



Founder & President

Aaron J. Dodini, Ph.D.
Licensed Clinical Psychologist
Licensed Marriage & Family Therapist

Associates:

Dave Dayton, Ph.D., Licensed Clinical Psychologist
Kerstin Perini, M.A., Licensed Professional Counselor
Sonia Kahn, Psy.D., Licensed Clinical Psychologist
Joy Lere, Psy.D., Licensed Clinical Psychologist
Joseph Schmidt, Psy.D., Licensed Clinical Psychologist
Michael Magenheimer, Psy.D., Licensed Clinical Psychologist

PSYCHOTHERAPY CONTRACT

Welcome to Dodini Behavioral Health. As your treatment provider, I want to share important information about the professional services we offer and our business policies, which will serve as a foundation for our work together. Please read this consent document carefully and inform me of any questions you might have so that we can discuss them at our next meeting. Once you sign this document, it represents an agreement between us that you have read, and agreed to everything discussed in this document.

PSYCHOLOGICAL SERVICES

Psychotherapy is not easily described in general statements. The experience varies depending on the personalities of the psychotherapist and patient, and the particular problems you bring forward. There are many different methods I may use to assist you in your goals, including individual therapy or group therapy models that I believe are very powerful. Psychotherapy is not like a medical doctor visit. It calls for a very active effort on your part. In order for the therapy to be most successful, you will have to work on things we talk about both during our sessions and at home.

Psychotherapy can have benefits and risks. 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, psychotherapy has also been shown to have benefits for people who engage in the process. Psychotherapy often leads to better relationships, solutions to specific problems, and significant reductions in feelings of distress. I believe that psychotherapy can be helpful in assisting one to achieve greater life balance, experience personal growth, and enjoy fulfillment in one's personal and professional life. However, each person's experience is unique to the individual and there are no guarantees of what you will experience.

Our first few sessions will involve an evaluation of your needs. By the end of the evaluation, I will be able to offer you some first impressions of what our work will include if you decide to continue with therapy. Therapy involves a large commitment of time, money, and energy, so you should be very careful about the therapist you select. You should evaluate this information along with your own opinions of whether you feel comfortable working with me. If you have questions about my procedures, we should discuss them whenever they arise. If concerns arise and persist, I will be happy to help you connect with another mental health professional for a second opinion.

ASSESSMENT INFORMATION DISCLOSURE STATEMENT

Psychological assessment is a relationship that works in part because of clearly defined rights and responsibilities held by each person. Psychological assessment involves the administration of standardized instruments/tests, clinical interviews, and a collaborative data gathering process. The results provide information about you, or your child that may be commensurate with your own observations and worldview, or may be quite different than preconceptions. We will discuss the results and recommendations in a feedback session so they can be helpful to you.

In some instances, testing or assessment may be required at the request of a court of law, government agency, school, or attorney. As the client, you and you alone hold the right to disclose the results of your assessments to whomever you choose through written consent. In a forensic setting, it is possible that a court or your attorney will request assessment. Your agenda may be different from the agenda of the requesting party. Because my professional expertise and professional ethics require me to answer the referral questions honestly using the data collected, I cannot promise the outcome you may desire.

MEETINGS

When meeting to discuss a course of psychotherapy, I normally conduct an initial evaluation that take place over the first two to four sessions. During this time, we will discuss goals, treatment interventions and our fit so we can assess whether I am the best person for providing the services you need to meet your treatment goals. If we agree to a course of psychotherapy after the evaluation period has concluded, I typically schedule one 45-minute session per week at a time we agree on. That said, the frequency of appointments will depend on your specific needs.

CANCELLATION & INCLEMENT WEATHER POLICY

Once an appointment hour is scheduled, you will be expected to attend and pay for it unless you provide 72 hours advance notice of cancellation. This includes cancellations for all reasons, including last-minute travel and illness. If you cancel a session with less than 72 hours notice, but I am able to fill your time slot, I will not charge you for the late cancellation. If you need to reschedule a session with less than 72 hours notice, I will try to find a time to meet with you, but you will still be required to pay for the cancelled session unless I am able to fill it with short notice.

