TREATMENT AGREEMENT

Welcome to the Anxiety and OCD Treatment Center of Ann Arbor. This document contains important information about my professional services and business policies. It is important that you read this document carefully and discuss any questions you have with me. When you sign this document, it will represent your informed consent for treatment and an agreement on policies.

PROFESSIONAL FEE SCHEDULE*

Type of Service	**LMSW/LLP/TLLP**	**PhD/LP**
Initial Evaluation	$200.00	$235.00
90832 (16-37 minute session)	$80.00	$95.00
90834 (38-52 minute session)	$135.00	$165.00
90837 (53-60 minute session)	$160.00	$185.00
90839 (60 minute crisis session)	$200.00	$235.00
90840 (Additional 30 minutes for crisis session)	$160.00	$185.00
Group session	$75.00	$75.00
Intensive ERP per hour	$160.00	$185.00
Other Fees		
Paperwork (per hour)	$100.00	$100.00
Communications**		
Phone/email (15 minutes or less)	$40.00	$40.00
Phone/email (16-37 minutes)	$80.00	$95.00
Phone/email (38-52 minutes)	$135.00	$165.00
Phone/email (53-60 minutes)	$160.00	$185.00
Form preparation per 15 minutes	$35.00	$35.00
Lost materials fee (plus replacement cost)	$100.00	$100.00
Travel Time (30 minute minimum plus 15 minute increments thereafter)	$80.00 $40 per add'l 15 min	$95.00 $45.00 per add'l 15 min
No shows, late cancellations:		
Weekday morning/afternoon	$150.00	$150.00
Late Afternoon(4p+)/Evening/Weekend	$200.00	$200.00

**We reserve the right to alter and update the Fee Schedule at any time. Review of the fee schedule occurs at minimum on an annual basis. All clients will be notified in writing of changes in fees at least 4 weeks prior to implementation. **These are to be used sparingly when appropriate and are not used as a substitute for a face-to-face sessions.*

BILLING AND PAYMENTS

You will be expected to pay for each session at the time it is held. We currently accept checks, cash and debit/FSA/credit credits. Late charges will be added to accounts with any balance over 30 days old. Late Fees are calculated at a rate of 2% monthly. If your account has not been paid for more than 60 days and you have not arranged payment, we have the option of using legal means to secure payment, including collection agencies or small claims. In most collection situations, the only information released regarding a client's treatment is his/her name, the nature of services provided, and the amount due. (If such action is necessary, the costs will be included in the claim.)

INSURANCE REIMBURSEMENT

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. Our clinicians are individually paneled with different companies. Most clinicians currently panel with BCBS *and/or* Blue Care Network. You are expected to contact your insurance company prior to service to determine your behavioral health benefits coverage. If at any point it is determined that your benefit doesn't pay for or pay fully for treatment you are responsible for the charges.

Please note that none of our clinicians are able to accept Medicaid, Blue Cross Complete, or Medicare Plus Blue insurance.

Out of network services. We can provide you an invoice that you can submit to your insurance company if you are seeking out-of-network reimbursement. We cannot guarantee successful out-of-network reimbursement and strongly encourage you to contact your insurance company prior to services to determine your out-of network benefits. Please note that we are not able to assist with obtaining out-of-network reimbursement beyond providing an invoice of the service received.

Flexible Spending. We can provide proof of service receipts to submit to your flexible spending/health savings account for reimbursement. Please ask your clinician if you require this.

CANCELLATION POLICY

Appointments must be cancelled with 24 hours advance notice. If an appointment is cancelled with less than 24 hours advance notice, you will be charged according to the current fee schedule. It is important to note that insurance companies do not provide reimbursement for cancelled sessions.

LATE ARRIVAL FEES

The fee will be based on a prorated charge (i.e., a charge for the portion of the session that was missed, calculated based on the full session cost). For example, our typical session is 60 minutes (90837) at a rate of $160 for an LMSW and $185 for a PhD. If you arrive 30 minutes late, we reserve the right to charge you for 50% of the session fee in addition to the shorter, 30 minute session fee (90832).

If you have insurance: Insurance will not pay for the late arrival fee. Insurance will be billed for time spent in session. You will still be responsible for the late arrival fee.

