Melanie J. Bliss, Ph.D., Stephanie Ezust, Ph.D.
Licensed Psychologists

317 W. Hill Street, Ste 205 b
Decatur, GA 30030-4319
Dr. Bliss 404.377.9000
Dr. Ezust 404.371.9171

PSYCHOTHERAPIST - PATIENT PROFESSIONAL SERVICES AGREEMENT (GEORGIA)

AGREEMENT FOR DBT SKILLS TRAINING GROUP

Welcome to the DBT Skills Training Group facilitated by Melanie Bliss, Ph.D., and Stephanie Ezust, Ph.D. This document contains important information about our professional services and business policies. It also contains summary information about the Health Insurance Portability and Accountability Act (HIPAA), a federal law that provides privacy protections and new 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. HIPAA requires that we provide you with a Notice of Privacy Practices for use and disclosure of PHI for treatment, payment and health care operations. The Notice, which is attached to this Agreement ("Georgia Notice Form"), explains HIPAA and its application to your personal health information in greater detail. The law requires that we obtain your signature acknowledging that we have provided you with this information.

Although these documents are long and sometimes complex, it is very important that you read them carefully. 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 us unless we have taken action in reliance on it or if you have not satisfied any financial obligations you have incurred.

PSYCHOLOGICAL SERVICES:

The content areas included in psychological services are broad and may include consultation, evaluation, and/or treatment. Consultation involves giving you information, opinions and/or advice in a general or specific sense about areas of psychological problems. Evaluation involves conducting an assessment of you and others in order to render a professional opinion, including child custody evaluations. Treatment involves rendering intervention services to assist you and others with psychological problems and may include psychotherapy as well as other forms of treatment. There are no guarantees that any of these psychological services will be successful. The outcome of them usually involves collaboration between us.

If you have questions about any of our procedures, we should discuss them whenever they arise. If your doubts persist, we will be happy to help you set up a meeting with another mental health professional for a second opinion.

You are entering a Skills Training Group using a model of therapy called **Dialectical Behavior Therapy (DBT)**. This therapy was originally developed to help women with extreme emotion dysregulation problems, and the resulting problems in living, including suicidal thoughts and behaviors. DBT has been empirically demonstrated to reduce suicidal behavior, inpatient hospitalizations, and anger, as well as improve social adjustment. You have been referred to this group and it has been determined that DBT is likely to be useful to you. However, there are no guarantees.

In order to generalize your skills training, you will be asked to do specific "homework assignments." These assignments are vital to your improvement during the course of therapy, and we will strongly encourage you to attempt to do them to the best of your ability. By signing this contract, you agree to attend skills training sessions and practice new skills as you learn them.

SELF-HARMING BEHAVIORS AGREEMENT:

If suicidal or other self-harm behaviors are a problem for you, reducing these behaviors will be a primary treatment goal. By signing this contract, you agree to work toward solving problems in ways that do not include intentional self-harm or suicide.

MEETINGS:

1. The DBT Skills Training Group will be held on Wednesdays from 2:30 p.m. to 4:00 or 4:30 p.m. depending on the number of group members. Your facilitator will inform you of the ending time.

2. Prior to the first meeting, we will conduct a psychological evaluation/intake to help determine whether you are a good match for the group and vice versa. This evaluation may involve psychological testing.

3. There will be three 12-week modules, entitled "Distress Tolerance," "Emotion Regulation," and "Interpersonal Effectiveness." The full program will last approximately 9-10 months, including one to two week breaks between each module.

4. We will notify you of the date of the first session for the next module. We reserve the right to change meeting times as necessary, but will give as much notice as possible should this become necessary.

PROFESSIONAL FEES, BILLING, AND PAYMENT:

1. The fee for the initial evaluation and for every 1.5 to 2 hour weekly meeting is $75.00.

2. The DBT group is self-pay only. We will not file your insurance for reimbursement. If you have insurance with mental health benefits, by signing this consent form you agree to voluntarily forfeit insurance reimbursement for session fees, even if one of the group facilitators (Dr. Stephanie Ezust or Dr. Melanie Bliss) are in-network providers for your insurance.

3. You are eligible for ONE "free" session per 12-session module should you be absent. You are required to pay for all sessions that you attend. **If you are absent more than one session during a 12-session module, you will be expected to pay for missed sessions.**

4. If you become involved in legal proceedings that require participation by one or both of us, you will be expected to pay for all of our professional time, including preparation and transportation costs, even if we are called to testify by another party. Because of the difficulty of legal involvement, we each charge $250 per hour for attendance at any legal proceeding including court testimony and depositions.

5. You will be expected to pay for each session at the time it is held through cash or check, unless we agree otherwise.

6. Returned checks will be assessed a $15 office administrative fee as well as any bank charges.

7. If your account is more than ninety days in arrears and suitable arrangements for payment have not been agreed to, we have the option of using legal means to secure payment, including collection agencies or small claims court. If such legal action is necessary, the costs of bringing that proceeding will be included in the claim. In most cases, the only information we release about a client's treatment would be the client's name and address, the nature of the services provided, and the amount due.

CONTACT INFORMATION:

1. We are often not immediately available by telephone. The hours that we are in the office vary, and we are not available to answer phone calls when with a client. When we are unavailable, our respective telephones will be answered by voice mail, which we check regularly.

2. For non-emergencies, we will make every effort to return your call as soon as possible. If you are difficult to reach, please leave times when you will be available.

3. **<u>If it is an emergency, your first course of action is to contact your individual therapist</u>**. If you cannot reach your individual therapist or one of us, you should call your family physician or the emergency room at the nearest hospital and ask for the psychologist or psychiatrist on call.

