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Patient Services Agreement

PLEASE READ CAREFULLY AND FULLY!

Patient-Psychologist Services Agreement

Welcome to Healing Path Counseling, LLC. This document contains important information about our professional services and business policies. We can discuss any questions you have about the procedures. This document represents an agreement between us. You may revoke this agreement in writing at any time. That revocation will be binding on me unless I have taken action in reliance on it; if there are obligations imposed on me by your health insurer in order to process or substantiate claims made under your policy; or if you have not satisfied any financial obligations you have incurred.

PSYCHOLOGICAL SERVICES

Psychotherapy is not easily described in general statements. It varies depending on the personalities of the psychologist and patient, and the particular concerns you bring forward. There are many different methods we may use to aid you with the problems that you wish to address. Psychotherapy is not like a visit with a medical doctor. Rather, it calls for a very active effort on your part. In order to optimize success in therapy, you will have to work on things we talk about both during our sessions and outside of them.

Psychotherapy can have benefits and risks. Since therapy often involves discussing unpleasant aspects of your life, you may experience uncomfortable feelings. However, psychotherapy can have important benefits for people who go through it. Therapeutic work can often lead to better relationships, solutions to specific problems, and significant reductions in feelings of distress. But there are no guarantees of what you will experience.

Our first few sessions will involve an evaluation of your needs. By the end of the evaluation, we 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.

For assessments for bariatric surgery clearance, you will meet with Dr. Zarbock. This tends to be 2 appointments. You will be provided with paperwork to complete before the appointments. Dr. Zarbock will conduct the evaluation and discuss the information I am sending to the physician who requested the evaluation.

MEETINGS

For psychotherapy, we normally conduct an initial evaluation that will last from 1 to 3 sessions. During this time, you and your therapist can both decide if they are the best person to provide the services you need in order to meet your treatment goals. If you agree to work together, it is customary to schedule one 45-minute or 60-minute session per week at a time we agree upon, although some sessions may be more frequent if necessary.

Once an appointment hour is scheduled, you will be expected to pay for it unless you provide 48 hours advance notice of cancellation, unless we both agree that you were unable to attend due to circumstances beyond your control. If it is possible, we will try to find another time to reschedule the appointment. (Please see "Cancellation and No Show").

CONTACTING YOUR THERAPIST

We are not often immediately available by phone. When they are unavailable, you can leave a voice message and they will return your call. Your therapist will make every effort to return your call in a timely manner, with the exception of time away from the office, weekends and holidays. If you are difficult to reach, please inform your therapist of some times when you will be available.

***If you in a psychiatric emergency go nearest emergency room and ask for the psychologist or psychiatrist on call. You can also call the national crisis hotline at 1-800-273-8255. If your therapist will be unavailable for an extended time, they will provide you with the name of a colleague to contact, if necessary.

PROFESSIONAL FEES

Below are the rates for services. These services do get billed to your insurance (if we are in your insurance network) and insurance will pay us the contracted rate.

Diagnostic Assessment (1st appt) \$180
Psychotherapy-60 minutes \$160
Psychotherapy-45 minutes \$140
Psychotherapy-30 minutes \$90
Crisis Session-60 minutes \$200
Crisis Session-75-90 minutes \$290
Prolonged psychotherapy session, additional time \$100-200
Group psychotherapy-\$60

Psychological Testing

1st Hour-\$220
Each hour after-\$180
Scoring measurements, first 30 min- \$120
Scoring measurements, each 30 min after- \$120

(This includes services provided during your appointment and test procedures conducted outside of your appointment, such as scoring of measurements, analysis, interpretation, report writing, etc.)

**Phone session fees are the same as in-office fees but will be charged as self-pay.

The in-session fees outlined above will be billed to your insurance unless we have agreed otherwise. You are responsible for fees that are not covered by insurance. All fees are required at time of service, unless otherwise discussed. In addition to weekly appointments, we charge this amount for other professional services you may need

PHONE CONSULTATION FEES

Phone calls that exceed 15 minutes will be charged using the following fee schedule
15-30 minutes \$45-\$90
30-45 minutes \$120-\$140
45-60 minutes \$140-\$160

**Phone calls are typically limited to scheduling, billing, and brief inquiries. Any topics that require attention should be discussed in session, first and foremost. If there is a concern/topic/exchange of information that requires more than 15 minutes of discussion, you will be charged the above stated fees per time increment, or you will be asked to further discuss this at your next session appointment. This may be used for consultation with family members or caregivers.

