Lydia C. Richardson, PsyD
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Chicago, IL 60601
(646) 481-5516 Phone or text
DrLydia@richardsonpsyd.com

Thank you for choosing me to provide you with assistance. I am looking forward to our work together.

This registration packet contains the paperwork needed to begin treatment, including the Client Agreement, the Notification of Privacy Practices, and the Signature Form for you to read carefully.

Please print out this entire packet, sign where indicated on Page 11, and bring it with you to our first session.

I appreciate your willingness to do this paperwork before we meet. It allows us to start our first session immediately with an evaluation of your problems and needs. If you have any questions, feel free to email or call. I am looking forward to meeting you in person soon.

CLIENT AGREEMENT DOCUMENT

This document contains important information about my professional services and business policies. Please read it carefully and jot down any questions you might have so that we can discuss them at our next meeting. When you sign the form associated with this document, it will represent an agreement between us. The Notice of Privacy Practices (NPP), as required by the Health Insurance Portability and Accountability Act (HIPAA), supplements this information.

PSYCHOLOGICAL SERVICES

I am a licensed clinical psychologist who provides mental health care services to clients in an independent private practice. My style of therapy is supportive, practical, and solution-oriented. I help clients learn skills to cope with stresses, manage troublesome feelings, and improve relationships.

Psychotherapy is not like a medical doctor visit. In order for the therapy to be successful, you (or your child, if she/he is the primary recipient of services) will have to work on things we talk about both during our sessions and at home.

Psychotherapy can have benefits and risks. Specifically, therapy often leads to better relationships, solutions to specific problems, and significant reductions in feelings of distress. Many carefully designed research studies document that it is effective, and have found that most clients display significant improvement within 12 to 18 sessions. On the other hand, because therapy sometimes involves discussing unpleasant aspects of life, clients may experience uncomfortable feelings like sadness, guilt, anger, frustration, loneliness, and embarrassment. There are no guarantees of what you will experience because results can vary depending on the individual and their circumstances.

Our initial 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 and a treatment plan to follow, if you decide to continue with therapy. You should evaluate this information along with your own opinions of whether you feel comfortable working with me. Therapy involves a commitment of time, money, and energy, so you should be careful about the therapist you select. If you have questions, we should discuss them whenever they arise.

MEETINGS

I normally conduct an evaluation that will last 1 or 2 sessions. During this time, we can both decide if I am the best person to provide the services you need in order to meet your treatment goals. If psychotherapy is begun, I will usually schedule one 50 to 55-minute session per week.

Once an appointment hour is scheduled, you will be expected to pay for it unless you provide 48 hours advance notice of cancellation (unless I feel that you were unable to attend due to very unusual circumstances beyond your control). ***In such event, a late cancellation charge of $125 will automatically be applied to your account***. ***If you fail to show for a scheduled appointment a $175 missed appointment charge will be automatically applied to your account.*** Please note that insurance companies will not reimburse you for late cancellation or no show charges. Because I am committed to providing effective services, I will need to discuss

and decide whether I can continue to provide you with therapy if you have repeated cancellations or do not attend your scheduled appointments.

PROFESSIONAL FEES

My fees are listed in a separate document at the end of this file. In addition to weekly appointments, I charge for other services including letter or report writing, telephone conversations with you or others you have authorized lasting longer than 5 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.

BILLING AND PAYMENTS

You will be expected to pay in full for each session at the time it is held. I accept payment by checks, credit/debit cards (Visa, MasterCard, American Express, and Discover) or cash. In the event of a returned check due to insufficient funds, there will be a $25 charge plus any incurred bank fees that will be added to your account. From then on, only credit/debit cards or cash will be accepted. Outstanding balances may not exceed the charges for two sessions for the continuation of ongoing services. If your account has not been paid for more than 60 days and arrangements for payment have not been agreed upon, I have the option of using legal means to secure payment. This may involve hiring a collection agency or going through small claims court. If such legal action is necessary, its costs will be included in the claim. In most collection situations, the only information I release regarding a patient's treatment is his/her name, the nature of services provided, and the amount due.

