# Maggie Hope, LPC-MHSP

**2323 21st Ave. S. Nashville, TN 37212** **615-417-9707**


**Client Agreement with Policies and Procedures**

**Welcome to my practice!**

The following information is provided to my clients to assist you in understanding policies and procedures at my office. These policies are for my private practice alone. I am not in business with any other mental health service providers, even though I share an office space with other providers. I strive to provide you with care which is both comfortable and of the highest quality. Please do not hesitate to ask questions of me at any time about these matters.

Attached to this patient Agreement Form is the newly required **Notification of Patient Rights** document now required with the passage of the federal "medical records privacy law" known as **HIPPA** (Health Insurance Portability and Accountability Act). I am required by law to give you a copy of this document and to secure your signature indicating that you have received a copy of it. In my **Notification of Patient Rights** document I have tried to inform you about your rights in plain, simple language. Please read the contract and do not hesitate to ask me about any questions you might have about these matters.

**Appointments**

I schedule my own appointments for my clients. Since clients are seen by appointment only, the appointment time given is reserved for you. Please give at least **twenty four (24) hours notice** if you must cancel your reserved time. Sometimes illnesses and emergencies happen which prevent you from keeping your reserved time and I do not charge a fee for these infrequent occurrences. In the absence of such circumstances, **you will be charged your usual fee for appointments that are not canceled 24 hours in advance.** If you need to change or reschedule your appointment, please call my office as soon as possible so I can accommodate other clients who wish to be seen.

As a courtesy and convenience to my clients, I am able to keep a credit card on file for you to charge at your appointments. I will then mail or email you a receipt. If you would like to utilize this service, please complete the information below. Additionally, **to save an initial appointment time, credit card information will be required**. **In the event you do not come to your initial appointment and do not give at least 24 hours notice, the full appointment fee will be charged to your credit card.** I you cannot come to your initial appointment, please call to cancel or reschedule as soon as possible. At the time of your appointment, you may choose another payment method if you do not wish your credit card to be charged.

**Credit/Debit Card Payment for Professional Services**

_____Visa _____Master Card _____Discover

Name as it appears on Card:_____ Billing Zip Code_____

Credit/Debit Card #:_____Exp. Date_____

3 Digit Security Code:_____

If you would like a receipt sent to you, please choose method of delivery:

Email (please provide email address):_____

Text (please provide phone number):_____

# Maggie Hope, LPC-MHSP

**2323 21st Ave. S. Nashville, TN 37212** **615-417-9707**


**Credit/Debit Card Payment for missed or cancelled appointments**

I authorize Maggie Hope, LPC-MHSP to charge the above credit/debit card when the client does not give advance notice for a late-cancellation or no-show, as per the above policies. I understand that if I do not want my credit card billed for this purpose, I am still responsible for these fees and will be billed accordingly.

Signature of Cardholder:_____Date_____

I authorize Maggie Hope, LPC-MHSP to bill the above credit/debit card for professional services at the time the services are provided for _____ (client name)

Signature of Cardholder:_____ Date:_____

**Emergencies and Telephone Calls**

You may leave me a message at any time on my office number 615-417-9707. If you feel you are in crisis and need immediate assistance, please call the Crisis Center at 615-244-7444, call 911, or go to the nearest emergency room. I generally do not return calls made to me between the hours of 7pm and 9am. Please use all of your resources if an emergency occurs between these hours, including the resources listed above.

If you call me and the discussion becomes clinical in nature, I do bill for phone time, the amount divided into 15-minute increments ($25 per 15-minute increment). The same principle applies to any email exchanges that you initiate. I estimate the cost based on the time I spend reading and responding to your emails. If you do not hear back from me for a number of unforeseen reasons and you do not feel able to keep yourself safe, please contact the Crisis Intervention Center at 615-244-744; go to your local hospital emergency room; or call 911.

**Fees and Payments**

My therapy session fee is **$125 for a 50 minute individual psychotherapy appointment**. The remainder of each session hour is spent on the documentation, preparation and planning for your next session. 90-minute sessions for individuals, couples, or families are $200. The fee for group psychotherapy is determined per group. Special fee structures for certain specified tasks such as consulting, or court ordered-appearances will be discussed with you and agreed upon before any actions are taken. **Clients are responsible for full payment of fees at the time services are rendered** in the form of cash, check, or credit card. Please note that **payment by credit card carries an additional processing fee of $5, making the total $130.** In cases where the non-custodial parents are paying the fees for their child or children either by court of agreement, the custodial parent is expected to pay the fee at the time of service and pursue reimbursement with the non-custodial parent. Accounts over 30 days are subject to a late fee. In the case of a bounced check, a $30 fee will be charged. Please note that I reserve the right to update my fees at any point, and typically adjust my fee on an annual basis.

