Bruce D. Kobal, PhD

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PSYCHOLOGIST-PATIENT SERVICES AGREEMENT

Welcome to my practice. This document (the Agreement) contains important information about my professional services and business policies. It also contains summary information about the Health Insurance Portability and Accountability Act (HIPAA), a new federal law that provides new privacy protections and new patient rights with regard to the use and disclosure of your Protected Health Information (PHI) used for the purpose of treatment, payment, and health care operations. HIPAA requires that I provide you with a Notice of Privacy Practices (the Notice) for use and disclosure of PHI for treatment, payment and health care operations. The Notice, which is attached to this Agreement, explains HIPAA and its application to your personal health information in greater detail. The law requires that I obtain your signature acknowledging that I have provided you with this information at the end of this session. Although these documents are long and sometimes complex, it is very important that you read them carefully. We can discuss any questions you have about the procedures. When you sign this document, it will also represent 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 problems you are experiencing. There are many different methods I may use to deal with the problems that you hope to address. Psychotherapy is not like a medical doctor visit. Instead, it calls for a very active effort on your part. In order for the therapy to be most successful, you will have to work on things we talk about both during our sessions and at home.

Psychotherapy can have benefits and risks. Since therapy often involves discussing unpleasant aspects of your life, you may experience uncomfortable feelings like sadness, guilt, anger, frustration, loneliness, and helplessness. On the other hand, psychotherapy has also been shown to have many

benefits. Therapy often leads 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, 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 large commitment of time, money, and energy, so you should be very careful about the therapist you select. If you have questions about my procedures, we should discuss them whenever they arise. If your doubts persist, I will be happy to help you set up a meeting with another mental health professional for a second opinion.

In addition to my psychology training, I have extensive training and experience with religious issues. I am quite comfortable discussing and assisting you with any religious concerns. It may be beneficial/necessary to consult your /minister/priest for further assistance.

MEETINGS

I normally conduct an evaluation that will last from 2 to 4 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-minute session (one appointment hour of 50 minutes duration) per week at a time we agree on, although some sessions may be longer or more frequent. **Once an appointment hour is scheduled, you will be expected to pay for it unless you provide 24 hours [1 business days] advance notice of cancellation [unless we both agree that you were unable to attend due to circumstances beyond your control]. It is important to note that insurance companies do not provide reimbursement for cancelled sessions.** [If it is possible, I will try to find another time to reschedule the appointment.]

PROFESSIONAL FEES

My hourly fee is $130.00. In addition to weekly appointments, I charge this amount for other professional services you may need, though I will break down the hourly cost if I work for periods of less than one hour. Other services include report writing, telephone conversations, consulting with other professionals with your permission, 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 all of my professional time, including preparation and transportation costs, even if I am called to testify by another party, at the rate of 300.00 per hour.

CONTACTING ME

Due to my work schedule, I am often not immediately available by telephone. When I am unavailable, my telephone is answered by an answering service [machine, voice mail, or by my secretary] [that I monitor frequently, or who knows where to reach me]. I will make every effort to return your call on the same day you make it, with the exception of weekends and holidays. If you are difficult to reach, please inform me of some times when you will be available. If you are unable to reach me and feel that you can't wait for me to return your call, contact your family physician or the nearest emergency room and ask for the psychologist [psychiatrist] on call. If I will be unavailable for an extended time, I will provide you with the name of a colleague to contact, if necessary.

