WISCONSIN SCHOOL OF PROFESSIONAL PSYCHOLOGY
PSYCHOLOGY CENTER
Training Institute

REGISTRATION AND PSYCHOTHERAPIST-PATIENT SERVICES AGREEMENT

Date: __________________ Type of Service: ______Therapy ________Assessment

Patient Name: ___________________________________ DOB: _______________________

Identified Gender: ____________ Preferred Pronouns: __________________________

Email Address:____

Address: ____
City State Zip

If Child, Custodial Parent's/Guardian Name: ____

Address (*if different*) ____
City State Zip

Home Phone: _______________ Work Phone: _______________Cell Phone: ______________

Marital Status: _________ Racial Identity: _______________ Last 4 digits of SS#:__________

Patient's/Parent's Employer: ____

All clients of the WSPP Psychology Center must agree to be video recorded.

Welcome to the Wisconsin School of Professional Psychology (WSPP) Psychology Center. This agreement contains important information about the Center's services and about the Health Insurance Portability and Accountability Act (HIPAA), a federal law that provides privacy protections and patient rights. HIPAA requires that I provide you with a Notice of Privacy Practices for use and disclosure of Protected Health Information (PHI). Please read these documents carefully. If you have any questions about them or about your rights, you can discuss them with me, with my supervisor, or with the Director of the WSPP Psychology Center. You may file a grievance if you feel that you have been treated unfairly. When you sign this document, it will also represent an agreement between us. You may revoke this Agreement in writing at any time. That revocation will be binding on me unless (a) I have already taken action on it, (b) there are health insurance claims already in progress, or (c) you have not met any financial obligations.

PSYCHOLOGY SERVICES

Psychotherapy varies depending upon the personalities of the psychologist and patient, and your particular problems. There are many different methods to deal with problems, but, for therapy to be most successful, you will have to work on things both during our sessions and at home.

Psychological assessment consists of an interview, administration of tests, scoring and interpretation, and production of a written report. This can take several weeks to complete, and at the end you will be provided with a copy of a report and feedback.

Psychotherapy can have risks and benefits. Since therapy often involves discussing unpleasant aspects of your life, you may experience uncomfortable feelings like sadness, guilt, anger, frustration, loneliness, and helplessness. On the other hand, therapy often leads to better relationships, solutions to specific problems,

and significant reductions in feelings of distress. But there are no guarantees of what you will experience. You have a right to be informed of the benefits of treatment, the possible side effects of treatment, alternatives to treatment, and the probable consequences of not receiving treatment as well as a right to withdraw from treatment.

I usually conduct an evaluation that will last from 2 to 4 sessions. We can both decide if I am the best person to provide your services. By the end of the evaluation, we can develop a treatment plan. If psychotherapy is begun, I will usually schedule on 50-minute session per week.

CONTACTING ME

Although I am often not immediately available by telephone, you can leave a message for me at (414) 466-9777. The telephone is usually answered by Center personnel from 9:00 AM to 5:00 PM, Monday through Friday, and from 9:00 AM to 2:00 PM on Saturday. At other times, or if the telephone cannot be answered on the above days and times, an answering machine will record your message. In the case of an urgent matter or an emergency situation, Center personnel will make every effort to reach me immediately. 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 call this Hotline (414) 257- 7222. If I will be unavailable for an extended time, I will provide you with the name of a colleague to contact if necessary.

PROFESSIONAL RECORDS

I keep Professional Health Information about you in two sets of records. Under HIPAA rules, one set constitutes your Clinical Record. It includes the following information: reasons for seeking services; a description of your problem; diagnostic treatment goals and progress; medical, social, and treatment history; billing records; and any reports sent to anyone including your insurance carrier. In addition, I also keep a set of Psychotherapy Notes. These Notes are for my own use, help me to provide the best treatment, and can include the content and analysis of our conversations. They also contain particularly sensitive information that does not have to be included in your Clinical Record. These Psychotherapy Notes are kept separate from your Clinical Record. While insurance companies can request and receive a copy of your Clinical Record, they cannot receive a copy of your Psychotherapy Notes without your signed, written Authorization. Insurance companies cannot require your Authorization as a condition of coverage nor penalize you in any way for your refusal. You may examine and/or receive a copy of both sets of records, if you request it in writing. 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.