Insurance

I do not enter into contracts with managed care companies due to the loss of patient confidentiality and the loss of patient control over their treatment. You may, however, choose to file out-of-network insurance coverage. In that case it is your responsibility to ascertain out-of-network insurance coverage and file your own claims. I will provide a HICFA form for you with the documentation and diagnosis needed in order to file a claim with your insurance company. Many companies will reimburse for services provided by a counselor holding a license. However, please note that when using insurance, **I will be required to give you or your child a formal diagnosis,**

**which will become part of your/their medical record.** As a result, some people choose to pay out of pocket to avoid this information becoming part of their record.

*Reminder on Cancellation Policy.* Appointment times are individually reserved. When appointments are cancelled at the last minute, it keeps others who want an appointment from being scheduled. For this reason; **cancellations must be made 24 hours in advance**. I understand and agree that I will be charged for and required to pay for missed appointments not cancelled at least 24 hours in advance.

*Delinquent Payments.* Additionally, a collection agency and/or the courts may be used in the event of a delinquent payment, which could require that Maggie Hope, LPC/MHSP release to the collection agency, attorneys, and/or the courts, information which identifies the parties involved, gives the patient diagnoses, and describes the dates and nature of the charges, as well as all other information contained on any claim filed. Collection agency charges and/or court fees will be added to your balance, and you are responsible for any other costs incurred from the collection agency or the court.

**Issues of Confidentiality and Privileged Communication**

Psychotherapists have a strong privileged communication law in our state which carries the same legal status as that of attorney-client. What you talk about in our established relationship with me is protected by privileged communication laws and confidentiality principles, with the exception of certain specific actions:

1. Imminent danger of client's harm to self or others (this includes potential transmission of a terminal communicable disease).
2. Suspected abuse or neglect of a child or adult who can not take care of themselves, including the elderly and disabled (made to the Department of Human Services).
3. Demographic information related to suspected domestic violence.
4. Court order for clinical records, if client is involved in legal proceedings.

Filing for out-of-network insurance coverage will also require your insurance company to ascertain your mental health diagnosis along with treatment types and dates of service. With these exceptions, unless you specifically sign a release of information authorizing me to talk to someone, all communications here are kept private, confidential, and privileged (i.e., if someone calls here asking for you, I will not acknowledge even knowing you unless you tell me otherwise).

*For those under the age of 18*:
Be aware that if you are under the age of 18 the law provides your parents the right to examine your records and to be informed about your treatment. It is policy for you to be aware if I talk to or meet with your parents. If I believe there is a high risk that you may threaten the safety of yourself or someone else, your parents will be notified.

**Termination of Treatment**

Clients are not obligated to continue treatment. If you decide to terminate at any time, you are encouraged to discuss your decision with Maggie Hope, LPC/MHSP. **Your medical chart will be automatically closed if I do not hear from you or see you after three months.**

**Electronic Mail (EMAIL) and Phone Policy:**

By agreeing to communicate via email, voicemail, or text, you are assuming a certain degree of risk of breach of privacy beyond that inherent in other modes of traditional communication (such as written or face-to-face). I cannot ensure the confidentiality of our electronic communications against

purposeful or accidental network interception. Due to this inherent vulnerability, I will save email and text correspondences with you and these communications should be considered part of the medical record. Therefore, you should consider that our electronic communications may not be confidential and will be included in your medical chart. Never send emails or texts of an urgent or emergent nature and please contact me if you have not received a reply within 24 hours.

I have read and agree to the terms of the email and phone policy.

Email Address: _____

Phone Number: _____

**Transfer Plan in Case of Clinician Incapacitation or Termination of Practice**

In the event of my death, disability, retirement, or inability to provide counseling services, Lynnette Davidson, LPC-MHSP, will service as custodian to provide those services and possess and maintain my clinical records for a period of seven (7) years.

**Your Informed Consent to Care**

I have provided this information to you in the hope of fully informing you about the policies of my office and some of the parameters of care you will receive here, such as the importance of confidentiality. Psychiatric and psychological care, like other things in life, offers no absolute guarantee of success and there are limitations to any form of care offered a client/patient. Since such limitations are always a function of the particular problem in question, I invite you to discuss your treatment with me.

Please feel free to discuss any of these matters with me in more detail.

Your signature acknowledges your informed consent for care by Maggie Hope, LPC-MHSP and when necessary, any provider covering in her absence. By signing below, you acknowledge having read, understood, and agreeing to these policies and procedures. You agree that you are responsible for all charges for services rendered and you agree to adhere to the payment policies.

| _____ | _____ | _____ |
|---|---|---|
| Signature of Adult Patient or Parent/Legal Guardian of Patient Less Than 18 Years of Age | Print Name | Date |

| _____ | _____ | _____ |
|---|---|---|
| Signature of Adult Patient or Parent/Legal Guardian of Patient Less Than 18 Years of Age | Print Name | Date |