**Mischca T. Scales, Ph.D.**
**Licensed Psychologist**
**4601 Spicewood Springs Road, Bldg. 4-200**
**Austin, TX 78759-7816**
**Office (512) 467-1376**

# DOCTOR-CLIENT SERVICES AGREEMENT

Welcome to my practice. This document contains important information about my professional services and business policies. It also contains summary information about the Health Insurance Portability and Accountability Act (HIPAA), a new 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. It is very important that you read the information. We can discuss any questions you have. 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 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.

Sessions are one appointment hour of 45-minute duration at an agreed upon specified interval and time. **Our first session will primarily focus on what brings you into treatment and developing a plan for treatment. There will also be an opportunity to address any questions or concerns that you may have about office policies and confidentiality.**

I make every effort to return client phone calls within 24 hours, with the exception of weekends and holidays. If you are unable to reach me and feel that you can't wait for me to return your call, contact your family physician, the nearest emergency room (ask for the psychiatrist on call), Austin Travis County Integral Care (ATCIC) Hotline (512-472-4357), dial 211 and ask for the LMHA or LBHA in your area, or dial 911 if there is a crisis or emergency.

Except in unusual circumstances that involve danger to yourself and/or others, you may examine and/or receive a copy of your Clinical Record if you request it in writing. You should be aware that pursuant to Texas law, psychological test data are not part of a client/patient record. If I refuse your request of records, you have a right of review, which I will discuss with you upon your request.

## PATIENT RIGHTS

HIPAA provides you with several rights with regard to your Clinical Record and disclosures of protected health information. These rights include requesting amendments to your record; requesting restrictions on what information from your Clinical Record is disclosed to others; requesting and 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 of your complaints about my policies and procedures documented in your record; and the right to a paper copy of this Agreement and the Notice of Privacy Practices.

## LIMITS ON CONFIDENTIALITY

The law protects the privacy of all communications between a client/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 imposed by HIPAA. Some exceptions are:

- If a court order or legal proceedings or statute requires disclosure.
- If a government agency is requesting the information for health oversight activities, I may be required to provide it for them.

- If a client/patient files a complaint or lawsuit against me, I may disclose relevant information regarding that patient in order to defend myself.
- If a client/patient files a worker's compensation claim, I must, upon appropriate request, provide records relating to treatment or hospitalization for which compensation is being sought.
- If I have cause to believe that a child under 18 or person 65 or older has been or may be abused, neglected, or exploited. The law requires that I make a report to the appropriate governmental agency, usually the Department of Family Protective and Regulatory Services.
- If you report to me that you are a victim of sexual abuse by a mental health professional or member of the clergy.
- If a client/patient threatens to harm self or another person.
- You should be aware that I employ administrative staff. In most cases, I need to share protected information with these individuals for both clinical and administrative purposes such as scheduling, billing, and quality assurance. All staff members have been given training about protecting your privacy and have agreed not to release any information outside of the practice without the permission of a professional staff member.
- I may occasionally find it helpful to consult other health and mental health professionals. During a consultation, I make every effort to avoid revealing the identity of the client/patient. The other professionals are also legally bound to keep the information confidential.

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 what is necessary. If you are referred to me by another provider, I will notify the referring provider of your appointment with me and provide a summary of the visit.

**MINORS & PARENTS/GUARDIANS**

Clients/Patients under 18 years of age (who are not emancipated) and their parents/guardians should be aware that the law may allow parents/guardians to examine their child's treatment records. However, if the treatment is for suicide prevention, chemical addiction or dependency, or sexual, physical or emotional abuse, the law provides that parents/guardians may not access their child's records. Because privacy in psychotherapy is often crucial to successful progress, for children between 13 and 17 it is my policy to request an agreement from the child and parent/guardian as to what information from therapy sessions will be disclosed. Any other communication will require the child's authorization unless the child is in danger or is a danger to someone else, in which case, I will notify parents/guardians of my concern. Before giving parents/guardians any information, I will discuss the matter with the child, if possible, and do my best to handle any objections expressed by the child.

