Psychological Services Agreement

Welcome to my practice. This agreement contains important information about my professional services and office policies. It also contains summary information about the Health Insurance Portability and Accountability Act (HIPPA), a federal law that provides for privacy protections and client 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. HIPPA requires that I provide you with a Notice of Privacy Practices (the Notice) for use and disclosure of PHI for treatment, payment, and health care operations. The Notice, which accompanies this agreement, explains HIPPA and its application to your personal health information in detail. As required by law, on the last page of this agreement you are asked for your signature acknowledging that I have provided you with this information. When you sign this document, it will represent an agreement between us. You may revoke this Agreement in writing at any time.

Description of Professional Services: Psychological services may include the following: Initial Evaluation, Individual, and Family Psychotherapy, Telephone Conferences, Clinical Consultation. The purpose of psychological services is to promote healthy individual and relational functioning.

Specific Information on Appointments: Each therapy appointment lasts approximately an hour. Psychotherapy is generally relatively brief, however this is not always the case. Ongoing evaluation of the treatment goals leads to a decision about lengthening or discontinuing treatment. Both the adolescent and the parent will be part of that decision process.

Fee Policies: My fee for Individual and/or Family Therapy is $150 per session. Some insurance is accepted, please check with your insurance company for coverage.

Professional Records: You/Your child should be aware that, pursuant to HIPPA, I keep Protected Health Information about you in one set of professional records. It includes information about your reasons for seeking therapy, a description of the ways in which your problem impacts on your life, your diagnosis, the goals that we set for treatment, your progress towards those goals, your medical and social history, your treatment history, any past treatment records that I receive from other providers, reports of any professional consultations, your billing records, and any reports that have been sent to anyone, including reports to your insurance carrier.

Your Rights:
HIPAA provides you/your child with several new or expanded rights with regard to your Clinical Record and disclosures of protected health information. These rights include requesting that I amend your record; requesting restrictions on what information from your Clinical Record 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 the protected information disclosures are sent; having any complaints that you/your child make about my policies and procedures recorded in your records; and the right to a paper copy of this Agreement, the attached Notice form, and my privacy policies and procedures.

Phone and Emergency Contact: If you need to contact me by phone my number is 203-848-7590. I typically return phone calls within 24 business hours.

Freedom to Withdraw:
You have the right to end your/your child's therapy at any time. If you wish, I will give you the names of other qualified therapists.

Informed Consent:
I have read and understood the preceding statements. I have an opportunity to ask questions about them, and I agree to enter a professional psychotherapy relationship with Dr. Bina Roginsky.

_____ _____

Client or Parent signature Date

_____ _____

Bina Roginsky, Psy.D, BCBA Date