If you are private pay: You will be responsible for late arrival fee plus the fee for time that was spent in session.

CONTACTING YOUR CLINICIAN

Our clinicians are often not immediately available due to the nature of their work. Please leave a message for your clinician and she/he will make every effort to respond within 24 hours (with the exception of weekends and holidays). Should you decide to contact your clinician via email, please note that this is not a secure means of communication and you are accepting the risk associated with transmitting personal information over the internet. Emails should be limited to scheduling, as they are not a means by which our clinicians can provide appropriate clinical care. If you cannot reach your clinician and feel that you have an emergency, call 911 or go to the nearest emergency room and ask for the psychiatrist on call. If your clinician will be unavailable for an extended period of time, you will be notified and provided with contact information for another clinician, if necessary.

CONFIDENTIALITY

In general, the law protects the privacy of all communication between a client and a behavioral health provider. In most situations, we only release information about your treatment to others if you sign a written Authorization form that meets certain legal requirements imposed by HIPAA. However, we must also release information without consent in the following situations:

- If a client presents an imminent danger to him/herself, we may be required to seek hospitalization for the client, or contact family members or others who can help provide protection.

- If there is cause to suspect a child under 18 is abused or neglected, or reasonable cause to believe that a disabled adult is in need of protective services, the law requires that a report be filed with the appropriate agency. Once such a report is filed, additional information may be required.

- If there is reason to believe that a client presents an imminent danger to the health and safety of another, we may be required to disclose information in order to take protective actions, including initiating hospitalization, warning the potential victim, and/or calling the police.

- Parental involvement is essential to successful treatment and this may require that some private information be shared with parents. It is our policy only to share information that is considered necessary with a minor client's parents. This includes general information about the progress of the child's treatment and his/her attendance at scheduled sessions. Before giving parents any information, this will be discussed with the child, if possible, and an attempt will be made to handle any objections he/she may have.

- Children over the age of eighteen have the right to independently consent to and receive mental health treatment without parental consent and, in that situation, information about that treatment cannot be disclosed to anyone without the client's agreement.

It is important that any questions or concerns that you may have now or in the future be discussed immediately with your clinician.

EXPOSURE THERAPY

Exposure therapy often takes us outside of the therapy office and into the "real world." Even in the therapy office we may be doing real world activities. We may encounter situations in which:

(1) confidentiality/privacy considerations arise (i.e., incidental disclosures according to HIPAA, such as overhearing conversations while social anxiety exposure is being conducted)

(2) potential liability may be a result of your voluntary participation in real world activities via exposure therapy.

Our attached "Release of Liability Waiver" reviews this in more detail. Your initials below indicate that you understand that:

- Your clinician(s) and the Clinic in general cannot ensure complete privacy/confidentiality during exposures.
- You (or your child) may observe other Clinic clients participating in exposures, and will respect their privacy and confidentiality (i.e., not discuss what you observe with others)
- You (or your child) are participating in exposure therapy on a voluntary basis, and in no way mandated by the Clinic. You hereby release the Anxiety and OCD Treatment Center of Ann Arbor as well as its staff and clinicians from any claims, demands, and causes of action as a result of your (or your child's) voluntary participation and enrollment in treatment at our Clinic.

_____ I HEREBY AFFIRM THAT I HAVE READ AND FULLY UNDERSTAND THE ABOVE.

CLINICIAN SUPERVISION

Our clinic provides training in evidence-based treatment to limited license clinicians. A limited license clinician is qualified by the State of Michigan to deliver assessment and treatment services under the supervision of a fully licensed provider. You will be notified of the name and contact information of the fully-licensed clinician within our Center who is supervising your clinician.

CLIENT RIGHTS

HIPAA provides you with several new or expanded rights concerning your Clinical Records and disclosures of protected health information. These rights include requesting that we amend your record; requesting restrictions on what information from your Clinical Records 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 my policies and procedures recorded in your records; and the right to view and copy your records. Your clinician will be happy to discuss any of these rights with you. These rights are explained further in the Privacy Notice. If you have a complaint, we encourage you to attempt to resolve it with your clinician. If the resolution is unsatisfactory to you, you may contact the Washtenaw County Recipient Rights Office at (734) 544-3000 and ask to speak with the Rights Officer of the Day.

