**General Information**

Today’s Date:\_\_\_\_\_\_\_\_\_\_\_\_\_

Client Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_ Age: \_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_City/State: \_\_\_\_\_\_\_\_ Zip:\_\_\_\_\_\_\_\_

Cell Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Whose # ?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Alternate Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Whose # ?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is it okay to call/text/email/leave messages this way regarding appointments?\_\_\_

By providing this information I am authorizing contact and understand the possible limitations regarding confidentiality and electronic communication.

How did you hear about my services? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Last Grade Completed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ School:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parents Names if child is being seen:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Health Insurance Portability and Accountability Act (HIPAA)**

By signing this document, I acknowledge that I was given the HIPAA Client Services Agreement that explains the privacy protection, use, and disclosure of personal information (Protected Health Information (PHI)). I acknowledge that I have reviewed and understand these policies.

**Payment Information**

Name on Credit Card: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Type: Visa / MC/ Amex

Credit Card Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Exp Date: \_\_\_\_\_ CVV: \_\_\_\_\_\_

I give permission to maintain this credit card on file and for Dr. Lavoie to process all future charges using this credit card.

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Payment Policies**

**General Information**

I want to provide the highest quality of service and have found the only way I can do this unfortunately is to not contract with insurance companies. I do wish this were different and apologize for any difficulties this may cause. I am committed to providing the best possible treatment, free of managed care and insurance restrictions. Because of this services are provided on a private-pay basis only and are collected at the time of service. I hope that it is helpful that I am able to accept cash, checks, credit cards, and health service accounts as payment.

Rates for clinical services listed below are available for your convenience in person, Skype, Face Time, phone or Google Hangout.

* 45 minute Individual Therapy Session: $175
* 80 minute Initial intake (First Session): $350
* 60 minute Couples/ Family Therapy: $225
* Neuropsychological evaluation: $3200 and includes intake interview, all assessments, record review, report writing and one feedback session.
* Record review, letter writing, second opinions and extensive telephone calls (billed in increments of 15 minutes): $200 per hour
* School meetings or other off-site consultative services: $200 per hour and may include a fee for travel time.

If you seek reimbursement from your insurance company I can assist by providing a statement of services, dates, charges, procedures and diagnostic codes.

**Missed Appointments and Cancellations**

Your appointment time is reserved just for you. Please let me know as soon as you can if you need to reschedule your appointment so I can offer the time to someone else who might need it. If you let me know at least 24 hours ahead of time, you can avoid the $175 missed appointment fee. Illness or emergencies are, of course, exceptions. Also the slot can be filled by someone else on short notice you will not be charged the fee.

**Policies Related to Use of Technology**

Due to the importance of confidentiality, I do not connect with current or former clients on social networking sites or accept friend requests. Although it may become useful to share information electronically, please be aware of the following risks to confidentiality:

* People in your home, school or other environments who have physical access to your devices or who are connected via the Cloud.
* Your employer, if you use your computer at work or use a work email account
* IT professionals, server administrators and/or computer hackers.
* Face Time/Skype sessions could be heard if someone is listening outside your door.

I have read, understand and agree to abide by the policies as written above.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Print Name Signature Date

**HIPPA Statement**

**CLIENT SERVICES AGREEMENT – PRIVACY POLICY**

These policies are in accord with the Health Insurance Portability and Accountability Act (HIPAA) Privacy and Security Rules. Under HIPAA, I am required to provide you with this information and obtain your signature acknowledging that I have given you this information. By signing your Client Registration form you acknowledge having received this information. Your signature additionally indicates informed consent for receiving services in my practice. I am happy to provide you with a copy of this document if you request it. Copies are readily available on line and in my office.

**Limits on Confidentiality**

The law protects the privacy and confidentiality of all communication between client and psychologist. In most circumstances, I can release information about you (or your child) only with your written authorization. This section of the document explains the few exceptions to confidentiality and situations in which information may be released without your authorization or consent or with consent only. Parents hold confidentiality rights of children under the age of 18 who are not emancipated. In the following paragraph, “your child” is added when “you” are referenced and applies if your child is the focus of care here.

Under HIPAA, use or disclosure of PHI for the purposes of treatment, payment, or healthcare operations, requires only your consent. Your signature on the Client Registration Form provides consent for those situations. I am mandated by law to report to the appropriate agencies suspected neglect or abuse of children under age 18, individuals with mental or physical disabilities, or elders. I may be required to provide additional information once I have made such a report. If you (or your child) appear to be at clear and immediate risk of self-harm or harming an identified person, I must take reasonable precautions to ensure safety. These cautions may include warning a potential victim, notification of law enforcement, or arranging for hospitalization. These precautions may involve disclosure of PHI without your consent or authorization, which is permitted under the law in these circumstances. If you file a Workers Compensation claim, your records relevant to that claim can be requested and provided to your employer, insurer, or the Department of Workers Compensation. The Board of Registration of Psychologists has the power to subpoena relevant records when necessary, should I be the focus of an inquiry. If you/your child are involved in court proceedings, unless there is a court order, your written authorization is required from you or your legal representative in order for me to release information. If your evaluation is court ordered, or there is a court order for your information, I am obligated to release your information.

When use and disclosure without your consent is authorized under other sections of section 164.512 of the Privacy Rule, and the state's confidentiality law, certain narrowly defined disclosures are required/allowed: to law enforcement agencies, to a health oversight agency (such as HHS or a state Department of Health), to a coroner or medical examiner, for public health purposes or FDA -- regulated products, or for specialized government functions such as fitness for military duties, eligibility for VA benefits, and national security and intelligence.

**Client Rights and Psychologist Duties**

You have the right to request restrictions on the disclosure of your PHI. I am not required to agree to or restriction your request but will make every effort to do so, within the legal limits and exceptions to confidentiality. You have the right to request the location at which you receive communications involving PHI, as in an alternative address or phone number. You have the right to request in writing to examine and/or receive a copy of your records, unless I determine that access would be a danger to you. In that situation, you have the right to a summary of the record and you can request that your record be sent to another mental health provider or to your attorney. You have the right to request an amendment to your record. I may deny your request but can document your concerns in the record. Your rights include requesting an accounting of disclosures of PHI for which you have provided neither consent nor authorization. You have the right to restrict certain disclosures of PHI to a health plan when you have paid for your care out of pocket. You have the right to be notified if there is a breach of any unsecured PHI. Unsecured PHI refers to PHI that has not been encrypted to government standards or if my risk assessment determines that the chance that your PHI has been compromised exceeds a low probability of compromise. I am required by law to maintain privacy of PHI and provide you with this notice of my legal duties and privacy policies. I reserve the right to amend or change the privacy policies described here. I am required to abide by the policy stated here unless I notify you of any changes.

If you have questions about these policies, disagree with a decision I make regarding access to your records, or have other concerns about privacy rights, you may contact me by phone or in writing. My contact information is at the beginning of this notice. You may also send a written complaint to the Secretary of the US Department of Health And Human Services.

Informed consent, which is required under Massachusetts state law, means that the purpose, procedures, and nature of the information that this evaluation or consultation can yield have been explained to you; that you understand this information; and that you agree to participate willingly in this evaluation or consultation.