LIMITS ON CONFIDENTIALITY

The law protects the privacy of all communications between a patient and a psychologist. In most situations, I can only release information about your treatment to others if you sign a written Authorization form that meets certain legal requirements imposed by HIPAA. There are other situations that require only that you provide written, advance consent. Your signature on this Agreement provides consent for those activities, as follows:

- I may occasionally find it helpful to consult other health and mental health professionals about a case. During a consultation, I make every effort to avoid revealing the identity of my patient. The other professionals are 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. I will note all consultations in your Clinical Record (which is called "PHI" in my Notice of Psychologist's Policies and Practices to Protect the Privacy of Your Health Information).
- I work with a group of independent mental health professionals. This group is an association of independently practicing professionals which share certain expenses and administrative functions. While the members share office space, I want you to know that I am completely independent in providing you with clinical services and I alone am fully responsible for those services. My professional records are separately maintained and no member of the group can have access to them without your specific, written permission.
- You should be aware that since I practice with other mental health professionals and that I employ administrative staff, in most cases, I need to share your protected information with these individuals for both clinical and administrative purposes, such as scheduling, billing

and quality assurance. All of the mental health professionals 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 without the permission of a professional staff member.

- I may also have contracts with business outside of this office (i.e. such as billing and collection services). As required by HIPAA, I have a formal business associate contract with this/these business(es), in which it/they promise to maintain the confidentiality of this data except as specifically allowed in the contract or otherwise required by law. If you wish, I can provide you with the names of these organizations and/or a blank copy of this contract.

- Disclosures required by health insurers or to collect overdue fees are discussed elsewhere in this Agreement.

- If a patient seriously threatens to harm himself/herself, I may be obligated to seek hospitalization for him/her, or to contact family members or others who can help provide protection.

There are some situations where I am permitted or required to disclose information without either your consent or Authorization:

- If you are involved in a court proceeding and a request is made for information concerning the professional services I provided to you, such information is protected by the psychologist-patient privilege law. I cannot provide any information without your 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 me to disclose information.

- If a government agency is requesting the information for health oversight activities, I may be required to provide it for them.

- If a patient files a complaint or lawsuit against me, I may disclose relevant information regarding that patient in order to defend myself.

- If I am treating a patient who files a worker's compensation claim, I may, upon appropriate request, be required to provide otherwise confidential information to your employer.

There are some situations in which I am legally obligated to take actions, which I believe are necessary to attempt to protect others from harm and I may have to reveal some information about a patient's treatment. These situations are unusual in my practice.

- If I have reason to believe that a child who I am evaluating or treating is an abused child, the law requires that I file a report with the appropriate government agency, usually the Department of Public Welfare. Once such a report is filed, I may be required to provide additional information.

- If I have reason to believe that an elderly person or other adult is in need of protective services (regarding abuse, neglect, exploitation or abandonment), the law allows me to report this to appropriate authorities, usually the Department of Aging, in the case of an elderly person. Once such a report is filed, I may be required to provide additional information.

- If I believe that one of my patients presents a specific and immediate threat of serious bodily injury regarding a specifically identified or a reasonably identifiable victim and he/she is likely to carry out the threat or intent, I may required to take protective actions, such as warning the potential victim, contacting the police, or initiating proceedings for hospitalization

If such a situation arises, I will make every effort to fully discuss it with you before taking any action and I will limit my disclosure to what is necessary.

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 now or in the future. The laws governing confidentiality can be quite complex, and I am not an attorney. In situations where specific advice is required, formal legal advice may be needed.

PROFESSIONAL RECORDS

You should be aware that, pursuant to HIPAA, I may keep Protected Health Information about you in two sets of professional records. One set constitutes your Clinical Record. It 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 treatment, your progress towards those goals, your medical and social history, your treatment history, any past treatment records that I 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. Except in unusual circumstances that involve danger to yourself and others or where information has been supplied to me by others confidentially, or the record makes reference to another person (unless such other person is a health care provider) and I believe that access is reasonably likely to cause substantial harm to such other person, you may examine and/or receive a copy of your Clinical Record if you request it in writing. Because these are professional records, they can be misinterpreted and/or upsetting to untrained readers. For this reason, I recommend that you initially review them in my presence, or have them forwarded to another mental health professional so you can discuss the contents. [I am sometimes willing to conduct this review meeting without charge.] In most circumstances, I am allowed to charge a copying fee and for certain other expenses. The exceptions to this policy are contained in the attached Notice Form. If I refuse your request for access to your records, you have a right of review (except for information supplied to me confidentially by others) which I will discuss with you upon request.