On the occasion that there is inclement weather, I will put on my outgoing message on my voicemail if sessions for that day have been cancelled. Please call as early as possible to check that outgoing message. If I am unable to safely get to the office, I will cancel sessions for that day. If I am able to safely get to the office, I expect that you will also be able to attend the session. If my office is open, but you are uncomfortable, or do not feel safe in driving, you may contact me to request that we meet via phone at the normally scheduled time.

PROFESSIONAL FEES

My fee is \$175.00 for a 45-minute, individual therapy session. For other professional services you may need that require more than 10 minutes of my time, I will charge by the minute based on my individual therapy session rate. Services requiring more than 10 minutes of time for which you may be billed include: report writing, telephone conversations lasting longer than 10 minutes, attendance at meetings with other professionals you have authorized, preparation of records or treatment summaries, and the time spent performing any other service you may request of me. If you become involved in legal proceedings that require my participation, you will be expected to pay for my professional time even if I am called to testify by another party. Because of the difficulty of legal involvement, I charge \$800.00 per hour for preparation and attendance at any legal proceeding.

Fees for 75-minute, group psychotherapy sessions are \$110. When you agree to join a psychotherapy group, you are "buying a slot" in the group that will be held for you. You are billed for each session, whether you attend the group session or not. This means you will be responsible for paying the fee of any group session

held, even if you have to miss the group for a trip or illness, regardless of whether you let me know you would not attend with more than 72 hours notice.

Fees for 45-minute, conjoint couples sessions (couples therapy with two therapists present) are \$150 for each member of the couple. Separate bills will be provided to each member of the couple, with separate diagnoses provided for each. Should you have couples therapy insurance coverage, having separate diagnoses may assist you in obtaining reimbursement. If the couple is seen by one therapist without the other therapist present, the present therapist will bill each member of the couple \$115.

Fees for 45-minute, couples sessions provided by one therapist are \$230. Separate diagnoses can be provided to each member of the couple with additional assessment.

Fees for 45-minute family therapy sessions provided by one therapist are \$230.

I typically have modest rate increases of \$5 to \$10 annually. My last rate increase occurred in February 2017.

BILLING AND PAYMENTS

You will be expected to pay for each session at the time it is held, until after the evaluation process, at which time we will decide on the terms of the treatment plan and I will bill on a monthly basis. I will email an invoice to you for the last session of the month and you will be expected to pay by check at that time. Payment can also be collected by electronic check (\$0.84 convenience fee) or credit/debit card (3% convenience fee) using the secure payment system PaySimple (<http://dodini.com/click-here-to-make-payment/>).

Payment is delinquent if received after the 10th of the month. If you are late in providing payment, that will be a topic of discussion in a subsequent session. Under those circumstances, I may choose not to schedule an appointment until after payment is made. If there are any concerns about finances and making payment, please bring that up as part of our work together.

INSURANCE REIMBURSEMENT

I do not participate as an in-network provider with any insurance companies, therefore I am considered an “out of network” provider. In order for us to set realistic treatment goals and priorities, it is important to evaluate what resources you have available to pay for your treatment. If you have a health insurance policy that includes an “out of network” option, it will usually provide some reimbursement for mental health treatment. I will provide you with a Superbill that contains all the information necessary for you to submit a claim for reimbursement. If you need assistance with submitting, please let me know and I will be happy to walk you through the process.

You -- not your insurance company -- are responsible for full payment of my fees. If you are going to seek reimbursement for my services, it is very important that you find out exactly what mental health services your insurance policy covers. You should carefully read the section in your insurance coverage booklet that describes mental health services. I will provide you with whatever information I can based on my experience and will be happy to help you in understanding the information you receive from your insurance company. If you have specific questions about the coverage, call your plan administrator by dialing the number on the back of your insurance card.

