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 evaluation and treatment and an agreement on policies.

Clinician Name_____________________________ Phone____________________________

PROFESSIONAL FEE SCHEDULE*

<table>
<thead>
<tr>
<th>Type of Service</th>
<th>LMSW</th>
<th>PhD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Initial Evaluation</td>
<td>$200.00</td>
<td>$235.00</td>
</tr>
<tr>
<td>90832 (16-37 minute session)</td>
<td>$80.00</td>
<td>$95.00</td>
</tr>
<tr>
<td>90834 (38-52 minute session)</td>
<td>$135.00</td>
<td>$165.00</td>
</tr>
<tr>
<td>90837 (53-60 minute session)</td>
<td>$160.00</td>
<td>$185.00</td>
</tr>
<tr>
<td>Group session</td>
<td>$75.00</td>
<td>$75.00</td>
</tr>
</tbody>
</table>

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 |

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 most clinicians accept credit credits. Checks need to be made out to your individual therapist. 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. A few clinicians may panel with other insurance companies. 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 or Blue Cross Complete 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.
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 can 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 concern that you may have now or in the future be discussed immediately with 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)

_____ The statement below does not pertain to (child’s name) __________________________.

I am the:

_____ Sole Legal Custodial Parent

_____ Joint Legal Custodial Parent

_____ Legal Guardian

of (child’s name) _______________________________ and 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.
By signing below I, _____________________________________________, acknowledge that I 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