Marian R. Zimmerman, Ph.D.
Clinical Health Psychology
www.mzpsychology.com
3550 Parkwood Blvd., 306 *(214)618-1451 Phone*
Frisco, TX 75034 *(214)618-2102 Fax*

Psychological Services Agreement

Welcome! Please read the following information regarding the services and policies pertaining to this office. You are encouraged to bring any questions to your next meeting and to request clarification as needed at any time.

SERVICES
Individual psychological services are provided to adult patients through this office. Cognitive Behavioral Therapy is the primary method of treatment which is used to assist patients examine and modify their thinking and behavior in order to feel differently and achieve their goals. Treatment involves setting clear goals and the completing tasks outside of the sessions to facilitate and expedite change. You will work with Dr. Zimmerman to clearly define these goals, which will then be used to design an individualized Plan of Care that will serve as a roadmap for the course of your therapy.

POTENTIAL RISKS AND BENEFITS
Like any healthcare service, no guarantee can be made about the outcome of psychological therapy. Treatment may bring to light uncomfortable or undesired feelings and it can seem like you feel worse before you feel better. This is a normal part of the process and you are encouraged to discuss this in your sessions. Of course, there are also many potential benefits including reduced distress, new skills or techniques, decreased stress and worry, improved quality of life, and better relationships.

SERVICES
Sessions are generally 45-60 minutes long, typically every week or every other week, but may occur more or less frequently depending on your individual needs. Appointments are reserved for you each time you visit. This time is kept for you will not be filled by another patient. Once a session is scheduled, you will be expected to keep your appointment unless you provide 24 hours advance notice of cancellation. **Appointments not canceled 24 hours prior to the scheduled session will be charged $50.00 to the individual.** (Insurance will not pay for missed sessions). If a patient misses two consecutive scheduled sessions, the patient will be considered to have given notice of termination of therapy.

TELEPHONE ACCESSIBILITY & EMERGENCIES
Due to my work schedule I may not be immediately available by telephone and will generally not answer the phone when I am with a patient. My phone is answered by an office staff member during regular business hours and by a voicemail system evenings, weekends, and holidays. The staff can schedule appointments and relay messages to me. I will return your call at the first opportunity. In case of an emergency, you may contact the Suicide and Crisis Center of North Texas Hotline at 214-828-1000 or go to your nearest emergency room.

OTHER FORMS OF COMMUNICATION
I do not communicate with patients via **email or text.** These forms of communication are less secure and your privacy cannot be guaranteed. Please use discretion in deciding whether to communicate with me via email. I cannot be held responsible for any information lost in transit or viewed by a third party. Emergencies, therapeutic issues, sensitive personal information, and scheduling should all be communicated to me or the office staff over the telephone or in person.

PROFESSIONAL FEES AND PAYMENTS
My standard fee for psychological services is $150.00 per 45-60 minute session. Initial evaluations may have an additional fee for testing, interpreting results, and report writing. This fee includes consultations with other professionals, if needed, to coordinate your care (i.e. psychiatrist, physician, previous therapist). **Payment is due in full at each session.** Cash and credit cards are accepted. Insurance payments are not accepted by this office. I will provide you with a receipt for services, which you may submit to your insurance company to request reimbursement for services. After 60 days, unpaid balances may be turned over to a collections agency or attorney to collect payment. In such situations, only the minimum amount of information needed to collect payment will be provided. By signing this agreement, you authorize me to employ the services of an outside collection agency or attorney to seek payment of all unpaid fees.

CONFIDENTIALITY
The confidentiality of our communications is generally protected by law. In order for me to provide information to a third party at your request, your written permission is required. You will be asked complete a Release of Information form for each person or entity I share information with.

Legal exceptions to the confidentiality of your information are as follows:

- Active or suspected abuse (physical, emotional, or sexual) or neglect of a child, an elder, or a dependent adult must be reported to the appropriate protective services.
- If the patient shows serious intent to harm themselves, I must take action to maintain their safety. This may include hospitalization or law enforcement intervention.
- If a patient threatens serious bodily harm to another person, I may be required to take protective actions such as notifying the potential victim, contacting law enforcement, or hospitalization.
- Sexual abuse of a patient by a mental health professional must be reported.
- Court ordered testimony or release of records.