DOCUMENTATION FROM PROVIDER FEES

(This is documentation that requires your provider to generate a letter for you, a brief treatment summary, a document indicating your diagnoses, or a brief statement indicating your progress or attendance).

15 minutes \$25

30 minutes \$50

45 minutes \$75

60 minutes \$100

A longer, or more intensive report, summary, or letter, will be charged at the same rate of psychological testing reports for one hour or more.

Over 60 minutes \$180

***Insurance does not pay for documentation as described above.

OTHER PROFESSIONAL FEES

This may include attendance at meetings with other professionals you have authorized for your care, preparation of records or treatment summaries, and the time spent performing any other service you may request of me. If you become involved in legal proceedings that require my participation, you will be expected to pay for our professional time even if we are called to testify by another party. Because of the difficulty of legal involvement, we charge \$300 per hour for preparation and attendance at any legal proceeding. ***Insurance does not cover such fees outlined above.

OUT OF NETWORK

If we are not in your insurance network, we will provide you with information to submit to your insurance for reimbursement. We will provide you with a self-pay contract. You are responsible for fees upfront.

BILLING & PAYMENTS

At the time of service, you will be expected to pay the amount you are responsible for (e.g., co-payment, towards deductible) unless we agree otherwise. Payment schedules for other professional services will be agreed to when they are requested. For your convenience and ease of payment, we keep payment information on file and, with authorization, we charge when any balances arise.

Healing Path Counseling, LLC will be billing your insurance carrier for therapy and or/evaluative services, if in network. If a bill is disputed due to the failure of the insurance company or yourself, then payment becomes your full responsibility.

As stated above, for out of network insurance carriers, Healing Path Counseling will provide you with a receipt to submit to your insurance for them to reimburse you. Payment is due at the time of service.

If your account has not been paid for more than 60 days, and arrangements for payment have not been agreed upon, we have the option of using legal means to secure the 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.

CANCELLATION AND NO SHOW

Once an appointment hour is scheduled, you will be expected to pay a fee unless you provide 48 hours advance notice of cancellation. This appointment time has been reserved for you. If we are not provided with 48 hour notice, the appointment is typically unavailable to anyone else.

For failed appointments, a fee of \$100 will be charged, and for appointments cancelled with less than 48 hour notice, a fee of \$80 will be charged. A failed appointment occurs when we are not informed before the appointment that you will not be coming in or if you do not show.

This cancellation policy is really important for our counseling practice because, while a medical doctor can see 35 patients in a day, a therapist, like us, generally sees a maximum of 6 or 7. We reserve for you, and all of our clients, a full hour of our time for the session and clinical notes. If a client cancels with less than a full 48-hour notice, it is highly unlikely we would be able to fill that time slot, and we lose an entire hour from our work schedule.

We want you to know that my cancellation policy is not a penalty or a punishment. In all honesty, if you are in counseling long enough, at some point you might forget about an appointment, or something will come up in your schedule that will result in you missing an appointment. Maybe you'll need to work late. Maybe you'll get a sudden onset of the flu. Maybe your kids will have doctor appointments, or your car will break down, or something unavoidable will come up.

We know that life happens! In return, our clients understand that scheduling an appointment with us is like buying a ticket to something. Without 48 hours in advance, you might not be able to get a refund for that ticket, no matter the circumstance.

INSURANCE REIMBURSEMENT

You (not your insurance company) are responsible for full payment of fees. It is very important that you find out exactly what mental health services your insurance policy covers. To obtain information regarding your benefits, you can call the Customer Service number on the back of your insurance card.

Important to note, insurance companies require you to authorize us to provide them with information relevant to the services that we provide you, including a clinical diagnosis. Sometimes we have to provide additional clinical information such as treatment plans or summaries, or copies of the entire record (in rare cases). We will make every effort to release minimum information about you that is necessary for the purpose requested. All insurance companies state that they keep such information confidential. Once we have all of the information about your insurance coverage, we will discuss what we can expect to accomplish with the benefits that are available and what will happen if there are session limits. It is important to remember that you always have the right to pay for services yourself to avoid the problems described above, unless prohibited by contract.