**PROFESSIONAL RECORDS**

Pursuant to HIPAA, I keep Protected Health Information about you in a Clinical Record. It can include information about your reasons for seeking services, a description of the ways in which your problem impacts on your life, interview notes, a test reports, 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. Except in unusual circumstances that involve danger to yourself and others, you may examine and/or receive a copy of your Clinical Record if you request it in writing. You should be aware that pursuant to Texas law, psychological test data are not part of a client/patient record. If I refuse your request for access, you have a right of review, which can I will discuss with you upon your request.

**PROFESSIONAL FEES & PAYMENT**

The fee for each 45-minute session is $160.00. **No shows or cancellations with less than 24 hours notification will result in a $80.00 charge (or the contracted rate I have with your insurance company) to your credit card. There are no exceptions.** Payment for each session is expected at time of service unless other arrangements have been made.

I charge for other professional services you may need, though I will break down the hourly cost for periods of less than 45 minutes. Other services include: letter/report writing, telephone conversations lasting longer than 5 minutes, consulting with other professionals, preparation of records or treatment summaries for another professional, and time spent performing any other professional services that you request.

I charge $250.00 per hour for preparation and attendance at any legal proceeding. This fee covers all professional time, including transportation costs, preparation for and attendance, even if I am called to testify by another party.

If your account has not been paid for more than 30 days and arrangements for payment have not been agreed upon, I have the option of using legal means to secure payments. *This will involve utilizing a collection agency to collect unpaid fees, collection fees charged by the collection agency, and interest.* In most collection situations, the only information I release regarding treatment is name and contact information, and the nature of services.

**CREDIT CARD AUTHORIZATION**

Name: _____

I am providing the following credit card information to Dr. Mischca Scales to keep on file and I agree to a one-time service charge of $0.10 (ten cents) for verification.

Select card type: **VISA** **MASTERCARD** **AMERICAN EXPRESS**

Card number: _____

Expiration Date: _____

Card Security Code (3-digit code on far right on back of card): _____

Name on Card: _____

Credit Card Billing Address: _____

City: _____ State: _____ Zip Code:_____

Credit Card Holder's phone number:_____

## INSURANCE INFORMATION

Insurance Company Name:_____

Insurance Company Phone Number:_____

Policy Holder Name:_____

Policy Holder Date of Birth:_____

Insurance ID Number:_____

Group Number:_____

Insurance Effective Date:_____

**Please contact your insurance company to verify you outpatient mental health benefits, co-pay amount, and deductible amount, if applicable.**

I called my insurance company to verify my outpatient mental benefits on _____ (date).

My copay for each visit is $_____. My insurance deductible is $_____.

I have met the deductible:_____ yes _____no

I have met $_____ of the deductible.

My insurance pays a percentage rate of _____ and I pay _____ percentage rate.

*Your signature below indicates you have read this agreement and agree to its terms and conditions, you have been informed of and understand the limits of confidentiality, and acknowledgement that you have been advised of how to review the HIPAA Notice form if you wish.*

_____ _____

Signature of Client (or Parent/Guardian Date

_____ _____

Please print name of Client (or Parent/Guardian) Date

## CLIENT INFORMATION & HEALTH HISTORY

Name: _____

Date of Birth & Current Age: _____

Client's relationship status: *single engaged married committed partnership separated divorced widowed*

Home Address: _____

Phone number: _____ Driver's License # & State Issued _____

Occupation: _____

Employer name & address: _____

Emergency Contact (name, relationship, and phone number):_____

_____

Primary Care Provider: _____

**COMPLETE THIS SECTION IF CLIENT IS A MINOR OR STUDENT**

**Parent/Guardian Name:**_____

**Address & Phone number:**_____

**Parent/Guardian Occupation:**_____

**Employer name & address:**_____

**Parent/Guardian Name:**_____

**Address & Phone number:**_____

**Parent/Guardian Occupation:**_____

**Employer name & address:**_____

Psychiatric History:
List any psychiatric medications you are currently taking: _____

_____

History of hospitalizations for psychiatric reasons (please include dates, name of hospitals, and reason for hospitalization): _____

_____

_____

Are you currently being treated by a psychiatrist, psychologist, therapist, counselor, etc.? (if so, include name and contact information) _____

_____

Has anyone in your family received psychiatric treatment or have a psychiatric illness? _____

_____

Medical History:
Please list any medical diagnoses or problems: _____

_____

List other medications that you take regularly, including any over the counter medications: _____

_____

Please indicate any other information that may be relevant for your treatment: _____

_____

_____

## APPOINTMENT REMINDER

You can receive appointment reminders to your email address or cell phone (via text, normal text message rates will apply) the day before your scheduled appointment.