MINOR CLIENTS

(please initial the appropriate option for your child ******PLEASE READ ALL OF THE OPTIONS******)

____ _____ lives with BOTH legal/biological parents/guardians and
(child's name) there is **NOT** a legal custody agreement in place,

_____ I am the Sole Legal Parent/Guardian of _____ and there is **NOT** a
(child's name) custody agreement in place,

_____ I am the Sole Legal Parent/Guardian of _____ and there **IS**
(child's name) a custody agreement in place,

_____ I am the Joint Legal Parent/Guardian of _____ and there **IS**
(child's name) a custody agreement in place,

_____ I am the Joint Legal Parent/Guardian of _____ and there is **NOT**
(child's name) a custody agreement in place,

therefore I have the legal authority to enter this child into therapy and to sign papers on the child's behalf. I understand that if there is joint legal custody with another person, that person may also be involved in the child's therapy and/or may receive communication from the therapist. I will provide the Anxiety and OCD Treatment Center of Ann Arbor a copy of any legal custody agreements in place regarding the client.

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By signing below I, _____, acknowledge that I
(Print) Client's Full Name or Parent/Guardian name if minor client
understand and accept all the terms in the above agreement for services provided by my clinician. I also acknowledge that I have received the HIPAA information (Notice of Privacy Practices) described above.

_____ _____
Client's Signature (required for clients 18 years or older) Date

_____ _____
Parent or Legal Guardian's Signature (required for minor clients 17 or younger) Date

_____ _____
Clinician Signature Date

WAIVER AND RELEASE OF LIABILITY

In consideration of the risk of injury while participating in Exposure Therapy with an Associate of the Anxiety and OCD Treatment Center of Ann Arbor (the "Activity"), and as consideration for the right to participate in the Activity, I hereby, for myself, my heirs, executors, administrators, assigns, or personal representatives, knowingly and voluntarily enter into this waiver and release of liability and hereby waive any and all rights, claims or causes of action of any kind whatsoever arising out of my participation in the Activity, and do hereby release and forever discharge The Anxiety and OCD Treatment Center of Ann Arbor and any and all clinicians I work with at the Center, located at 2610 W. Liberty, Ann Arbor, Michigan 48103, their affiliates, managers, members, agents, attorneys, staff, volunteers, heirs, representatives, predecessors, successors and assigns, for any physical or psychological injury, including but not limited to illness, paralysis, death, damages, economical or emotional loss, that I may suffer as a direct result of my participation in the aforementioned Activity, including traveling to and from an event related to this Activity.

I AM VOLUNTARILY PARTICIPATING IN THE AFOREMENTIONED ACTIVITY AND I AM PARTICIPATING IN THE ACTIVITY ENTIRELY AT MY OWN RISK. I AM AWARE OF THE RISKS ASSOCIATED WITH TRAVELING TO AND FROM AS WELL AS PARTICIPATING IN THIS ACTIVITY, WHICH MAY INCLUDE, BUT ARE NOT LIMITED TO, PHYSICAL OR PSYCHOLOGICAL INJURY, PAIN, SUFFERING, ILLNESS, DISFIGUREMENT, TEMPORARY OR PERMANENT DISABILITY (INCLUDING PARALYSIS), ECONOMIC OR EMOTIONAL LOSS, PROPERTY LOSS, AND DEATH. I UNDERSTAND THAT THESE INJURIES OR OUTCOMES MAY ARISE FROM MY OWN OR OTHERS' NEGLIGENCE OR ACTIONS, CONDITIONS RELATED TO TRAVEL, THE CONDITION OF THE ACTIVITY

LOCATION(S), OR OTHER FACTORS. NONETHELESS, I ASSUME ALL RELATED RISKS, BOTH KNOWN OR UNKNOWN TO ME, OF MY PARTICIPATION IN THIS ACTIVITY, INCLUDING TRAVEL TO, FROM AND DURING THIS ACTIVITY.

