employee, or volunteer.

\_\_\_\_ Client initials

## Professional Fees

In order for us to set realistic treatment goals and priorities, it is important to evaluate the resources you have available to pay for treatment. My fees for treatment services are comparable to usual and customary charges for services in the area. At times, I may accept payment that is less than usual and customary to meet the needs of clients. I may waive insurance, Medicaid and Medicare co-payments I can, but this is subject to limitations imposed by the respective third party payers. **I do have a sliding fee scale for treatment available to patients who do not have resources to assist with payment. Please discuss your need for sliding fee services with me prior to scheduling further appointments.**

I appreciate all business communications to take place at the start of each session. This includes payment for the session, scheduling issues, etc.... Please have your payment ready before the session starts so that your therapy time is not infringed upon. Payment is accepted in the form of cash, cashier's check, check, money order, debit or credit card. You will be expected to pay for each session at the time it is held, unless we agree otherwise, you have insurance, or you have other third party liability coverage which requires another arrangement. **I do accept** Medicaid, Medicare, ATR III and Victims Crime Compensation for patients.

My charge for an initial consultation, assessment and treatment planning is \$235.00. My hourly fee for psychotherapy and consulting is \$145.00-\$155.00 per 45-50 minute hour. Family therapy fees are \$165.00-\$175.00 per 45-50 minute hour. In addition to weekly appointments, I charge up to \$200.00 to \$300.00 per hour for other professional services you may need. 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 longer than 10 minutes, attendance at meetings with other professionals you have authorized, preparation of records or treatment summaries, and the time spent performing other services you request. If you become involved in legal proceedings requiring my participation, you will be expected to pay for my time even if I am called to testify by another party. I charge \$300.00 an hour for preparation for and attendance at any legal proceeding.

My hourly fee for education and treatment groups differ. Court ordered education program charges are detailed on your Court referral if you were referred by the Court. If you are engaged in those groups voluntarily, the same charges will apply to you if you have no other third party payor available or no sliding fee scale is otherwise arranged. My usual and customary fee for group psychotherapy is \$45.00 - \$65.00 per hour. When engaged in weekly education and/or treatment groups there will be times when you will be required to meet individually with me. At those times, the fee to you is \$145.00- \$155.00 per 45-50 minute hour. These fees may be adjusted off and/or governed by a specific agreement between you and me, for example, a Court referral or sliding fee. All costs will be discussed with you ahead of time and all fees will be expected to be paid prior to or at the time the service is provided.

If your account has not been paid for more than 60 days and arrangements for payment are not agreed upon, your account is considered delinquent. **Delinquent accounts must be paid in full before another session can be scheduled.** Overdue bills are charged 1.5% per month interest. I reserve the right to use legal means to secure payment. This may involve hiring a collection agency or going through small claims court. If such legal action is necessary, the cost will be added to the claim. In most collection situations, the only information I release is a patient's name, nature of services provided, and amount due.

\_\_\_\_\_ Client initials

## Insurance Reimbursement and Patient Balances

If you have a health insurance policy, it may provide some coverage for mental health treatment. I will fill out forms and provide you with whatever assistance I can in helping you receive the benefits to which you are entitled; however, you (not the insurance company) are responsible for full payment of fees and working with your insurance company related to their requests. It is important you find out exactly what mental health services your insurance policy covers.

I accept assignment of insurance benefits from most insurance companies for your primary insurance only. **I do require deductibles and co-payments be paid in full at the time of service.** Copayments may be waived according to limitations imposed by third party payers. Deductibles will not be waived. The balance is your responsibility whether your insurance company pays me or not. Your insurance policy is a contract between you and your insurance; I am not a party to that contract. If your insurance company has not paid your account in full within 60 days, the balance becomes your responsibility.

Please be aware that in some cases the services provided may be considered non-covered services by your insurance plan. You should carefully read the section in your insurance coverage booklet that describes mental health services. Your coverage, co-payments, and benefits could be quite different from your regular medical coverage. If your insurance plan includes a managed care component, you may be required to obtain preauthorization and coverage may be limited. **It is your responsibility to contact your insurance to determine if preauthorization must be obtained by you prior to treatment.**