PAYMENT

A credit card will be stored on file to charge your balances. This includes weekly co-pays, fees you may incur if you have not met your deductible, and services your insurance does not cover. When a balance arises, we charge for it. This is why it is important to know your coverage.

PROFESSIONAL RECORDS

The laws and standards of our profession require that we keep Protected Health Information about you in your Clinical Record. Your Clinical Record includes information about your reasons for seeking therapy, a description of the ways in which your problem impacts on your life, your diagnosis, the goals that we set for your treatment, your progress towards those goals, your medical and social history, your treatment history, any past treatment records that we receive from other providers, reports of any professional consultations, your billing records and any reports that have been sent to anyone, including reports to your insurance carrier.

In addition, we may also keep a set of Psychotherapy Notes. These notes are for our own use and assist in providing you the best possible treatment. These Psychotherapy Notes are kept separate from your Clinical Record.

You may examine and/or receive a copy of your records if you request it in writing, unless we believe that access would endanger you. In those situations, you have a right to a summary and to have your record sent wherever you may need them to be sent. Because these are professional records, they can be misinterpreted and/or upsetting to untrained readers. For this reason, we recommend that you initially review them in the presence of your therapist or have them forwarded to another mental health professional so you can discuss the contents.

LIMITS OF CONFIDENTIALITY

The law protects the privacy of all communications between a patient and a licensed mental 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 and/or Illinois law. However, in the following situations, no authorization is required:

- We may occasionally find it helpful to consult other health and mental health professionals about a case. During a consultation, we make every effort to protect the identity of my patient. The other professionals are also legally bound to keep the information confidential.
- Disclosures required by health insurers or to collect overdue fees are discussed elsewhere in this Agreement.
- If you are involved in a court proceeding and a request is made for information concerning your diagnosis and treatment, such information is protected by the psychologist-patient privilege law. We cannot provide any information without your (or your legal representative's) written authorization, or a court order. If you are involved in or contemplating litigation, you should consult with your attorney to determine whether a court would be likely to order us to disclose information
- If a government agency is requesting the information for health oversight activities, we may be required to provide it for them.
- If a patient files a complaint or lawsuit against us, we may disclose relevant information regarding that patient, in order to defend HPC and the providers.
- If a patient files a worker's compensation claim, we must, upon appropriate request, provide appropriate information, including a copy of the patient's record, to the patient's employer, the insurer or the Department of Worker's Compensation.

There are some situations in which we are legally obligated to take actions, which are necessary to attempt to protect others from harm. We may have to reveal some information about a patient's treatment. These situations are unusual in our practice and are as follows:

Child and Elder Abuse or Neglect

We may disclose your PHI to a state or local agency that is authorized by law to receive reports of child and elder abuse or neglect. If there is any reasonable cause to believe that a child under 18 may be abused or neglected by a parent, caregiver, or other person responsible for a child's welfare, the law requires mental health professionals to report this to Department of Children and Family Services. If there is any reasonable cause to believe an adult over 59, or under 60 with a disability, has been abused, neglected, or financially exploited in the preceding 12 months, the law requires mental health professionals to report this to the Department of Aging.

Imminent Risk to Self

If a mental health professional believes you present a clear, imminent risk of serious physical or mental injury or death to yourself, they are required to take protective actions that can include: notifying the police, seeking hospitalization, or releasing relevant information to friends/family to keep you safe.

Public Safety/Imminent Risk to Others

We may disclose your PHI if necessary, to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. If information is disclosed to prevent or lessen a serious threat it will be disclosed to a person or persons reasonably able to prevent or lessen the threat, including the target of the threat. If such a situation arises, we will make every effort to fully discuss it with you before taking any action and will limit our disclosure to what is necessary.

MINORS & PARENTS

Patients under 12 years of age and their parents should be aware that the law allows parents to examine their child's treatment records. Parents of children between 12 and 18 cannot examine their child's records unless the child consents and unless we 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. Any other communication will require the child's Authorization, unless we feel that the child is in danger or is a danger to someone else, in which case, we will notify the parents of our concern. Before giving parents any information, we will discuss the matter with the child, if possible, and do our best to handle any objections he/she may have.