INSURANCE INFORMATION

In terms of insurance, I am contracted with Blue Cross Blue Shield Illinois PPO (BSBS-IL PPO), Medicare, and Cigna as an "in network" provider of services. This contract also includes some of the BCBS PPO related networks, but not all of them. You can use the BCBS-IL website using their "Find a Doctor" search to see whether I am in network for your specific plan and product. For those clients with BCBS PPO, Medicare, or Cigna as their primary plan for insurance, I will fill out and electronically submit forms on your behalf and will help you receive the benefits to which you are entitled. However, *you* (not your insurance company) are responsible for payment of my fees. This is especially important to remember for claims that your insurance company denies or for which your insurance company delays payment for longer than 60 days. It is also important that you find out exactly what mental health services your insurance policy covers and to verify that I am an in-network provider with your specific plan. Sometimes employers or insurance companies subcontract with a completely different insurance company for mental health benefits, so this verification is especially important. Please be sure to let me know if your address or insurance plan changes during the course of treatment as well. In all other instances (including when BCBS-IL is your secondary plan for insurance), I am considered an out-of-network provider of services. Some insurance companies may still reimburse you for a certain percentage of the costs when you work with an out-of-network psychologist, but the amount depends entirely on the terms of your policy. In these situations, clients pay me in full at the time of service and then may receive a check in the mail from their insurance company for whatever amount that the insurance company determines after they process the claim. If you have questions about the coverage, call your plan administrator. 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 it is necessary to clear confusion, I will be willing to call the company on your behalf with your consent. For many out-of-network plans, I can submit the claim electronically for you to reduce your paperwork and to speed your possible reimbursement. Regardless, I will provide you with a detailed bill of services each week, and you may choose to submit this to your insurance company for reimbursement on your own. You should also be aware that your contract with your health insurance company requires that you authorize me to provide it with information relevant to the services that I provide to you. If you are seeking reimbursement for services under your health insurance policy, you will be required to sign an authorization that allows me to provide such information. I am required to provide a clinical diagnosis. On rare occasions, I am required to provide additional clinical information such as treatment plans or summaries, or copies of your entire Clinical Record. In such situations, I will release only the minimum information about you that is necessary for the purpose requested. This information will become part of insurance company files and I have no control over what they do once it is in their possession.

CONTACTING ME

Due to my work schedule, I am not always immediately available by telephone. When I am unavailable, my telephone is directed to voice mail that I monitor frequently. I will make every effort to return your call on the same day you make it, with the exception of holidays and weekends. If you are difficult to reach, please inform me of some times when you will be available. In emergencies that may result in harm to yourself or someone else, call 911, contact your physician, the nearest emergency room, or a 24-hour crisis number **773-296-5380** and ask for a crisis worker. If I will be unavailable for an extended time I will provide you with the name of a colleague to contact if necessary.

PROFESSIONAL RECORDS

The laws and standards of my profession require that I keep records. You are entitled to receive a copy of your records, or I can prepare a summary for you instead. Because these are professional records, they can be misinterpreted and/or upsetting to untrained readers. If you wish to see your records, I recommend that you review them in my presence so that we can discuss the contents or have them forwarded directly to another health professional with an appropriately completed authorization form.

PHYSICIAN VISIT SUGGESTION

I routinely suggest that clients schedule a visit with their physician when working with me. Some medical conditions relate to psychological symptoms (e.g., thyroid disease is sometimes associated with mood and anxiety symptoms), so it is prudent to rule them out through a physical exam with your doctor. I will also ask you to authorize me to exchange information with other care providers so as to be able to provide you with the most informed care.

CONFIDENTIALITY

The law protects the privacy of all communications between a patient and a psychologist. In most situations, I can only release information about you (or your child) to others if you sign an Authorization Form. When treatment involves work with multiple people (like couples therapy or family therapy), consent of all adults may be needed on the Authorization Form before I am able

to release information. However, authorization is not required in situations in which I am legally obligated to act:

• If I have reasonable cause to believe that a child under 18 known to me in my professional capacity may be an abused or neglected child, Illinois law requires that I file a report with the office of the Department of Children and Family Services.

• If I have reason to believe that an adult over the age of 60 living in a domestic situation has been abused or neglected in the preceding 12 months, Illinois law requires that I file a report with the agency designated to receive such reports by the Department of Aging.

• If you have made a specific threat of violence against another or if I believe that you present a clear, imminent risk of serious physical harm to another, I may be required to disclose information in order to take protective actions. These actions may include notifying the potential victim, seeking hospitalization, contacting the police, or notifying the DHS FOID mental health reporting system regarding firearms.

• If I believe that you present a clear, imminent risk of serious physical or mental injury or death to yourself, I may be required to disclose information in order to take protective actions. These actions may include seeking your hospitalization or contacting family members or others who can assist in protecting you. If such a situation arises, I will make every effort to discuss it with you before taking any action, as appropriate, and I will limit my disclosure to what is necessary.