LIMITS ON CONFIDENTIALITY:

The law protects the privacy of all communications between a patient and a psychologist. You will be participating in a GROUP SETTING in which other patients will be present. Group rules and expectations require that you maintain confidentiality for every patient in the group and that nothing that is stated in group is repeated outside of group, nor is any identifying information provided to anyone outside of group about a group member. However, by signing this agreement, you acknowledge that we cannot guarantee confidentiality by other group members and that you take a risk by participating in this group that someone may break confidentiality.

In most situations, we can release information about your treatment to others only if you sign a written Authorization form that meets certain legal requirements imposed by HIPAA. There are other situations that require only that you provide written, advance consent. Your signature on this Agreement provides consent for those activities, as follows:

1. We may find it helpful to consult other professionals about a case. In particular, we will be consulting with other DBT therapists and with your individual therapist. With the exception of speaking to your individual therapist, during a consultation, we will make every effort to avoid revealing your identity. The consultant is legally bound to keep the information confidential. Unless you object, we will not tell you about these consultations unless we feel that it is important to our work together. We will note all consultations in your Clinical Record (which is called "PHI" in the "Georgia Notice Form: Notice of Psychologist's Policies and Practices to Protect the Privacy of Your Health Information" which you have been provided).

2. Dr. Ezust employs a billing person and it may be necessary for her to share protected information with this individual for both clinical and administrative purposes, such as scheduling, billing and quality assurance. All mental health professionals are bound by the same rules of confidentiality. 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. At this time, Dr. Bliss does not employ any administrative staff.

3. Disclosures required by health insurers or to collect overdue fees are discussed elsewhere in this Agreement.

4. If a patient threatens to harm himself/herself, we may be obligated to seek hospitalization for him/her or to contact family members or others who can help provide protection.

There are some situations where we are permitted or required to disclose information without either your consent or Authorization:

1. If you are involved in a court proceeding and a request is made for information concerning one of our professional services, such information is protected by the psychologist-patient privilege law. We cannot provide any information without your written authorization, or a court order. If you are involved in or contemplating litigation, you should consult with your attorney to determine whether a court would be likely to order one of us to disclose information.

2. If a government agency is requesting the information for health oversight activities, we may be required to provide it for them.

3. If a patient files a complaint or lawsuit against either of us, we may disclose relevant information regarding that patient in order to defend myself.

There are some situations in which we are legally obligated to take actions if we believe it is necessary to attempt to protect others from harm. In this case, we may have to reveal some information about a patient's treatment.

1. If we believe that a child has been abused, the law requires that one of us file a report with the appropriate governmental agency, usually the Department of Human Resources (Department of Family and Children Services). Once such a report is filed, one of us may be required to provide additional information. In addition, the Georgia Child Endangerment Law requires that one of us report to the appropriate governmental agency, usually the Department of Human Resources (Department of Family and Children Services) if we are made aware of a child witnessing acts of violence between adults.

2. If we have reasonable cause to believe that a disabled adult (of any age) or elder person (over 65 years) has had a physical injury or injuries inflicted upon such disabled adult or elder person, other than by accidental means, or has been neglected or exploited, we must report to an agency designated by the Department of Human Resources. Once such a report is filed, we may be required to provide additional information.

3. If we determine that a patient presents a serious danger of violence to another, we may be required to take protective actions. These actions may include notifying the potential victim, and/or contacting the police, and/or seeking hospitalization for the patient.

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.

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, and we are not attorneys. In situations where specific advice is required, formal legal advice may be needed.

PROFESSIONAL RECORDS

The laws and standards of our profession require that we keep Protected Health Information about you in your Clinical Record. You may examine and/or receive a copy of your Clinical Record if you request it in writing, except in unusual circumstances that involve 1) danger to yourself and others, 2) that make reference to another person (unless such other person is a health care provider) and we believe that access is reasonably likely to cause substantial harm to such other person or 3) where information has been supplied to us confidentially by others. Because these are professional records, they can be misinterpreted and/or upsetting to untrained readers. For this reason, we recommend that you initially review them in our presence, or have them forwarded to another mental health professional so you can discuss the contents. In most situations, we are allowed to charge a copying fee of $1.00 per page (and for certain other expenses). If we refuse your request for access to your records, you have a right of review (except for information provided to me confidentially by others), which we will discuss with you upon request.

REQUEST FOR CONFIDENTIAL HANDLING OF HEALTH INFORMATION

All reasonable requests to receive communication of your health information will be granted (i.e., telephone, mail). If you wish to receive protected health information in one particular manner, please indicate that to me in writing. Otherwise, we will leave messages at the phone numbers you provide and send mail to the mailing address you have indicated. If there is an alternative mailing address that you would like us to use (for example, some people prefer that we send mail ONLY to a P.O. box or to their work address), or a specific phone number that you want us to use, than please indicate that as well. Otherwise, your signature

below indicates that we may notify you at any of the phone numbers and/or addresses that you have provided.

PATIENT RIGHTS

HIPAA provides you with several rights with regard to your Clinical Record and disclosures of protected health information. These rights include requesting that we 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 protected information disclosures are sent; having any complaints you make about our policies and procedures recorded in your records; and the right to a paper copy of this Agreement, the attached Notice form, and our privacy policies and procedures.

YOUR SIGNATURE BELOW INDICATES THAT:

1. You have read this agreement
2. You agree to its terms
3. You acknowledge that you have read the HIPAA "Georgia Notice Form" described above

____
Print Name - Patient

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Patient Signature

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Date

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Stephanie L. Ezust, Ph.D.

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Melanie J. Bliss, Ph.D.

Rev. 01/09