“Managed Healthcare” plans such as HMOs and PPOs often require authorization before they provide reimbursement for mental health services. These plans are often limited to short-term treatment approaches designed to address specific problems that interfere with a person’s usual level of functioning. It may be necessary to seek approval for more therapy after a certain number of sessions. If you choose to seek reimbursement, it is your responsibility to seek approval for services from your insurance company.

You should also be aware that most insurance companies require you to authorize me to provide them with a clinical diagnosis. Sometimes I have to provide additional clinical information, such as treatment plans or summaries, or copies of the entire record (in rare cases). This information will become part of the insurance

company files and will probably be stored in a computer. Though all insurance companies claim to keep such information confidential, I have no control over what they do with it once it is in their hands. In some cases, 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.

It is important to remember that you always have the right to pay for my services out of pocket and not submit to your insurance company for reimbursement. This will allow you to avoid the problems described above.

I do not work with Medicare, so Medicare will not pay for any portion of your therapy. At this time, I also cannot treat anyone who plans to submit claims to TriCare.

CONTACTING ME

Because email is not a confidential form of communication and is not covered by HIPAA regulations, I discourage the use of email as a form of communicating with me. If you choose to email me, please do so only for scheduling purposes and with the understanding that I cannot guarantee the confidentiality of your message. While I will not share that email, the folks at Google and other email providers do have access to email content.

I therefore request phone contact as the primary means of communication. I am often not immediately available by telephone because I will not answer the phone when I am with a patient. When I am unavailable, my telephone is answered by a confidential voicemail that I monitor frequently. I will make every effort to return your call on the same day you make it, with the exception of weekends and holidays and if you call after office hours. If you are difficult to reach, please inform me of some times when you will be available. If you are unable to reach me and feel that you cannot wait for me to return your call, contact your physician, psychiatrist, or the nearest emergency room and ask for the psychiatrist on call. If I will be unavailable for an extended time, I will provide you with the name of a colleague to contact.

I am not available for contact on the weekends. I also do not check my email or voicemail on the weekends, or after business hours. Any messages left after 5:00 PM on Friday will be received on Monday morning.

PROFESSIONAL RECORDS

I keep a record of your attendance at a given session and a brief note about general topics or issues that may have been discussed. You are entitled to receive a copy of the records unless I believe that seeing them would be emotionally damaging, in which case I will be happy to send them to a mental health professional of your choice. Because these are professional records, they can be misinterpreted and/or upsetting to untrained readers. I recommend that you review them in my presence so that we can discuss the contents.

CONFIDENTIALITY

Confidentiality is protected between all modalities of therapy. This means that information that you may share in an individual session will not be shared in a couples session or a group session. In the case of couples counseling, both parties must agree to this confidentiality policy.

In general, the privacy of all communications between a patient and a psychologist is protected by law, and I can only release information about our work to others with your written permission. There are some situations in which I am legally obligated to take action to protect others from harm, even if this means that I have to reveal some information about a patient's treatment. Here is a list of the exceptions:

- In most legal proceedings, you have the right to prevent me from providing any information about your treatment. In some proceedings, for example those involving child custody, or those in which your emotional condition is an important issue, a judge may order my testimony if he/she determines that the issues demand it. While I will do everything in my power to protect your private information, I will abide by the legal requirements imposed upon me.

- For example, if I believe that a child, elderly person, or disabled person is being abused or has been abused in the past, I may be required to file a report with the appropriate state agency.
- If a patient threatens to harm himself/herself, I may be obligated to seek hospitalization for him/her, or to contact family members or other persons who can help provide protection.
- If I believe that a patient is threatening serious bodily harm to another person, I may be required to take protective actions. These actions may include notifying the potential victim, contacting the police, or seeking hospitalization for the patient.

These situations have rarely occurred in my practice. If a similar situation occurs, I will make every effort to fully discuss it with you before taking any action and invite you to participate in the process with me.