Occasionally, I may find it beneficial to consult with other professionals about a case. Consultations do not include the identifying information about the patient and the consultant is also legally bound to keep information confidential. Unless you object, I will not tell you about these consultations unless it is helpful in our work together.

My administrative staff 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.

PROFESSIONAL RECORDS

The laws and standards of my profession require that we keep Protected Health Information about you in your clinical record. The clinical record includes information about your reasons for seeking therapy, a description of the ways in which the problem impacts on your life, the diagnosis, the goals that we set for treatment, progress towards those goals, medical and social history, treatment history, any past treatment records that we receive from other providers, reports of any professional consultations, billing records, and any reports that have been sent to anyone. Except in unusual circumstances that involve danger to yourself and/or others or when there is a need to protect the integrity of a test we administered, you may examine and/or receive a copy of your clinical record, upon written request. You should be aware that pursuant to Texas law, psychological test data are not part of a patient's record. Because these are professional records, they can be misinterpreted and/or upsetting to untrained readers, I recommend you either review them in my presence so that we can discuss the contents or have them forwarded directly to another mental health professional. In most circumstances, I charge a copying fee of $0.50 per page.

In addition, I may also keep a set of psychotherapy notes. These notes are for my own use and are designed to assist me in providing you with the best treatment. While the contents of psychotherapy notes vary from client to client, they can include the contents of our conversations, my analysis of those conversations, and how they impact your therapy. They also contain particularly sensitive information that you may reveal to me that is not required to be included in your clinical record. These psychotherapy notes are kept separate from your clinical record. You may examine and/or receive a copy of your psychotherapy notes unless we determine that release would be harmful to your physical, mental or emotional health. If you become involved in litigation, be advised that these psychotherapy notes may be subject to release to other parties pursuant to a valid subpoena or court order.

PATIENT RIGHTS

You have the right to:

- Ask questions about the process and course of therapy.
- Voice your concerns or complaints to me about our work together or contact the Texas State Board of Examiners of Psychologists about unethical treatment by a psychologist.
- Decide not to receive treatment from me. I can provide you with referrals to other professionals.
- End therapy at any time. I do request that you inform me of this decision, and if possible allow time to wrap-up and provide some closure.
- Expect that I will maintain appropriate professional and ethical boundaries. This includes not acknowledging you in public or entering into any other type of relationship with you (personal, financial, professional, etc.) in order to maintain the privacy and integrity of our work together. If for some reason such a situation cannot be avoided, we will discuss this together.

I have read and understand this Agreement, and my questions have been answered. I agree to the terms of this Agreement, as indicated by my signature below. I also acknowledge that I have received the Notice of Psychologists' Policies and Practices to Protect the Privacy of Your Health Information. This notice is also available at www.mzpsychology.com/forms

_____ _____

Patient Date

Marian R. Zimmerman, Ph.D.
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Financial Policy

I am committed to providing you with the best care possible. This goal is best achieved if everyone is aware of my policies. Your clear understanding of my financial policy is important to our professional relationship. Everyone is treated equally and fairly.

PROFESSIONAL FEES AND PAYMENTS
My standard fee for psychotherapy services is $150.00 per 45-60 minute session. Initial evaluations may have an additional fee for testing, interpreting results, and report writing. My fee for psychological testing services (such as pre-surgical evaluations) is $150.00 per hour of psychological testing, including test administration, scoring, interpretation, and report writing. This fee includes consultations with other professionals, if needed, to coordinate your care (i.e. psychiatrist, physician, previous therapist). **Payment for services is due at each session.** "Payment" includes deductibles, co-insurance, and co-pays for participating insurance companies. Cash and credit cards are accepted.