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 on 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. Your Psychotherapy Notes are not available to you and cannot be sent to anyone else, including insurance companies without your written, signed Authorization. Insurance companies cannot require your authorization as a condition of coverage nor penalize you in any way for your refusal to provide it.

PATIENT 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 I 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 my policies and procedures recorded in your records; and the right to a paper copy of this Agreement, the attached Notice form, and my privacy policies and procedures. I am happy to discuss any of these rights with you.

MINORS & PARENTS

Patients under 18 years of age who are not emancipated and their parents should be aware that the law may allow parents to examine their child's treatment records. Because privacy in psychotherapy is often crucial to successful progress, particularly with teenagers, it is sometimes my policy to request an agreement from parents that they consent to give up their access to their child's records. If they agree, during treatment, I will provide them only with general information about the progress of the child's treatment, and his/her attendance at scheduled sessions. I will also provide parents with a summary of their child's treatment when it is complete. Any other communication will require the child's Authorization, unless I feel that the child is in danger or is a danger to someone else, in which case, I will notify the parents of my concern. Before giving parents any information, I will discuss the matter with the child, if possible, and do my best to handle any objections he/she may have.

BILLING AND PAYMENTS

You will be expected to pay for each session at the time it is held, unless we agree otherwise or unless you have insurance coverage that requires another arrangement. Payment schedules for other professional services will be agreed to when they are requested. [In circumstances of unusual financial hardship, I may be willing to negotiate a fee adjustment or payment installment plan.]

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 the payment. This may involve hiring a collection agency or going through small claims court which will require me to disclose otherwise confidential information. 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. [If such legal action is necessary, its 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. If you have a health insurance policy, it will usually provide some coverage for mental health treatment. I will fill out forms and provide you with whatever assistance I can in helping you receive the benefits to which you are entitled; however, you (not your insurance company) are responsible for full payment of my fees. It is very important that you find out exactly what mental health services your insurance policy covers.

You should carefully read the section in your insurance coverage booklet that describes mental health services. If you have questions about the coverage, call your plan administrator. Of course, 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.

Due to the rising costs of health care, insurance benefits have increasingly become more complex. It is sometimes difficult to determine exactly how much mental health coverage is available. "Managed Health Care" plans such as HMOs and PPOs often require authorization before they provide reimbursement for mental health services. These plans are often limited to short-term treatment approaches designed to work out specific problems that interfere with a person's usual level of functioning. It may be necessary to seek approval for more therapy after a certain number of sessions. While much can be accomplished in short-term therapy, some patients feel that they need more services after insurance benefits end. [Some managed-care plans will not allow me to provide services to you once your benefits end. If this is the case, I will do my best to find another provider who will help you continue your psychotherapy.]

You should also be aware that your contract with your health insurance company requires that I provide it with information relevant to the services that I provide to you. I am required to provide a clinical diagnosis. Sometimes 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 make every effort to release only the minimum information about you that is necessary for the purpose requested. This information will become part of the insurance company files and will probably be stored in a computer. Though all insurance companies claim to keep such information confidential, I have no control over what they do with it once it is in their hands. In some cases, they may share the information with a national medical information databank. I will provide you with a copy of any report I submit, if you request it. By signing this Agreement, you agree that I can provide requested information to your carrier.

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 they run out before you feel ready to end your sessions. It is important to remember that you always have the right to pay for my services yourself to avoid the problems described above [unless prohibited by contract].

YOUR SIGNATURE BELOW INDICATES THAT YOU HAVE READ THIS AGREEMENT AND AGREE TO ITS TERMS AND ALSO SERVES AS AN ACKNOWLEDGEMENT THAT YOU HAVE RECEIVED THE HIPAA NOTICE FORM DESCRIBED ABOVE.