Your name:_____

**Pick <u>one</u> option for receiving appointment reminders:**

_____EMAIL address: _____

_____CELL phone:_____

***This service is provided as a courtesy. A third party is used to handle these reminders and although the delivery rate is 99%, there are circumstances where messages will not be successfully delivered. It is your responsibility to record and keep any appointments that have been made, as we cannot guarantee you will successfully receive a reminder every time. Also appointment information is considered to be "Protected Health Information" under HIPAA. By my signature, I am waiving my right to keep this information completely private, and requesting that it be handled as I have noted above.***

_____ _____

Signature Date

**Mischca T. Scales, Ph.D.**
**Licensed Psychologist**
O (512) 467-1376
C (512) 507-6342

# INFORMED CONSENT FOR TELEPSYCHOLOGY

The informed consent for Telepsychology contains important information focused on psychotherapy using the Internet or phone. Please read carefully, and let me know if you have any questions. This signed document represents and agreement between us.

**Benefits and Risks of Telepsychology**
Telepsychology refers to providing psychotherapy services remotely using telecommunications technologies, such as video conferencing or telephone. One of the benefits of telepsychology is that the client and clinician can engage in services without being in the same physical location. This can be helpful in ensuring continuity of care if the client or clinician moves to a different location or are otherwise unable to continue to meet in person. It is also more convenient and takes less time. Telepsychology, however, requires technical competence on both out parts to be helpful. Although there are benefits of telepsychology, there are some differences between in-person psychotherapy and telepsychology, as well as some risks. For example:

**Risks to confidentiality**. Because telepsychology sessions take place outside of the therapist's private office, there is the potential for other people to overhear sessions if you are not in a private place during your session. On my end, I will take reasonable steps to ensure your privacy. But it is important for you to make sure you find a private place for our session where you will not be interrupted. It is also important for you to protect the privacy of our session on your cell phone or other devise. You should participate in therapy only while in a room or area where other people are not present and cannot overhear the conversation.

**Issues related to technology.** There are many ways that technology issues might impact telepsychology. For example, technology may stop working during a session, other people might be able to get access to our private conversation, or stored data could be accessed by unauthorized people or companies.

**Crisis management and intervention.** Usually, I will not engage in telepsychology with clients who are currently in a crisis situation requiring high levels of support and intervention. Before engaging in telepsychology, we will develop an emergency response plan to address potential crisis situations that may arise during the course of our telepsychology work.

**Efficacy.** Most research shows that telepsychology can be as effective as in-person psychotherapy. However, some therapists believe that something is lost by not being in the same room. For example, there is debate about a therapist's ability to fully understand nonverbal information when working remotely.

**Electronic Communications**
I use doxy.me telepsychology service and Zoom. There is no need for you to obtain special equipment, accessories, or software to take part in telepsychology using doxy.me.

Please pay your session fee using the electronic link provided to you prior to your scheduled appointment.

You should be aware I cannot guarantee the confidentiality of any information communicated by email or text. Therefore, I will not discuss any clinical information by email or text and prefer that you do not either. Also, I do not regularly check my emails or texts, and may not respond immediately, so these methods **should not** be used if there is an emergency.

**Confidentiality**
I have a legal and ethical responsibility to make my best efforts to protect all communications that are part of our telepsychology. However, the nature of electronic communications technologies is such that I cannot guarantee that our communications will be kept confidential or that other people may not gain access to our communication. I will try to use updated encryption methods, firewalls, and back-up systems to help keep your

information private, but there is risk that our electronic communications may be compromised, unsecured, or accessed by others. You should also take reasonable steps to ensure security of our communications (for example, only using secure networks for telepsychology sessions and having passwords to protect the device you use for telepsychology).

The extent of confidentiality and the exceptions to confidentiality are outlined in the Doctor-Client agreement that you signed and is also applicable in telepsychology. Please let me know if you have any questions about exceptions to confidentiality.