If I am a network provider with your insurance company, I will submit a claim to your insurance company for payment. Any services not paid by your insurance carrier for whatever reason within 90 days will become your responsibility. Although I verify your insurance benefits, insurance plans vary considerably and I cannot predict or guarantee what part of my services will or will not be covered. It is your responsibility to know your insurance benefits. It is your responsibility to inform my office of either new insurance or any change in your current policy. If the new insurance information is not provided and verified 24 hours prior to your appointment, you will be responsible for the charges for that date of service and any subsequent appointments.

If I am not a network provider with your insurance company, I will provide you with a receipt for services, which you may submit to your insurance company to request reimbursement.

All personal balances over 120 days will be sent to a collection agency. In such situations, only the minimum amount of information needed to collect payment will be provided. By signing this agreement, you authorize me to employ the services of an outside collection agency or attorney to seek payment of all unpaid fees.

There will be a charge of $50.00 for no shows and appointments cancelled with less than 24 hours notice. There will be a charge of $25.00 for completing disability, medical leave, or other similar forms.

ASSIGNMENT AND RELEASE
I hereby authorize my insurance benefits be paid directly to Marian R. Zimmerman, Ph.D. I understand that I am financially responsible for non-covered services. I also authorize Marian R. Zimmerman, Ph.D. to release information required in the processing of insurance claims. I have read and fully understand the financial policy set forth by this office. I understand and agree that the terms of this financial policy may be amended by the practice at any time without prior notification to me.

Patient/Legal Representative _____ Date _____

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AUTHORIZATION FOR RELEASE OF MENTAL HEALTH INFORMATION

I hereby authorize Marian Zimmerman, Ph.D. to disclose the individually identifiable health information as described below, which may include psychotherapy notes. I understand that this authorization is voluntary and I may refuse to sign this authorization. I further understand that my health care and the payment for my health care will not be affected if I do not sign this form. I also understand that if I do not sign this form, federal and state law will prohibit Dr. Zimmerman from releasing records regarding her treatment of me/my child to the designated Recipient.

I understand that if the recipient is authorized to receive the information is not a covered entity, e.g. insurance company or health care provider, the released information may no longer be protected by federal and state privacy regulations.

_____

Print Patient Name Date of Birth Social Security Number

Date(s) of service (if known): _____

Description of information to be released: (check all that apply)

_____ Entire Record _____ Evaluation Reports
_____ Billing Records _____ Consultation Notes
_____ Psychotherapy Notes
_____ Other: _____

Description of the purpose of the use and/or disclosure: _____
_____

The individually identifiable health information described herein shall be released to:
_____
_____

I intend for this Authorization to remain in full force and effect until I revoke it in writing. Further, it is my intent that a copy of this Authorization shall have the same effect as the original.

I further understand that I may revoke this authorization at any time by notifying Dr. Zimmerman in writing at 3550 Parkwood Blvd, Suite 306, Frisco, TX 75034. I also understand that the written revocation must be signed and dated with a date that is later than the date on this authorization. The revocation will not affect any actions taken before the receipt of the written revocation.

_____ _____
Signature of Client or Client's Representative Date

_____
Printed Name of Client or Client's Representative

_____ or _____
Relationship to Client Legal Authority (attach documentation)

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Notice of Privacy Practices

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

If you have any questions about this Notice of Privacy Practices, please contact our Privacy Officer.

INTRODUCTION

We are required by law to maintain the privacy of Protected Health Information ("PHI"), to provide individuals with notice of our legal duties and privacy practices with respect to PHI, and to notify affected individuals following a breach of unsecured PHI. PHI is information that may identify you and that relates to your past, present or future physical or mental health or condition and relates to the provision of health care or payment for the provision of health care for your past, present or future physical or mental health or condition and related healthcare services. This Notice of Privacy Practices ("Notice") describes how we may use and disclose PHI to carry out treatment, obtain payment or perform our health care operations and for other specified purposes that are permitted or required by law. The Notice also describes your rights with respect to PHI about you.