LIMITS ON CONFIDENTIALITY

The law protects the privacy of all communications between a patient and a psychologist. 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 of state law and HIPAA. There are other situations that require only that you provide written, advance consent. Your signature on the Agreement provides consent for the following activities:

- As a student trainee, I routinely receive supervision from a licensed psychologist who has access to your Clinical Record and Psychotherapy Notes. During other consultations with student trainees/professionals affiliated with WSPP and any consultations with student professionals outside of WSPP, I will make every effort to conceal your identity.
- Center staff may see your records in the course of their clerical duties. All staff members have been given training about protecting your privacy and have agreed not to release any information outside of the Center except as noted in this Agreement.
- Disclosures required by health insurers or to collect overdue fees are discussed elsewhere.
- If a patient threatens to harm himself/herself, I may be obliged to seek hospitalization for him/her, or to contact family members or others who can help provide protection.

There are some situations where I am permitted or required to disclose information without either your consent of Authorization:

- If I receive a court order
- If a government agency is requesting the information for health oversight activities
- If I need to defend myself against a patient complaint or lawsuit
- If an employer requests information regarding the worker's compensation claim of a patient.

There are some situations where I may have to reveal information about a patient's treatment in order to take legally obligated action to protect others from harm

- If I have reason to believe that a child that I have seen has been abused or neglected or has been threatened with abuse or neglect that I believe is likely to occur, the law requires that I file a report with the appropriate governmental agency
- If I have reason to believe or suspect that abuse, material abuse or neglect of an elder adult has occurred, the law allows me to file a report with the appropriate government agency
- If I believe that a patient presents a foreseeable risk of harm to another, I may have to take protective actions including notifying the potential victim, contacting the police, or seeking hospitalization for the patient.

If such a situation arises, I will make every effort to fully discuss it with you before taking any action and I will limit my disclosure to the minimum necessary.

MINORS AND PARENTS

Patients under 18 years of age, who are not emancipated, and their parents should be aware that the law may allow parents to examine their child's treatment records unless I decide that such access is likely to injure the child, or we agree otherwise. Because privacy in psychotherapy is often crucial to progress, particularly with teenagers, it is my policy to request an agreement from parents to give up their access to their child's records. If they agree, I will provide them with general information about the progress of the child's treatment, and his/her attendance at scheduled sessions. Any other communication will require the child's authorization, unless I feel that the child is in danger or is a danger to someone else, in which case, I will notify the parents of my concern. Before giving parents any information, I will discuss the matter with the child, if possible, and do my best to handle any objections he/she may have.

PROFESSIONAL FEES, BILLING, AND PAYMENTS

Costs for services were determined prior to this agreement and are indicated on the payment agreement form. (If you become involved in legal proceedings that require participation of Center personnel, there may be additional charges) You will be expected to pay for service at the time it is provided, unless we agree otherwise or unless you have insurance coverage that requires another arrangement. If you account has not been paid for more than 60 days and arrangements for payment have not been agreed upon, I may hire a collection agency. This will require me to disclose confidential information, but I can usually limit this to the patient's name, the nature of services provided, and the amount due.

INSURANCE REIMBURSEMENT

If you have a health insurance policy, it will usually provide some coverage for mental health treatment. I will fill out forms and provide you with whatever assistance I can; however, you (not your insurance company) are responsible for full payment of my fees. Your health insurance company requires that I provide information regarding my services to you including a clinical diagnosis. I will make every effort to release only the minimum information that is necessary. Though all insurance companies claim to keep such information confidential, I have no control over what they do with it. They may share the information with a national medical information databank. I will provide you with a copy of any report I submit, if you request it. By signing this Agreement, you agree that I can provide requested information to your carrier.

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YOUR SIGNATURE BELOW INDICATES THAT YOU HAVE READ THE PSYCHOTHERAPISTPATIENT SERVICES AGREEMENT AND AGREE TO ITS TERMS AND ALSO SERVES AS AN ACKNOWLEDGEMENT THAT YOU HAVE RECEIVED THE HIPAA NOTICE FORM AND GRIEVANCE PROCEDURE.

Signature of Patient /Legal Representative	Signature of Therapist	Date
Signature of Patient /Legal Representative	Signature of Therapist	Date
Signature of Patient /Legal Representative	Signature of Therapist	Date

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If legal representative, state relationship and authority to act for the patient

I realize that the WSPP Psychology Center is a training clinic which serves important educational and research functions. I also realize that without using my name or any information which could identify me, students might use materials from my file for research purposes. When such information is used, it will be for important purposes which can benefit others. I approve of the use of information in my file for educational and research purposes so long as my privacy is protected and I can never be identified as an individual.

Signature of Patient /Legal Representative	Signature of Therapist	Date
Signature of Patient /Legal Representative	Signature of Therapist	Date
Signature of Patient /Legal Representative	Signature of Therapist	Date

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If legal representative, state relationship and authority to act for the patient