Very occasionally, I find it helpful to consult other professionals about a case. During a consultation, I avoid revealing the identity of my patient. The consultant is also legally bound to keep the information confidential. If you don't object, I will not tell you about these consultations unless I feel that it is important to our work together.

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. You also can find more information about this topic in the Notice of Privacy Practices document that follows.

Finally, as you are no doubt aware, it is impossible to fully protect the confidentiality of information that is transmitted electronically. This is particularly true of systems that do not utilize encryption and other security protection. If you send me an email containing clinical information, you agree to waive your confidentiality for the information transmitted and you authorize me to respond to your questions in kind. My email (DrLydia@richardsonpsyd.com) is encrypted and HIPAA compliant. If you choose to communicate with me via text (646-481-5516) you should be aware that this is not a confidential means of communication and there is a reasonable chance that a third party may intercept these messages. I will provide you with a consent form to sign indicating that you understand these risks.

SOCIAL MEDIA

In order to protect client confidentiality, I do not accept friend or contact requests from current or former clients on social networking sites. It can also blur the boundaries of the professional relationship.

DEFAMATION

By signing these documents, you agree that you will not post defamatory comments about me on any website or social media site. I hope that you will instead share your feelings and reactions about our work with me directly so we can effectively address them.

THERAPIST'S INCAPACITY OR DEATH

In the event of my incapacitation or death, you give consent by these documents to allow another licensed mental health care professional that I have selected to take possession of your records so that he or she can provide you with your records or deliver them to a therapist of your choice.

MINORS AND SERVICES

Parents must provide consent to start services for children. If parents are divorced and have joint custody, then both parents need to sign the Signature Form to authorize services. If either parent with custody decides services should end, I will honor that decision.

Patients under 12 years of age and their parents should be aware that Illinois law allows parents to examine their child's records. Parents of children between 12 and 18 years old cannot examine their child's records unless the child consents and unless I find that there are no compelling reasons for denying the access. Parents are entitled to information concerning their child's current physical and mental condition, diagnosis, treatment needs, services provided, and services needed.

Prior to beginning treatment with a child/minor, it is important for you to also understand my approach to child therapy and agree to some rules about your child's confidentiality during the course of his/her treatment. Therapy is most effective when a trusting relationship exists between the psychologist and the patient. It is often necessary for children to develop a "zone of privacy" whereby they feel free to discuss personal matters with greater freedom. This is particularly true for adolescents who are naturally developing a greater sense of independence and autonomy.

It is my policy to provide you with information about treatment status. However, I will not always share with you everything your child has disclosed to me without your child's consent. I will tell you if your child does not attend sessions. I will also provide you with treatment summaries that describe the issues were discussed, what progress was made, and what areas are likely to require intervention in the future.

If your child is an adolescent, it is possible that he/she will reveal sensitive information regarding sexual contact, alcohol and drug use, or other potentially problematic behaviors. Sometimes these behaviors are within the range of normal adolescent experimentation, but at other times they may require parental intervention. We must carefully and directly discuss your feelings and opinions regarding acceptable behavior. If I ever believe that your child is at serious risk of harming him/herself or another, I will inform you. Although my responsibility to your child may require my involvement in conflicts between the two of you, I need your agreement that my involvement will be strictly limited to that which will benefit your child. In particular, I do not participate in court proceedings (e.g., child custody disputes) and I need you to agree that you will not ask me to testify in court, whether in person, or by affidavit. You also agree to instruct your attorneys not to subpoena me or to refer in any court filing regarding such matters.

Note that some judges may still require my testimony despite this agreement, but I may still work to prevent such an event. If I am required to testify, I am ethically bound not to give my opinion about either parent's custody or visitation suitability. If the court appoints a custody evaluator, guardian ad litem, or parenting coordinator, I will provide information as needed (if appropriate releases are signed or a court order is provided), but I will not make any recommendation about the final decision. Furthermore, if I am required to appear as a witness, the party responsible for my participation agrees to reimburse me at the rate of $400 per hour for time spent traveling, preparing reports, testifying, being in attendance, and any other case-related costs.

NOTICE OF PRIVACY PRACTICES (NPP)

This notice describes how medical information about you may be used and disclosed and how you can access this information. Please review it carefully.

MY COMMITMENT TO YOUR PRIVACY

My practice is dedicated to maintaining the privacy of your personal health information (PHI) as part of providing professional care. I am also required by law to keep your information private. These laws are complicated, but I must give you this important information. Please contact me about any questions or problems you may have.