We are required to follow the terms of this Notice currently in effect. We will not use or disclose PHI about you without your written authorization, except as described in this Notice. We reserve the right to change our practices and this Notice and to make the new Notice effective for all PHI we maintain. Upon request, we will provide any revised Notice to you.

OUR PLEDGE

The privacy of your personal health information (PHI) is important to us. Your PHI includes, but is not limited to, medical, dental, pharmacy, and mental health information. This Notice describes our privacy practices. Our privacy practices must be followed by all of our employees and staff. This Notice tells you about the ways in which we may use and disclose your PHI. Also described are your rights and certain obligations we have regarding the use and disclosure of your PHI. We use and disclose your PHI in compliance with all applicable state and federal laws.

HOW PHI ABOUT YOU MAY BE USED AND DISCLOSED

The following categories describe different ways that we use and disclose PHI. For each category of use or disclosure, an explanation of what is meant and some examples are provided. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose PHI will fall within one of the categories.

- **For Treatment.** We may use or disclose your health information to provide and coordinate the mental health treatment and services you receive. For example, if your mental health care needs to be coordinated with the medical care provided to you by another physician, we may disclose your health information to a physician or other healthcare provider.
- **For Payment.** We may use and disclose your health information for various payment-related functions, so that we can bill for and obtain payment for the treatment and services we provide for you. For example, your PHI may be provided to an insurance company so that they will pay claims for your care.
- **For Healthcare Operations.** We may use and disclose your health information for certain operational, administrative and quality assurance activities, in connection with our healthcare operations. These uses and disclosures are necessary to run the practice and to make sure that our patients receive quality treatment and services. For example, healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.
- **For Special Purposes.** We are permitted under federal and applicable state law to use or disclose your PHI without your permission only when certain circumstances may arise.

We are likely to use or disclose your PHI without your permission for the following purposes:

- **Individuals Involved in Your Care or Payment for Your Care**. We may disclose PHI to a close personal friend or family member who is involved in your medical care or payment for your care.
- **Disclosures to Parents or Legal Guardians.** If you are a minor, we may release your PHI to your parents or legal guardians when we are permitted or required under federal and applicable state law.
- **Worker's Compensation.** We may disclose your PHI to the extent authorized by and necessary to comply with laws relating to worker's compensation or other similar programs established by law.
- **Public Health.** We may disclose your PHI to federal, state, or local authorities, or other entities charged with preventing or controlling disease, injury, or disability for public health activities.
- **Health oversight activities:** We may disclose your PHI to an oversight agency for activities authorized by law. These oversight activities include audits, investigations, and inspections, as necessary for our licensure and for government monitoring of the health care system, government programs, and compliance with federal and applicable state law.
- **Law Enforcement.** We may disclose your PHI for law enforcement purposes as required by law or in response to a court order, subpoena, warrant, summons, or similar process; to identify or locate a suspect, fugitive, material witness, or missing person; about a death resulting from criminal conduct; about crimes on the premises or against a member of our workforce; and in emergency circumstances, to report a crime, the location, victims, or the identity, description, or location of the perpetrator of a crime.