PATIENT'S RIGHTS

HIPAA provides you with several new or expanded rights with regard to your Clinical Record and disclosures of protected health information. These rights include requesting that we amend your record; requesting restrictions on what information from your Clinical Record is disclosed to others; requesting an accounting of most disclosures of protected health information that you have neither consented to nor authorized; determining the location to which protected information disclosures are sent; having any complaints you make about our policies and procedures recorded in your records; and the right to a paper copy of this Agreement, the attached Notice form, and our privacy policies and procedures. We would be happy to discuss any of these rights with you.

By signing, I am verifying that I have read the Patient Services agreement, I understand and agree with or will abide by the policies outlined within this agreement.



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Notice of Privacy Practices

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

I. MY PLEDGE REGARDING HEALTH INFORMATION:

I understand that health information about you and your health care is personal. I am committed to protecting health information about you. I create a record of the care and services you receive from me. I need this record to provide you with quality care and to comply with certain legal requirements. This notice applies to all of the records of your care generated by this mental health care practice. This notice will tell you about the ways in which I may use and disclose health information about you. I also describe your rights to the health information I keep about you, and describe certain obligations I have regarding the use and disclosure of your health information. I am required by law to:

- Make sure that protected health information (“PHI”) that identifies you is kept private.
- Give you this notice of my legal duties and privacy practices with respect to health information.
- Follow the terms of the notice that is currently in effect.
- I can change the terms of this Notice, and such changes will apply to all information I have about you. The new Notice will be available upon request, in my office, and on my website.

II. HOW I MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU:

The following categories describe different ways that I use and disclose health information. For each category of uses or disclosures I will explain what I mean and try to give some examples. Not every use or disclosure in a category will be listed. However, all of the ways I am permitted to use and disclose information will fall within one of the categories.

For Treatment Payment, or Health Care Operations: Federal privacy rules (regulations) allow health care providers who have direct treatment relationship with the patient/client to use or disclose the patient/client’s personal health information without the patient’s written authorization, to carry out the health care provider’s own treatment, payment or health care operations. I may also disclose your protected health information for the treatment activities of any health care provider. This too can be done without your written authorization. For example, if a clinician were to consult with another licensed health care provider about your condition, we would be permitted to use and disclose your person health information, which is otherwise confidential, in order to assist the clinician in diagnosis and treatment of your mental health condition.

Disclosures for treatment purposes are not limited to the minimum necessary standard. Because therapists and other health care providers need access to the full record and/or full and complete information in order to provide quality care. The word “treatment” includes, among other things, the coordination and management of health care providers with a third party, consultations between health care providers and referrals of a patient for health care from one health care provider to another.

Lawsuits and Disputes: If you are involved in a lawsuit, I may disclose health information in response to a court or administrative order. I may also disclose health information about your child in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

III. CERTAIN USES AND DISCLOSURES REQUIRE YOUR AUTHORIZATION:

1. Psychotherapy Notes. I do keep “psychotherapy notes” as that term is defined in 45 CFR § 164.501, and any use or disclosure of such notes requires your Authorization unless the use or disclosure is:
 - a. For my use in treating you.
 - b. For my use in training or supervising mental health practitioners to help them improve their skills in group, joint, family, or individual counseling or therapy.
 - c. For my use in defending myself in legal proceedings instituted by you.
 - d. For use by the Secretary of Health and Human Services to investigate my compliance with HIPAA.
 - e. Required by law and the use or disclosure is limited to the requirements of such law.
 - f. Required by law for certain health oversight activities pertaining to the originator of the psychotherapy notes.
 - g. Required by a coroner who is performing duties authorized by law.
 - h. Required to help avert a serious threat to the health and safety of others.
2. Marketing Purposes. As a psychotherapist, I will not use or disclose your PHI for marketing purposes.
3. Sale of PHI. As a psychotherapist, I will not sell your PHI in the regular course of my business.