For treatment

I use your medical information to provide you with psychological treatments or services. These might include individual, family, or couples therapy, psychological testing, treatment planning, or measuring the benefits of my services. I may share or disclose your PHI to others who provide treatment to you with your appropriate authorization. For example, I can share your information with your personal physician if you provide consent. If a team is treating you, they can share some of your PHI with me so that the services you receive will be able to work together. If you receive treatment in the future from other professionals, I can also share your PHI with them with your permission.

For payment

I may use your information to bill you or others so I can be paid for the treatments I provide to you.

Your health care operations

There are a few ways I may use or disclose your PHI for what are called health care operations. For example, I may use your PHI to see where I can make improvements in the care and services I provide. I may be required to supply some information to some government health agencies so they can study disorders and treatment and make plans for services that are needed. If I do, your name and personal information will be removed from what I send.

Other uses in healthcare

Appointment reminders. I may use and disclose medical information to reschedule or remind you of appointments for treatment or other care. If you want me to call or write to you only at your home or your work or prefer some other way to reach you, I usually can arrange that. Just tell me.

Treatment alternatives. I may use and disclose your PHI to tell you about or recommend possible treatment or alternatives that may be of help to you.

Other benefits and services. I may use and disclose your PHI to tell you about health-related benefits or services that may be of interest to you.

Business associates. There are some jobs that I may hire other businesses to do for me. In the law, they are called business associates. Examples include software vendors and billing agencies. I have also designated a colleague to contact my clients in the event of my incapacitation or death to ensure continuity of care. This psychologist also will provide emergency coverage for me when I am traveling Page 8 and am inaccessible. These business associates need to receive some of your PHI to do their jobs properly if the situation arises. To protect your privacy they will agree in their contract with me to safeguard your information.

USES AND DISCLOSURES THAT REQUIRE YOUR AUTHORIZATION

If I want to use your information for any purpose beside those described above, I need your permission on an Authorization form. I don't expect to need this very often. I will also obtain an authorization from you before using or disclosing psychotherapy notes or PHI in a way that is not described in this Notice. If you do authorize me to use or disclose your PHI, you can revoke (cancel) that permission, in writing, at any time. After that time I will not use or disclose your information for the purposes that we agreed to. Of course, I cannot take back any information I have disclosed with your permission or that we had used in our office.

I will keep your health information private, but there are some times when the law requires me to use or share it. For example:

1. When there is a serious threat to your health and safety or the health and safety of another individual or the public. I will only share information with a person or organization that is able to help prevent or reduce the threat.

2. Some lawsuits and legal or court proceedings.

3. If a law enforcement official requires me to do so.

4. For Workers Compensation and similar benefit programs.

5. When I receive information about abuse or neglect of a child, disabled adult, or person over age 60.

6. When the use and disclosure without your consent or authorization is allowed under other sections of Section 164.512 of the HIPAA Privacy Rule and the state's confidentiality law. This includes certain narrowly-defined disclosures to law enforcement agencies (such as HHS or a state department of health), to a coroner or medical examiner, for public health purposes relating to disease or FDA-regulated products, or for specialized government functions such as fitness for military duties, eligibility for VA benefits, and national security and intelligence.

YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION

1. You can ask me to communicate with you about your health and related issues in a particular way or at a certain place that is more private for you. For example, you can ask me to call you at home and not at work to schedule or cancel an appointment. I will try my best to do as you ask.

2. You have the right to ask me to limit what I tell people involved in your care or the payment for your care, such as family members, and friends. While I don't necessarily have to agree to your request, if I do agree, I will keep our agreement except if it is against the law, or in an emergency, or when the information is necessary to treat you.

3. You have the right to look at health information I have about you, such as your medical or billing records. You can even get a copy of these records, but I may charge you.

4. You have the right to restrict certain disclosures of PHI to a health plan when you pay out-of pocket in full for my services.

5. You have a right to be notified if: (a) there is a breach (a use or disclosure of your PHI in violation of the HIPAA Privacy Rule) involving your PHI; (b) that PHI has not been encrypted to Page 9 government standards; and (c) my risk assessment fails to determine that there is a low probability that your PHI has been compromised.

6. If you believe the information in your records is incorrect or missing important information, you can ask me to make some kinds of changes (called amending) to your health information. You have to make this request in writing and send it to me. You must tell me the reasons you want to make the changes.

7. Upon written request, you may obtain an accounting of certain disclosures of PHI made by me during any period of time prior to the date of your request provided such period does not exceed six years.