- **Judicial and administrative proceedings.** If you are involved in a lawsuit or a legal dispute, we may disclose your PHI in response to a court or administrative order, subpoena, discovery request, or other lawful process.
- **United States Department of Health and Human Services**. Under federal law, we are required to disclose your PHI to the U.S. Department of Health and Human Services to determine if we are in compliance with federal laws and regulations regarding the privacy of health information.
- **Research.** Under certain circumstances, we may use or disclose your PHI for research purposes. However, before disclosing your PHI, the research project must be approved by an institutional review board or privacy board that has reviewed the research proposal and established protocols to ensure the privacy of your PHI.
- **Coroners, medical examiners, and funeral directors.** We may release your PHI to assist in identifying a deceased person or determine a cause of death.
- **Organ or tissue procurement organizations**. Consistent with applicable law, we may disclose your PHI to organ procurement organizations or other entities engaged in the procurement, banking, or transplantation of organs for the purpose of tissue donation and transplant.
- **Notification.** We may use or disclose your PHI to assist in a disaster relief effort so that your family, personal representative, or friends may be notified about your condition, status, and location.
- **Correctional institution**. If you are or become an inmate of a correctional institution, we may disclose to the institution or its agents PHI necessary for your health and the health and safety of others.
- **To Avert a Serious Threat to Health or Safety.** We may use and disclose your PHI to appropriate authorities when necessary to prevent a serious threat to your health and safety or the health and safety of another person or the public. We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes.
- **Military and Veterans.** If you are a member of the armed forces, we may release your PHI as required by military command authorities. We may also release PHI about foreign military personnel to the appropriate military authority.
- **National Security, Intelligence Activities and Protective Services for the President and Others.** We may disclose your PHI to authorized federal officials for intelligence, counterintelligence, provision of protection to the President, other authorized persons or foreign heads of state, and other national security activities authorized by law.
- **As required by law.** We must disclose your PHI when required to do so by applicable federal or state law.
- **Treatment Alternatives**. We may use and disclose PHI to tell you about or recommend possible alternative treatments, therapies, health care providers, or settings of care that may be of interest to you.
- **Health-Related Benefits and Services**. We may use and disclose PHI to tell you about health-related benefits or services that may be of interest to you.
- **Appointment Reminders.** We may use or disclose PHI to provide you with appointment reminders (such as voicemail messages, postcards, or letters). You have a right, as explained below, to request restrictions or limitations on the PHI we disclose. You also have a right, as explained below, to request that information be communicated with you in a certain way or at a certain location.

Other Uses and Disclosures of PHI

Your Authorization. We will obtain your written authorization before using or disclosing your PHI for purposes other than those described above (or as otherwise permitted or required by law). If you give us an authorization, you may revoke it by submitting a written notice to our Privacy Officer at the address listed below. Your revocation will become effective upon our receipt of your written notice. If you revoke your authorization, we will no longer use or disclose health information about you for the reasons covered by the written authorization. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

Psychotherapy Notes. We will not use or disclose psychotherapy notes without your written authorization, and only as permitted by law.

Marketing Health-Related Services. We will not use or disclose your protected health information for marketing communications without your written authorization, and only as permitted by law.

Sale of PHI. We will not sell your protected health information without your written authorization, and only as permitted by law.

CHANGES TO THIS NOTICE

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changed Notice effective for all health information that we maintain, including health information we created or received before we made the changes. When we make a change in our privacy practices, we will change this Notice and make the new Notice available to you.

YOUR HEALTH INFORMATION PRIVACY RIGHTS

You have privacy rights under federal and state laws that protect your health information. These rights are important for you to know. You can exercise these rights, ask questions about them, and file a complaint if you think that your rights are being denied or your health information is not being protected. Providers and health insurers who are required to follow federal and state privacy laws must comply with the following rights:

To Request Restrictions on Certain Uses and Disclosures of PHI. You have the right to request restrictions on our use or disclosure of your PHI by sending a written request to the Privacy Office. We are not required to agree to those restrictions. We cannot agree to restrictions on uses or disclosures that are legally required, or which are necessary to administer our business. We must agree to the request to restrict disclosure of PHI to a health plan if the disclosure is for the purpose of carrying out payment or health care

operations and is not otherwise required by law, and the PHI pertains solely to a health care item or service for which you, or another individual other than a health plan on behalf of you, has paid us in full.

To Request Confidential Communications. You have the right to request that PHI be communicated to you by alternative means or at alternative locations. For example, you can ask that you only be contacted at work or by mail. We will accommodate all reasonable requests.

To Access PHI. You have the right of access to inspect and obtain a copy of your PHI. You may not be able to obtain all of your information in a few special cases. For example, if your treatment provider determines that the information may endanger you or someone else. In most cases, your copies must be given to you within thirty (30) days, but may be extended for another thirty (days) if you are given a reason by us in writing. We may charge you a fee for the costs of copying, mailing and supplies that are necessary to fulfill your request.