IV. CERTAIN USES AND DISCLOSURES DO NOT REQUIRE YOUR AUTHORIZATION. Subject to certain limitations in the law, I can use and disclose your PHI without your Authorization for the following reasons:

1. When disclosure is required by state or federal law, and the use or disclosure complies with and is limited to the relevant requirements of such law.
2. For public health activities, including reporting suspected child, elder, or dependent adult abuse, or preventing or reducing a serious threat to anyone’s health or safety.
3. For health oversight activities, including audits and investigations.
4. For judicial and administrative proceedings, including responding to a court or administrative order, although my preference is to obtain an Authorization from you before doing so.
5. For law enforcement purposes, including reporting crimes occurring on my premises.
6. To coroners or medical examiners, when such individuals are performing duties authorized by law.
7. For research purposes, including studying and comparing the mental health of patients who received one form of therapy versus those who received another form of therapy for the same condition.
8. Specialized government functions, including, ensuring the proper execution of military missions; protecting the President of the United States; conducting intelligence or counter-intelligence operations; or, helping to ensure the safety of those working within or housed in correctional institutions.
9. For workers’ compensation purposes. Although my preference is to obtain an Authorization from you, I may provide your PHI in order to comply with workers’ compensation laws.
10. Appointment reminders and health related benefits or services. I may use and disclose your PHI to contact you to remind you that you have an appointment with me. I may also use and disclose your PHI to tell you about treatment alternatives, or other health care services or benefits that I offer.

V. CERTAIN USES AND DISCLOSURES REQUIRE YOU TO HAVE THE OPPORTUNITY TO OBJECT.

1. Disclosures to family, friends, or others. I may provide your PHI to a family member, friend, or other person that you indicate is involved in your care or the payment for your health care, unless you object in whole or in part. The opportunity to consent may be obtained retroactively in emergency situations.

VI. YOU HAVE THE FOLLOWING RIGHTS WITH RESPECT TO YOUR PHI:

1. The Right to Request Limits on Uses and Disclosures of Your PHI. You have the right to ask me not to use or disclose certain PHI for treatment, payment, or health care operations purposes. I am not required to agree to your request, and I may say “no” if I believe it would affect your health care.
2. The Right to Request Restrictions for Out-of-Pocket Expenses Paid for In Full. You have the right to request restrictions on disclosures of your PHI to health plans for payment or health care operations

purposes if the PHI pertains solely to a health care item or a health care service that you have paid for out-of-pocket in full.

3. The Right to Choose How I Send PHI to You. You have the right to ask me to contact you in a specific way (for example, home or office phone) or to send mail to a different address, and I will agree to all reasonable requests.
4. The Right to See and Get Copies of Your PHI. Other than “psychotherapy notes,” you have the right to get an electronic or paper copy of your medical record and other information that I have about you. I will provide you with a copy of your record, or a summary of it, if you agree to receive a summary, within 30 days of receiving your written request, and I may charge a reasonable, cost based fee for doing so.
5. The Right to Get a List of the Disclosures I Have Made. You have the right to request a list of instances in which I have disclosed your PHI for purposes other than treatment, payment, or health care operations, or for which you provided me with an Authorization. I will respond to your request for an accounting of disclosures within 60 days of receiving your request. The list I will give you will include disclosures made in the last six years unless you request a shorter time. I will provide the list to you at no charge, but if you make more than one request in the same year, I will charge you a reasonable cost based fee for each additional request.
6. The Right to Correct or Update Your PHI. If you believe that there is a mistake in your PHI, or that a piece of important information is missing from your PHI, you have the right to request that I correct the existing information or add the missing information. I may say “no” to your request, but I will tell you why in writing within 60 days of receiving your request.
7. The Right to Get a Paper or Electronic Copy of this Notice. You have the right get a paper copy of this Notice, and you have the right to get a copy of this notice by e-mail. And, even if you have agreed to receive this Notice via e-mail, you also have the right to request a paper copy of it.

EFFECTIVE DATE OF THIS NOTICE

This notice went into effect on 6/12/19

Acknowledgement of Receipt of Privacy Notice

Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), you have certain rights regarding the use and disclosure of your protected health information. By checking the box below, you are acknowledging that you have received a copy of HIPPA Notice of Privacy Practices.

By signing, I attest that I have read and understand this Notice of Privacy Practices.