DRS. ROFFMAN, CAVANAGH
& ASSOCIATES

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Mental Health Services Agreement

Welcome to our practice. This document contains important information about our professional services and business polices. Our practice requires that we obtain your signature acknowledging that we have provided you with this information at or before the end of the first meeting. Although these documents are long and sometimes complex, it is very important that you read them carefully. We can answer questions you have about the procedures during the first meeting. When you sign this document, it will also represent an agreement between us. You may revoke this agreement in writing at any time.

Psychoeducational Evaluation _____ (initial)
By signing this agreement, you are giving consent for your son/daughter to undergo a comprehensive psychological evaluation. A licensed psychologist will be performing this evaluation. The evaluation typically requires a parent intake appointment, 3 testing sessions (each of 2-3 hours duration) depending on your child's needs, plus a parent feedback session. The parent feedback session is typically scheduled four weeks after testing is completed and all information is collected. During the feedback meeting, the psychologist will review the evaluation's findings and discuss recommended services, interventions and/or supports. In addition, we provide a comprehensive report which is included in the testing fee. The benefits of an evaluation include having a better understanding of your child's learning needs to help determine educational interventions and services, should they require. Although no significant risk is anticipated due to the evaluation, the tasks that your child completes may be difficult or challenging, which may make your child upset. In addition, the nature of the information revealed, such as identification of specific weaknesses and diagnoses of psychological disorders can make some individuals feel uncomfortable. If you or your child experiences any distress or discomfort, please notify the psychologist immediately so that we can discuss your concerns.

Therapy Services _____ (initial)
By signing this agreement, you are giving consent for your son/daughter to receive therapy services. A mental health provider, a licensed psychologist or a licensed clinical social worker, will meet with you for an intake evaluation. The intake will determine the initial treatment plan for your child, in addition to the frequency at which sessions will be held. The therapy treatment plan is dependent on the nature of the presenting

problems, and the methods used in therapy will vary given the goals of treatment. Therapy is a collaborative process between the therapist and the patient and parents' calls for a very active effort on the part of you and/or your child. In order for therapy to be successful, your child will have to work on things addressed in session at home. A standard therapy session is 50 minutes unless agreed otherwise. Time is billed on a "per session" basis and is collected at the time of service.

You are giving consent for your son/daughter to undergo, when appropriate, standardized assessments performed by a licensed psychologist or a licensed clinical social worker. This maximizes clinical care and provides parents with ongoing feedback. **_____ (initial)**

Cancellation Policy and Rescheduling Appointments _____ (initial)
If you need to reschedule an appointment, please do so within 24 hours of the original appointment. For therapy patients, a *one-hour fee will be charged for cancellations made with less than 24-hour notice*. We understand there may be situations in which your child may be unable to attend due to circumstances beyond your control. Under these circumstances, the one-hour fee will be waived.

Insurance Reimbursement _____ (initial)
Your insurance company may reimburse you for our services, but we do *not* participate in insurance plans and therefore should be considered as an out-of-network provider. Some insurance companies also require pre-authorization for psychoeducational testing. It is your responsibility to be aware of your insurance plans' requirements. We are happy to provide receipts upon request documenting services and complete any form necessary to submit to your insurance. It is the obligation of parents to deal with all direct correspondences with their insurance company. We do not accept fees directly from insurance companies. **_____ (initial).**

Contact Information and Emergency Procedures _____ (initial)
Email is not a secure form of communication and therefore no discussions of clinical matters should be held via email. No clinical reports will be sent out on the internet, in order to maintain privacy. In the event that email addresses are exchanged, email communications should be restricted for scheduling/administrative matters

In order to maintain confidentiality and to protect your privacy, it is our policy to not accept friend or contact requests from current or former clients on social networking sites (e.g., Facebook, Linkedin, etc.)

It is best to contact your provider by telephone. However, your provider may not be available immediately by telephone. We do not answer the phone when we are in a meeting with a patient. Additionally, all the providers have different office hours. If you are trying to get in touch with your treating provider, feel free to contact the office number at 410-561-3651 on business days to leave a confidential voicemail. During business hours, we check the voicemail frequently. We will return your call within one business day of receiving it, with the exception of weekends and holidays.

Please let us know any number on which we may leave a discrete message. The phone number you prefer we use is _____.
_____ (initial)

Our practice does not have 24-hour crisis availability, support staff, or a psychiatrist. In an emergency, please go to the nearest emergency room and ask for the psychologist or psychiatrist on call. Then, please inform your treating provider of the situation. We

also have a secretary who may return calls to you. Please initial that you understand any of the providers or our secretary may return your call _____ **(initial)**

Professional Records _____ (initial)
The laws and standards of our profession require that we keep Protected Health Information about your child in your child's clinical chart. Because these are professional records, they can be misinterpreted and/or unclear to untrained readers. For this reason, we are happy to provide a copy of your child's report at any time, but are not able to release copies of chart contents due to ethical and professional reasons. If you require additional clarification that would require a chart review, we recommend that you schedule an appointment in our office to discuss the contents.