I agree to indemnify and hold harmless The Anxiety and OCD Treatment Center of Ann Arbor and any and all clinicians I work with at the Center against any and all claims, suits or actions of any kind whatsoever for liability, damages, compensation or otherwise brought by me or anyone on my behalf, including attorney's fees and any related costs, if litigation arises pursuant to any claims made by me or by anyone else acting on my behalf. If The Anxiety and OCD Treatment Center of Ann Arbor and any and all clinicians I work with at the Center incurs any of these types of expenses, I agree to reimburse The Anxiety and OCD Treatment Center of Ann Arbor and any and all clinicians I work with at the Center as said expenses are incurred.

I acknowledge that The Anxiety and OCD Treatment Center of Ann Arbor and any and all clinicians I work with at the Center and their directors, officers, volunteers, representatives and agents are not responsible for errors, omissions, acts or failures to act of any party or entity conducting a specific event or activity on behalf of The Anxiety and OCD Treatment Center of Ann Arbor and any and all clinicians I work with at the Center.

I ACKNOWLEDGE THAT I HAVE CAREFULLY READ THIS "WAIVER AND RELEASE" AND FULLY UNDERSTAND THAT IT IS A RELEASE OF LIABILITY. I EXPRESSLY AGREE TO RELEASE AND DISCHARGE The Anxiety and OCD Treatment Center of Ann Arbor and any and all clinicians I work with at the Center AND ALL OF ITS AFFILIATES, MANAGERS, MEMBERS, AGENTS, ATTORNEYS, STAFF, VOLUNTEERS, HEIRS, REPRESENTATIVES, PREDECESSORS, SUCCESSORS AND ASSIGNS, FROM ANY AND ALL CLAIMS OR CAUSES OF ACTION AND I AGREE TO VOLUNTARILY GIVE UP OR WAIVE ANY RIGHT THAT I OTHERWISE HAVE TO BRING A LEGAL ACTION AGAINST The Anxiety and OCD Treatment Center of Ann Arbor and any and all clinicians I work with at the Center FOR PERSONAL INJURY OR PROPERTY DAMAGE.

To the extent that statute or case law does not prohibit releases for negligence, this release is also for negligence on the part of The Anxiety and OCD Treatment Center of Ann Arbor and any and all clinicians I work with at the Center, its agents, and employees.

In the event that I should require medical care or treatment, I agree to be financially responsible for any costs incurred as a result of such treatment. I am aware and understand that I should carry my own health insurance.

In the event that any damage to equipment or facilities occurs as a result of my or my family's willful actions, neglect or recklessness, I acknowledge and agree to be held liable for any and all costs associated with any actions of neglect or recklessness.

This Agreement was entered into at arm's-length, without duress or coercion, and is to be interpreted as an agreement between two parties of equal bargaining strength. Both the Undersigned Participant and The Anxiety and OCD Treatment Center of Ann Arbor and any and all clinicians I work with at the Center agree that this Agreement is clear and unambiguous as to its terms, and that no other evidence will be used or admitted to alter or explain the terms of this Agreement, but that it will be interpreted based on the language in accordance with the purposes for which it is entered into.

In the event that any provision contained within this Release of Liability shall be deemed to be severable or invalid, or if any term, condition, phrase or portion of this agreement shall be determined to be unlawful or otherwise unenforceable, the remainder of this agreement shall remain in full force and effect, so long as the clause severed does not affect the intent of the parties. If a court should find that any provision of this agreement to be invalid or unenforceable, but that by limiting said provision it would become valid and enforceable, then said provision shall be deemed to be written, construed and enforced as so limited.

I, the undersigned participant, affirm that I am of the age of 18 years or older, and that I am freely signing this agreement. I certify that I have read this agreement, that I fully understand its content and that this release cannot be modified orally. I am aware that this is a release of liability and a contract and that I am signing it of my own free will.

Participant's Name: _____

_____

Signature: _____Date: _____

_____

PARENT / GUARDIAN WAIVER FOR MINORS

In the event that the participant is under the age of consent (18 years of age), then this release must be signed by a parent or guardian, as follows:

I hereby certify that I am the parent or guardian of the participant/client named above, and do hereby give my consent without reservation to the foregoing on behalf of this individual.

Parent / Guardian Name: _____Relationship to Minor: _____

_____

Signature: _____Date:_____

_____