I find it helpful to consult other professionals about cases. This allows me to ensure that I am providing my patients the best treatment possible. Even though a consultant is legally bound to keep the information confidential, I make every effort to avoid revealing the patient's identity during consultation. Unless you object, I will not tell you about these consultations unless I feel it is important to our work for us to discuss them.

MINORS & PARENTS

Because privacy in psychotherapy is often crucial to successful progress, particularly with teenagers, and because it is important for parents to have some information about their child's treatment, I typically request that the parents and child agree about what information the parents will receive about their child's treatment.

Legally, psychologists can provide psychological services to minors without parental consent if the psychologist determines that the minor is knowingly and voluntarily seeking the services, and provision of services is clinically indicated for the minor's well being. These services can only be provided for 90 days, but can be continued if the psychologist determines that the services are still clinically indicated. In these situations, parents do not have access to the minor's records. Patients over the age of 14, but under the age of 18 (who are not emancipated), whose parents have consented to treatment should be aware that parents can only review the child's records with the written authorization of the child. Children under 14, whose parents have consented to the treatment, should be aware that their parents can examine their treatment records unless I decide that such access is likely to injure the child, or we all agree otherwise.

If the patient agrees, during treatment, I will provide parents only with general information about the progress of the child's treatment, and his/her attendance at scheduled sessions. I will also provide parents with a summary of their child's treatment when it is complete. 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.

HIPAA NOTICE OF PRIVACY PRACTICES

Federal and state laws regulate privacy within the practice of psychotherapy. The following notice outlines how medical information about you may be used and disclosed. It also outlines how you are able to obtain access to your protected health information (PHI) includes the records that I create and, with your permission, obtain from other health professionals (such as psychological testing or medical reports). This information includes my clinical documentation, diagnoses, treatments, referrals, and your billing history and records. This information, in accordance with the law, is kept confidential and in accordance with this described notice of privacy practices. I am also required to give you a copy of this privacy practice for your own use or records. I reserve the right to change my privacy practices as long as they remain in accordance with the current regulations. If I do change my privacy practices, I will provide you with written notification.

Permitted Uses and Disclosures of Protected Health Information: I am permitted, under federal law, to use and disclose your PHI without authorization for treatment, payment, or health care operations. Examples of such potential uses or disclosures are provided below:

- **Treatment:** For example, I may give information about your treatment to other health care providers to facilitate your treatment, referrals, or consultations. If or when I disclose information to other people or companies, I require them to protect your privacy as well.
- **Health Care Operations:** Your PHI may be used or disclosed as part of my internal health care operations. Examples of such health care operations may include, among other things, accreditation, training programs, certification, licensing, or other credentialing activities.
- **Payment:** I may use and disclose your PHI to bill and collect payment for the treatment and services that I have provided to you. For example, obtaining a pre-authorization for treatment may require that your PHI be disclosed to your health insurance plan.

I may use your mental health information for other purposes without your written consent in the following other situations. While legally I am entitled to do this, I will make every effort, when appropriate, to inform you that I have made such a disclosure or that I intend to do so.

Abuse, Neglect, or Domestic Violence: As required by law, I may disclose your PHI to report suspected abuse, neglect or domestic violence.

Communication: For appointments and services to remind you of an appointment or tell you about treatment alternatives or health related benefits of services.

Health Oversight: I may disclose your PHI for oversight activities authorized by law or to an authorized health oversight agency to facilitate auditing, inspection, or investigation related to my provision of health

Judicial and Administrative Proceedings: I may be required to disclose your PHI in the course of a judicial or administrative proceeding, in accordance with my legal obligations.

Law Enforcement: I may disclose your PHI to a law enforcement official for certain law enforcement purposes. For example, I may report certain types of injuries as required by law or make a report concerning a crime or suspected criminal conduct.

Minors: I may disclose information to individuals involved in your treatment, such as your parents or guardian, if you are a minor. Additionally, if you are an unemancipated minor under Virginia law, there may be circumstances in which I disclose your PHI to a parent, guardian, or other person acting in loco parentis, in accordance with my ethical and legal responsibilities.