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. Some plans such as HMOs and PPOs often require authorization before they provide reimbursement for mental health services. These plans may be 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 a lot can be accomplished in short-term therapy, some patients 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 be aware that most insurance agreements require you to authorize me to provide basic clinical information such as diagnosis and treatment plans. Occasionally an entire copied record is required. While it is my policy to release only the minimum necessary information required to activate your insurance benefits, you need to be aware that I cannot control its use by your insurance company. Any concerns you may have about confidentiality of managed care records should be directed to them. Some insurance companies require I send billing and other information electronically (*e.g., by facsimile or e-mail*). The confidentiality of such communications cannot be guaranteed. If you do not consent to electronic communications, please inform the office immediately, before beginning treatment, so that we can determine whether and how to proceed. Once information about your insurance coverage has been determined, it is important for us to discuss what can be accomplished with the benefits available, and what will happen should your benefits expire before you feel ready to end treatment. It is important to remember you always have the right to pay for services yourself and not involve your health insurer at all.

If you are a Montana Medicaid client you need to be aware that if Medicaid does not pay for services that are provided to you, you will be responsible for the costs of those services. You will not be billed for services which Medicaid does cover.

\_\_\_\_\_ Client initials

## Emergency Contact Information and Client Contact Preferences

I do ask that you give contact information for a person we can contact in case of emergency. Contact with this individual will only be made if we believe you or someone else is in immediate danger or if you become ill and unable to continue or depart therapy without assistance.

Emergency Contact Person \_\_\_\_\_  
Relationship \_\_\_\_\_ Phone \_\_\_\_\_  
Address \_\_\_\_\_

\_\_\_\_ Client initials indicate agreement for contact with named person in emergency circumstances.

There are circumstances where I may need to contact you in the normal course of our business relationship related to appointments, billing, inclement weather, or a change in my circumstances, for example. Please initial giving me permission and instructions about how you would prefer to be contacted. List any specific instructions or requests about leaving messages or sending correspondence:

\_\_\_\_ Mail: Provide the address you wish to be contacted at: \_\_\_\_\_  
\_\_\_\_ Phone: Number I may leave a message at: \_\_\_\_\_  
\_\_\_\_ Text: Number I may text you at: \_\_\_\_\_  
\_\_\_\_ Email: See the Consent for Email contact below.

Special instructions, if any: \_\_\_\_\_

### Consent for email contact:

If you wish to send and receive messages from me by email, please review and sign the consent form below. By signing this form you acknowledge it is your wish to send/receive messages to/from Wellness Possibilities and Lisa H. Hjelmstad, LCSW using e-mail addresses you list below. Please know using email is generally limited to setting or canceling appointments. It will not be used as a means of providing therapy or crisis intervention. E-mail is not a secure way of sending/receiving information. By signing below you agree you may not hold Wellness Possibilities or Lisa H. Hjelmstad, LCSW responsible for any breach of confidentiality that results from the use of the e-mail addresses listed below.

Email Address: \_\_\_\_\_  
Client Signature \_\_\_\_\_ Date \_\_\_\_\_  
Client Signature \_\_\_\_\_ Date \_\_\_\_\_

### Termination

You are allowed to terminate treatment at any point. I would ask for you to inform me of plans to discontinue therapy for any reason and would like the opportunity to meet with you for at least one additional session to allow for termination issues to be discussed. Final therapy sessions are an important part of the therapeutic process and help to summarize your progress and appreciate the change and growth that has occurred. If you decide to terminate therapy, you are still responsible for payment of any unpaid therapy sessions already received. If you do not show up for two scheduled therapy appointments with no contact with me, your case may be closed. This does not necessarily mean that you cannot receive further services, but your commitment to therapy will need to be assessed.

\_\_\_\_ Client Initials



I may discontinue therapy with you if I have reason to believe further services will not be beneficial. I may also refer you to other more appropriate services elsewhere.

**In Closing**

It is important you understand and are comfortable with the issues outlined above. Please bring up any questions or concerns you might have with your therapist in your first treatment session. Do not sign this Agreement if you do not understand or are not comfortable with the issues as outlined.

I have read, understand, have been given the opportunity to ask questions about and agree to the information stated in this form.

Client Name (Printed) \_\_\_\_\_ Date \_\_\_\_\_  
Client or Client Representative Signature \_\_\_\_\_

Client Name (Printed) \_\_\_\_\_ Date \_\_\_\_\_  
Client or Client Representative Signature \_\_\_\_\_

Client Name (Printed) \_\_\_\_\_ Date \_\_\_\_\_  
Client or Client Representative Signature \_\_\_\_\_

Witness (therapist) Signature \_\_\_\_\_ Date \_\_\_\_\_