**Appropriateness of Telepsychology**
From time to time, we may have a "check-in" with one another. These may occur via electronic or in-person sessions. I will let you know if I decide that telepsychology is no longer an appropriate form of treatment for you and we will discuss options for continued treatment.

**Emergencies and Technology**
Assessing and evaluating threats and other emergencies can be more difficult when conducting telepsychology than in traditional in-person therapy. To address some of these difficulties, we will create an emergency plan before engaging in telepsychology services. I will ask you to identify an emergency contact person who is at or near your location. I will contact this person in the event of a crisis or emergency to assist in addressing the situation. I will ask that you sign a separate authorization form allowing me to contact your emergency contact person as needed during such a crisis or emergency.

If the session is interrupted for any reason, such as technological connection fails, and you are having an emergency, do not call me back; instead call 911, or the National Suicide Prevention Hotline 1-800-273-8255, or go to your nearest emergency room. You can call me back after you have called or obtained emergency services.

If the session is interrupted and you are not having an emergency, disconnect from the session and attempt to re-enter my digital waiting room with the url you were provided. I will wait two (2) minutes and then re-contact you via the telepsychology platform on which we agreed to conduct therapy. If you do not receive a call back within two (2) minutes, then call me at 512-507-6342.

If there is a technological failure and we are unable to resume the connection, you will only be charged a prorated amount of the actual session time.

**Fees**
The same fee rates will apply for telepsychology as apply for in-person psychotherapy. However, insurance or other managed care providers may not cover sessions that are conducted via telecommunication. If your insurance, HMO, third-party payor, or other managed care provider does not cover electronic psychotherapy sessions, you will be solely responsible for the entire fee for the session.

**Records**
The telepsychology session shall not be recorded in any way unless agreed to in writing by mutual consent. I will maintain a record of our session in the same way I maintain records of in-person sessions in accordance with my policies.

**Informed Consent**
This agreement is intended as a supplement to the general informed consent and does not amend any of the terms of that agreement. Your signature below indicates agreement with its terms and conditions.

_____ _____
Signature of Client (or Parent/Guardian) Date

_____ _____
Psychologist Date

11/2020

**Mischca T Scales, Ph.D.**
**Licensed Psychologist**
**4601 Spicewood Springs, 4-200**
**Austin, Texas 78759**
**Office (512) 467-1376**

## Notice of Psychologists' Policies and Practices to Protect the Privacy of Your Health Information

THIS NOTICE DESCRIBES HOW PSYCHOLOGICAL AND MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

---

### My Legal Duty

I am required by federal and state law to maintain the privacy of your protected health information (PHI) – information in your health record that could identify you -- and to provide you with a notice of my legal duties and privacy practices with respect to PHI. I must follow the privacy practices that are described in this notice while it is in effect. This notice takes effect January 1, 2020, and will remain in effect until I replace it. You may request a copy of this notice at any time.

I do reserve the right to change the privacy policies and practices described in this notice, provided such changes are permitted by applicable law. Unless I notify you of such changes, however, I am required to abide by the terms currently in effect. If I revise my policies and procedures, I will change this notice and provide you with a revised notice at your next appointment or by email or mail.

---

### I. Uses and Disclosures for Treatment, Payment, and Health Care Operations

I may *use* or *disclose* your *protected health information (PHI)*, for *treatment, payment, and health care operations* purposes with your *consent*. To help clarify these terms, here are some definitions:

- "*Use*" applies only to activities within my office such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.
- "*Disclosure*" applies to activities outside of my office, such as releasing, transferring, or providing access to information about you to other parties.
- *"Treatment, Payment and Health Care Operations"*
  - *Treatment* is when I provide, coordinate or manage your health care and other services related to your health care. An example of treatment would be when I consult with another health care provider who is providing treatment to you, such as your family physician or another mental health provider.
  - *Payment* is when I obtain reimbursement for your healthcare. Examples of payment are when I disclose PHI to a health insurer to obtain reimbursement for your health care or to determine eligibility or coverage.
  - *Health Care Operations* are activities that relate to the performance and operation of my practice. Examples of health care operations are quality assessment and improvement activities, business-related matters such as audits and administrative services, and case management and care coordination.