Notification: I may use or disclose your PHI to notify a family member or other person responsible for your care about your location and about your general condition. If you are unavailable because, for example, you are incapacitated or because of some other emergency circumstance, I will use my best professional judgment to determine what is in your best interest and whether a disclosure may be necessary to ensure an adequate response to the emergency circumstances.

Parents: If you are a parent of an unemancipated minor, and are acting as the minor's personal representative, I may disclose health information about your child to you under certain circumstances. For example, I am legally required to obtain your consent as your child's personal representative in order for your child to receive care from me. In some circumstances, I may not disclose health information about an unemancipated minor to you. For example, if your child is legally authorized to consent to treatment (without separate consent from you), consents to such treatment, and does not request that you be treated as his or her personal representative, I may not disclose your child's PHI to you without your child's written consent.

Personal Representative: If you are an adult or an emancipated minor, I may disclose your PHI to a personal representative authorized to act on your behalf in making decisions about your health care.

Public Safety: Because of my legal and ethical obligations, I may disclose your PHI based on a good faith determination that such disclosure is necessary to prevent a serious or imminent threat to the health or safety of a person or the public to apprehend an individual sought by law enforcement.

Required by Law: I may be required by Federal, State or local law to disclose your PHI.

Worker's Compensation: I may disclose your PHI to comply with laws regarding workers' compensation. You have rights in regards to your PHI.

Requesting Restrictions: You have the right to ask me to limit my use or disclosure of your PHI. I am not required to agree with your request, but if I do agree to it, I will abide by your request except, as required by law, in emergencies or when the information is necessary for your treatment. Your request must be: in writing, describe the information that you want restricted, state if the restriction is to limit my use or disclosure, and state to whom the restriction applies.

Confidential Communications: You may ask that I communicate with you in a particular way, or at a certain location, to maintain your confidentiality. Your request must be in writing and must tell me how you intend to satisfy your financial obligation and specify an alternate way that I can confidentially contact you. You do not have to give a reason for your request.

Inspect and Copy: You may request to review or to receive a copy of your PHI that is maintained in my files. Federal law prohibits the inspection or copying of: psychotherapy notes, information compiled in reasonable anticipation of, or use, in a civil, criminal, or administrative action or proceeding; and PHI that is subject to the law that prohibits access to PHI. If I am unable to satisfy your request, I will tell in writing the reason for the denial and you right, if any, to request a review of the decision. I may charge you a fee for this service.

Paper Copy of this notice: You are entitled to receive a paper copy of my Notice of Privacy Practices by using the contact information supplied on the first page.

File a Complaint: If I have violated your privacy rights you may file a complaint directly with me using the contact information on the first page. You may also file a complaint directly with the Secretary of the Department of Health and Human Services. You will not be penalized for complaining.

Provider Authorization for Other Uses and Disclosures: I will not disclose your PHI for any reason except those described in this notice, unless you provide me with a written authorization to do so. I may request such an authorization to use or disclose your PHI for any purpose, but you are not required to give me such an authorization as a condition of your treatment. Any written authorization from you may be revoked by you in writing at any time, but such revocation will not affect any prior authorized uses or disclosures.



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I have read the Informed Consent/Psychotherapy Contract and the HIPAA Notice & Privacy Practices documents and agree to the provisions indicated. I understand that I have the right to withdraw from treatment at any time.

Printed Name _____ Signature _____ Date _____

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: _____ Date of Birth: _____

I request and authorize DODINI BEHAVIORAL HEALTH to release and exchange healthcare information of the patient named above to and with:

Name of Individual/Organization: _____

Phone _____ Fax _____ Email _____

Address _____

City _____ State _____ Zip Code _____

This request and authorization applies to healthcare information relating to coordination of treatment, condition, prognosis, or dates of services. This authorization may be revoked at any time.

Patient Signature: _____ Date Signed: _____