Name:_____

Signature:_____

Date:_____

Rev. 05.31.18

Patient Information Form:

In order to accurately submit claims for services to your insurance company it is essential that you present a current insurance identification card and the patient information form must be filled out completely and accurately. Any omission of necessary information will result in your being responsible for the charges for services you receive.

I have read and understand the above statement.

Patient signature

Standard Fees

For your information this section lists the fees for the more common services offered. There may be times where other services may be provided (including but not limited to: letters, summaries of treatment and/or legal/court issues) and if necessary I will inform you of the fees for those services at the time of request.

90791	INITIAL EVALUATION	160.00
90832	INDIVIDUAL THERAPY 20-30 MIN	80.00
90834	INDIVIDUAL THERAPY 45 MIN	120.00
90837	INDIVIDUAL THERAPY 60 MIN	130.00
90846	FAMILY THERAPY 50 MIN (WITHOUT PATIENT PRESENT)	130.00
90847	FAMILY THERAPY 50 MIN (WITH PATIENT PRESENT)	130.00
REL	COUPLE/RELATIONSHIP COUNSELING 60 MIN	130.00
MA	MISSED APPOINTMENT	105.00
STMT	STATEMENT CHARGE MISSED COPAY FEE	10.00

PLEASE PRINT CLEARLY

Please check if ☐ RETURNING CLIENT

PATIENT REGISTRATION FORM

(1) PATIENT'S INFORMATION

Patient's LEGAL Last Name, First Name, Middle Initial	Family Physician Name	Driver's License Number

Patient's Street Address	City, State, Zip	Patient's Telephone Number	Patient's Birth Date
		( ) Home ( ) Work	/ /

Patient's Gender	Student Status	Marital Status	Employment Status	Patient's Social Security Number
M F	FT PT Not	S M D Widowed Separated	PT FT Retired Not Self	

School Name	Employer Name	Employer Address	City, State, Zip

(2) PRIMARY INSURED'S INFORMATION

DO NOT FILL OUT THIS SECTION IF IT IS THE SAME AS THE PATIENT INFORMATION ABOVE

Primary Insured's LEGAL Last Name, First Name, Middle Initial	Primary Insured's Street Address	City, State, Zip

Primary Insured's Date of Birth	Gender	Primary Insured's Telephone Number	Social Security Number	Employer's Name Street Address, City, Zip
/ /	M F	( ) Home ( ) Work		

(3) SECONDARY INSURED'S INFORMATION

(DO NOT FILL OUT THIS SECTION IF THERE IS ONLY ONE INSURED

Secondary Insured's LEGAL Last Name, First Name, Middle Initial	Secondary Insured's Street Address	City, State, Zip

Secondary Insured's Date of Birth	Gender	Telephone Number	Social Security Number	Employer's Name Street Address, City, Zip
/ /	M F	( ) Home ( ) Work		

(4) INSURANCE CARRIER INFORMATION

Primary Insurance Company	Insurance ID Number	Insurance Policy/Group Number	Patient's Relationship to Policy Holder
			Individual Spouse Child
Insurance Type Group Individual	Policy Holder Name	Group Name	Other: _____
Secondary Insurance Company	Insurance ID Number	Insurance Policy/Group Number	Patient's Relationship to Policy Holder
			Individual Spouse Child Other: _____
Insurance Type Group Individual	Policy Holder Name	Group Name	
Tertiary (3rd) Insurance Company	Insurance ID number	Insurance Policy/Group Number	Patient's Relationship to Policy Holder
			Individual Spouse Child
Insurance Type Group Individual	Policy Holder Name	Insurance Policy/Group Number	Other: _____

WORKER'S COMPENSATION INSURANCE

Worker's Comp. Insurance Company Name	Worker's Compensation Claim Number	
Address	Accident Date	Accident State
	/ /	

AUTO ACCIDENT INSURANCE

Auto Insurance Company Name	Auto Insurance Claim Number	
Address	Auto Accident Date	Accident State
	/ /	

Patient's Attorney/Address (provider please mail lien letter to this address)

_____

_____

_____

_____

Disability Information (if applicable)