8. You have a right to a copy of this notice. If I change this NPP, I will provide you with a revised copy.

9. If you need more information or have question about the privacy practices described above, please contact me. If you have a problem with how your PHI has been handled or if you believe your privacy rights have been violated, contact me as well. You have the right to file a complaint with me and with the Secretary of the Federal Department of Health and Human Services. I promise that I will not in any way limit your care here or take any actions against you if you complain. The effective date of this notice is October 14, 2016.

SIGNATURE FORM

Acknowledgment of documents. I acknowledge that I have received, read, and understand the Client Agreement document and agree to abide by its terms. I acknowledge that I have also received a copy of this therapist's Notice of Privacy Practices and agree to its terms as well.

Consent to services. I do hereby seek and consent to take part in the assessment or treatment services by Dr. Lydia C. Richardson and participate in services as described in the Client Agreement document, or do so on behalf of my child. I understand that no promises have been made to me as to the results of treatment or of any procedures provided by this therapist. I am aware that I may stop services with this therapist at any time.

Agreement to pay for professional services. I acknowledge that payment is due at the time of service. I understand that parents, guardians, or personal representatives are responsible for all fees and services rendered for treatment of a minor/child. I accept full financial responsibility for all services or items provided to me, to my minor/child, or to the patient for whom I have legal responsibility, whether or not they are ultimately reimbursed by insurance or are part of my benefit plan. I understand that filing a claim with my insurance company does not relieve me from my responsibility for payment of all charges. Outstanding balances as a result of deductibles, co-payments, or co-insurance may be automatically charged to my debit/credit card. I further agree that in the event of my non-payment, I will bear the cost of collection and/or court costs and reasonable legal fees, should this be required. I understand that I am responsible for charges for checks returned due to non-sufficient funds. I also know that I must call to cancel an appointment at least 48 hours before the time of the appointment. ***If I do not cancel within this timeframe and/or do not show up, I will be charged for that appointment and automatic debit/credit card billing may be used for this charge as well***.

Acknowledgment of insurance procedures. I understand that Dr. Richardson is an in-network provider for Blue Cross Blue Shield Illinois (BCBS-IL) PPO, Medicare, and Cigna and not necessarily for all *related* BCBS and Cigna plans. Lydia C. Richardson, PsyD will electronically submit claims for BCBS PPO, Medicare, and Cigna patients, and I am responsible for my deductible and co-pay/co-insurance amount for covered services at the time of service. If I have a different insurance plan and I am seeking services on an out-of-network basis, I understand that I must pay in full at the time of service. Lydia C. Richardson, PsyD will submit claims for me upon request, and I may receive reimbursement directly from my insurance company in accordance with my policy specifications. Regardless of my insurance, I understand that it is my responsibility to contact my insurance company (by calling the number on the back of my insurance card) prior to my visits with Dr. Richardson in order to verify eligibility, to fully understand my benefits, and to obtain any necessary preauthorizations. Dr. Richardson may provide a preliminary check of my benefits, but I understand that I will obtain the most accurate information if I call my insurance directly. Verification of benefit coverage is not a guarantee of claim payment by insurance companies.

For those patients using BCBS PPO, Medicare, or Cigna: I hereby assign payment of authorized medical benefits from my insurance carrier to Lydia C. Richardson, PsyD. This assignment will remain in effect until revoked by me in writing. Any benefits payment received from the above named insurance companies over and above my balance due will be refunded to me when my account is paid in full.

For all patients who request billing to insurance companies on their behalf: I authorize Lydia C. Richardson, PsyD to release any and all medical information to my insurance carrier(s) for the purposes of claim administration and evaluation, utilization review and/or financial audit. This includes information related to mental health services such as assessments, history, diagnoses, medication information, treatment plans and progress, dates of service, and progress notes. This authorization will expire one year from the last date of service. I may revoke this authorization at any time, but revocation will not apply to information already released. Failure to authorize the release of this information may result in my insurance carrier denying claims.

I understand that I need to update Dr. Richardson with changes to my insurance or address for billing purposes as soon as I become aware of them.

It is also understood that if I have an insurance plan, some services may not be authorized for payment under my benefit plan and I am fully responsible for these charges. My signature below shows that I understand and agree with all of these statements.

_____ _____

Signature of client (or parent) Date

_____ _____

Printed name Relationship to client (or indicate "self")

Please indicate your preference for receiving a copy of this signed agreement packet.
Provide me with: ____ scanned copy via email _____ paper copy _____ no copy

I, the therapist, have discussed the issues above with the client (and/or his or her parent, guardian, or other representative). My observations of this person's behavior and responses give me no reason to believe that this person is not fully competent to give informed and willing consent.

_____ _____

Signature of therapist Date