CLIENT COPY

### II. Uses and Disclosures Requiring Authorization

I may use or disclose PHI for purposes outside of treatment, payment, and health care operations when your appropriate authorization is obtained. An "*authorization*" is written permission above and beyond the general consent that permits only specific disclosures. In those instances when I am asked for information for purposes outside of treatment, payment and health care operations, I will obtain an authorization from you before releasing this information. I will also need to obtain an authorization before releasing your psychotherapy notes. *"Psychotherapy notes"* are notes I have made about our conversation during a private, group, joint, or family counseling session, which I have kept separate from the rest of your medical/clinical record. These notes are given a greater degree of protection than PHI.

You may revoke all such authorizations (of PHI or psychotherapy notes) at any time, provided each revocation is in writing. You may not revoke an authorization to the extent that (1) I have relied on that authorization; or (2) if the authorization was obtained as a condition of obtaining insurance coverage, and the law provides the insurer the right to contest the claim under the policy.

## III. Uses and Disclosures with Neither Consent nor Authorization

There are certain limited circumstances in which I may use or disclose PHI without your consent or authorization:

- **Child Abuse:** If I have cause to believe that a child has been, or may be, abused, neglected, or sexually abused, I must make a report of such within 48 hours to the Texas Department of Family Protective and Regulatory Services, or to any local or state law enforcement agency.
- **Adult and Domestic Abuse:** If I have cause to believe that an elderly or disabled person is in a state of abuse, neglect, or exploitation, I must immediately report such to the Department of Family Protective and Regulatory Services.
- **Health Oversight:** If a complaint is filed against me with the Texas Behavioral Health Executive Council (TBHEC), they have the authority to subpoena confidential mental health information from me relevant to that complaint.
- **Judicial or Administrative Proceedings:** If you are involved in a court proceeding and a request is made for information about your diagnosis and treatment and the records thereof, such information is privileged under state law, and I will not release information, without written authorization from you or your personal or legally appointed representative, or a court order. The privilege does not apply when you are being evaluated for a third party or where the evaluation is court ordered. You will be informed in advance if this is the case.
- **Serious Threat to Health or Safety:** If I determine that there is a probability of imminent physical injury by you to yourself or others, or there is a probability of immediate mental or emotional injury to you, I may disclose relevant confidential mental health information to medical or law enforcement personnel.
- **Worker's Compensation:** If you file a worker's compensation claim, I may disclose records relating to your diagnosis and treatment to your employer's insurance carrier.

## IV. Patient's Rights

- *Right to Request Restrictions* –You have the right to request restrictions on certain uses and disclosures of protected health information about you. However, I am not required to agree to a restriction you request.
- *Right to Receive Confidential Communications by Alternative Means and at Alternative Locations* – You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations. (For example, you may not want a family member to know that you are seeing me and may request that I send your bills to another address.) You must make your request in writing.
- *Right to Inspect and Copy* – You have the right to inspect or obtain a copy (or both) of PHI and psychotherapy notes in my mental health and billing records used to make decisions about you for as long as the PHI is maintained in the record. I may deny your access to PHI under certain circumstances, but in some cases you may have this decision reviewed. On your request, I will discuss with you the details of the request and denial process.
- *Right to Amend* – You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. I may deny your request. On your request, I will discuss with you the details of the amendment process.
- *Right to an Accounting* – You generally have the right to receive an accounting of disclosures of PHI for which you have neither provided consent nor authorization (as described in Section III of this Notice). On your request, I will discuss with you the details of the accounting process.
- *Right to a Paper Copy* – You have the right to obtain a paper copy of the notice from me upon request, even if you have agreed to receive the notice electronically.

CLIENT COPY

## V. Questions and Complaints

If you have questions about this notice, disagree with a decision I make about access to your records, or have other concerns about your privacy rights you may contact me, Mischca Scales, Ph.D., at 467-1376

If you believe that your privacy rights have been violated and wish to file a complaint with me, you may send your written complaint to me at 4601 Spicewood Springs Road, 4-200, Austin, Texas 78759. You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services. I can provide you with the appropriate address upon request.

You have specific rights under the Privacy Rule. I will not retaliate against you for exercising your right to file a complaint with me or with the U.S. Department of Health and Human Services.