In accordance with Texas law, you have the right to obtain a copy of your PHI in electronic form for records that we maintain using an Electronic Health Records (EHR) system capable of fulfilling the request. Where applicable, we must provide those records to you or your legally authorized representative in electronic form within fifteen (15) days of receipt of your written request and a valid authorization for electronic disclosure of PHI. You may request a copy of an authorization from the Privacy Office at the address below.

To Obtain a Paper Copy of the Notice Upon Request. You may request a copy of our current Notice at any time. Even if you have agreed to receive the Notice electronically, you are still entitled to a paper copy. You may obtain a paper copy from the Privacy Office at the address below. A reasonable fee may be charged for the costs of copying, mailing or other supplies associated with your request.

To Request an Amendment of PHI. If you feel that PHI we have about you is incorrect or incomplete, you may request an amendment to the information. Requests must identify: (i) which information you seek to amend, (ii) what corrections you would like to make, and (iii) why the information needs to be amended. We will respond to your request in writing within 60 days (with a possible 30-day extension). In our response, we will either: (i) agree to make the amendment, or (ii) inform you of our denial, explain our reason, and outline appeal procedures. If denied, you have the right to file a statement of disagreement with the decision. We will provide a rebuttal to your statement and maintain appropriate records of your disagreement and our rebuttal.

To Receive an Accounting of Disclosures. You have the right to request an accounting of your PHI disclosures for purposes other than treatment, payment or healthcare operations. Your request must state a time period. The time period for the accounting of disclosures must be limited to less than 6 years from the date of the request. We will respond in writing within 60 days of receipt of your request (with a possible 30-day extension). We will provide an accounting per 12-month period free of charge, but you may be charged for the cost of any subsequent accountings. We will notify you in advance of the cost involved, and you may choose to withdraw or modify your request at that time.

To Notification in the Event of a Breach. You have a right to be notified of an impermissible use or disclosure that compromises the security or privacy of your PHI.
We will provide notice to you as soon as is reasonably possible and no later than sixty (60) calendar days after discovery of the breach and in accordance with federal and state law.

To File a Complaint. If you believe your privacy rights have been violated, you may file a complaint with our privacy officer, listed below. You may also file a complaint directly with any or all of the following federal and state agencies: the Secretary of the Department of Health and Human Services, the Office of the Attorney General of Texas, or the Texas State Board of Examiners of Psychologists. We will provide you with the addresses to file your complaint with the Secretary, the Office of the Attorney General of Texas or the applicable Board of the Texas State Board of Examiners of Psychologists upon request. You will not be penalized in any way for filing a complaint. However, if you file a complaint, we may be required by our ethical rules and code of conduct to terminate our professional services with you and refer you to other providers.

If you want more information about our privacy practices or have questions or concerns, please contact us.

Privacy Officer:

Marian R. Zimmerman, Ph.D.
3550 Parkwood Blvd., Suite 306
Frisco, TX 75034
Telephone: (214) 618-1451
Facsimile: (214) 618-2102

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Patient Name: _____

I have been given a copy of Dr. Marian R. Zimmerman's Notice of Privacy Practices ("Notice"), which describes how my health information is used and shared. I understand that Dr. Zimmerman has a right to change this Notice at any time. I may obtain a current copy by contacting the practice's Privacy Officer, or by visiting Dr. Zimmerman's website at: www.mzpsychology.com.

My signature below acknowledges that I have been provided with a copy of the Notice of Privacy Practices.

_____ _____
Signature of Patient or Personal Representative Date

_____
Print Name

_____
Personal Representative's Title
(e.g. guardian, executor of estate, health care power of attorney

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For practice use only: Complete this section if you were unable to obtain a signature.

If patient or personal representative is unable or unwilling to sign this Acknowledgement, or the Acknowledgement is not signed for any other reason, state the reason:

_____

Describe the steps taken to obtain the patient's or personal representative's signature on the Acknowledgement:

_____

_____

Completed by:

_____ _____
Signature of Practice Representative Date

_____
Printed Name