For therapy services, you are entitled to request your child's records. However, in most cases, a treatment summary will be provided because it is more succinct and provides clear information to parents or other providers. Patients will be charged an appropriate fee for any time spent in responding to information requests.
_____ **(initial)**

It is standard professional policy to retain clients' records for at least seven (7) years after the end of our evaluation or at the conclusion of therapy services, at which time we will destroy them.

HIPAA provides you with several new or expanded rights with regard to your Clinical Records and disclosures of protected health information. We ask that you review the HIPAA agreement carefully.

Confidentiality _____ (initial)
The law protects the privacy of all communications between a patient and a psychologist or social worker. In most situations, we can only release information about your treatment to others if you sign a written Authorization Form that meets certain legal requirements imposed by HIPAA and/or Maryland law. However, in the following situations, no authorization is required:

- If you are involved in a court proceeding involving custody and/or a request is made for information concerning your child's diagnosis and treatment, a judge may order that that information be released if he/she determines that the information is relevant or warranted. If you are involved in or contemplating litigation, you should consult with your attorney to determine whether the court would be likely to order Drs. Roffman, Cavanagh & Associates to disclose information.
- If your child's mental and emotional state is offered as a defense.
- If a patient files a complaint or lawsuit against one of the providers from Drs. Roffman, Cavanagh & Associates, the provider may disclose relevant information regarding that patient in order to defend him/herself.

There are some situations in which we are legally obligated to take actions. These situations include instances when we believe it is necessary to attempt to protect others from harm. Under such circumstances, we may have to reveal some information about a patient. These situations are very unusual in our practice, but could include:

- If we know or have reasonable cause to suspect that a child under 18 has been or is likely to be abused or neglected, or that an elderly or disabled person has been abused, neglected or exploited, the law requires that we file a report with the

appropriate government agency, usually Child Protective Services. Once such a report is filed, we may be required to provide additional information.

- If we determine that the patient poses a direct threat of imminent harm to the health or safety of any specified individual, we may be required to disclose information in order to take protective actions(s). These actions may include notifying the potential victim, contacting the police, seeking hospitalization for the patient, or contacting family members or others who can assist in providing protection. If such a situation arises, we will make every effort to fully discuss it with you before taking any action and we will limit our disclosure to what is necessary.
- If we believe that there is an imminent risk for the child/adolescent to harm him/herself, then we will be required to take protective action including notifying family members or individuals to keep the child safe and/or initiating a hospitalization.
- While this written summary of exceptions to confidentiality should prove helpful in informing you about potential problems, it is important that we discuss any questions or concerns that you may have now or in the future. The laws governing confidentiality can be quite complex.

- Drs. Roffman, Cavanagh & Associates is comprised of licensed psychologists, licensed clinical social workers, and an administrative secretary. In order to maximize clinical care, it is not uncommon for the providers to discuss information regarding their patients. It is important to acknowledge that only the information necessary to benefit the patient is disclosed and that we strive to protect patients' confidentially during discussions whenever it is possible. **_____ (initial).** Please initial your understanding and acceptance of shared communication between our providers and administrative assistant.

Compliance _____ (initial)
We endeavor to abide by all the rules of the American Psychological Association (APA) and the Association of Social Work Boards (ASWB) by those of our state license.

Problems can arise in our relationship, just as in any other relationship. If you are not satisfied with any area of our work, please let us know at once. We care deeply about the service we provide and hope that every patient is satisfied to the fullest extent possible. We will make every effort to hear any complaints you have and to seek solutions to them.

I have read or had read to me the information in this document and agree to abide by its terms. I acknowledge that I have received the HIPAA Notice of Psychologist's Practices to Protect the Privacy of Your Health Information described in this agreement. I have discussed all questions and concerns I have about this document with Dr. Nancy Roffman, Dr. Barbara Cavanagh, Dr. Tracey Horn, Dr. Sarah Cornbrooks, Mrs. Cassidy Demos, LCSW-C, and Mrs. Bentley Stephens, LCSW-C have received satisfactory answers or explanations.

_____ _____ _____
Signature of Parent/Guardian Printed Name of Parent/Guardian Date

_____ _____
Signature of Witness Date

_____ _____

Signature of Patient
(if 16 years of age or older)

Date