FROM DATE: THRU DATE:

NONE PARTIAL TOTAL

SHORT TERM LONG TERM PERMANENT NONE

(5) PHYSICIAN INFORMATION

PROVIDER, PLEASE FILL OUT ALL AREAS WHERE APPLICABLE

Primary Dx. Code	Second Dx. Code	Third Dx. Code	Fourth Dx. Code	Provider Name	Location	Referring Provider's UPIN # (Call to obtain)
				BRUCE KOBAL	BK	

(6) PATIENT OR AUTHORIZED REPRESENTATIVE AUTHORIZATION AND CONSENT

I request that payment under the medical insurance program be made directly to the above named provider on any unpaid bills for services provided on or after the date indicated below. I further authorize any holder of medical or other information about me to release to the Social Security Administration, its intermediaries or carrier of insurance companies, any information needed for this or a related Medicare or insurance claim. I permit a copy of this authorization to be used in place of the original.

SIGNATURE OF PATIENT OR AUTHORIZED REPRESENTATIVE X **DATE / /**

Bruce D. Kobal, Ph.D.

Licensed Psychologist

3800 West 12th Street
Erie, PA 16505
Phone) 814-923-8410 – (fax) 814-315-6044

Individual Client Information Questionnaire

Your cooperation in completing this questionnaire will be helpful in planning our services for you. Please answer each item carefully or ask your therapist for clarification if you do not understand an item.

Full Name: _____ Date: _____

Address: _____

_____

Telephone: _____ _____ _____
(home) (cell) (work)

Age_____ **Birth Date**_____ **Marital Status**_____

Social Security Number_____

Occupation_____ **Employer**_____

Education_____

Who suggested you contact us?_____

Physician's Name_____

When did you last see a physician and why?_____

_____

Please briefly describe your reason for seeking assistance: _____

_____

_____

_____

_____

_____

_____

_____

_____

Please list the members of your family and all others in your home:

Name(s)	Age/birth date	relationship	occupation

Please circle any of the following problems which pertain to you:

Nervousness	Depression	Fears	shyness
sexual problems	suicidal thoughts	separation	divorce
finances	drug use	alcohol use	friends
anger	self-control	unhappiness	sleep
stress	work	relaxation	headaches
tiredness	legal matters	memory	ambition
energy	insomnia	making decisions	loneliness
inferiority feelings	concentration	education	career choices
health problems	temper	nightmares	marriage
children	appetite	stomach trouble	bowel trouble
being a parent	my thoughts	physical problems	losses

Please add any additional information which you feel may be useful to us:

Bruce D. Kobal, Ph.D.

3800 West 12th Street
Erie, PA 16505
Phone) 814-923-8410 – (fax) 814-315-6044

Primary Care Physician Authorization Form

This form when completed and signed by you, authorizes me to release protected information from your clinical record to the person you designate for the purposes of continuity of care.

I, _____ authorize my psychologist, _Bruce D. Kobal, Ph.D._ to release
(Please Print Name)

Pleas check one:

_____ to release any applicable information to my PCP

_____ to release medical information only to my PCP

_____ NOT to release information to my PCP

This information should only be released to (name and address of person to whom the information is to be released)
_____
_____

This authorization shall remain in effect until (fill in expiration date) or until (fill in an event that relates to the individual or the purpose of the use or disclosure).
_____

You have the right to revoke this authorization, in writing, at any time by sending such written notification to my office address. However, your revocation will not be effective to the extent that I have taken action in reliance on the authorization or if this authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

I understand that my psychologist generally may not condition psychological services upon my signing an authorization unless the psychological services are provided to me for the purpose of creating health information for a third party.

I understand that information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient of your information and no longer protected by the HIPAA Privacy Rule.

_____ _____
Signature of Patient Date

_____

If the authorization is signed by a personal representative of the patient, a description of such a representative's authority to act for the patient must be provided.

A copy or Fax of this document is considered as valid as the original._____