INNOVATIVE INTERVENTIONS, LLC
Methodist Medical Plaza East
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Indianapolis, IN 46229
(317) 890-5722 Fax (317) 890-5725

Therapist-Patient Services Agreement

Welcome to our practice. This document contains important information about our professional services and business policies. It also contains summary information about the Health Insurance Portability and Accountability Act (HIPAA), a federal law that provides privacy protections and client 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 Policies and Practices at Innovative Interventions, LLC, to Protect the Privacy of Your Health Information** (the "Notice"), which is attached to this Agreement, explaining HIPAA and its application to your personal health information in greater detail. Please read this Agreement and the Notice carefully. We will request that you sign the Notice of Privacy Practices acknowledging that we have provided you with this information. We will discuss any questions that you have about this Agreement and the attached Notice in our first meeting. Your signature on this Therapist-Patient Services Agreement will constitute a binding agreement between Innovative Interventions, L.L.C., and you as well as your consent to begin counseling services (treatment) with you or your minor-aged child.

COUNSELING SERVICES

The therapists at Innovative Interventions all have Master level degrees. These Master level degrees include the field of Social Work, Mental Health Counselor, and Marriage and Family Therapy. The counseling services (treatment) rendered by the therapists through Innovative Interventions are supervised by a Licensed Clinical Psychologist with HSPP (i.e., Health Service Provider in Psychology). The Licensed Clinical Psychologist who is contracted with Innovative Interventions to provide supervision is Thomas A. Battocletti, Ph.D., HSPP. Neither Dr. Thomas Battocletti nor the therapists are physicians; thus, we cannot prescribe medications or perform medical procedures. If a medication evaluation seems indicated, we will consult with your family physician upon your request and written (signed) authorization.

MEETINGS

The therapist will conduct an "Intake Assessment" in the first session. Input from the patient/family regarding the Goals and Interventions outlined in the "Master Treatment Plan" will be sought during the first session. On the basis of this assessment, along with supervision provided by Dr. Thomas A. Battocletti, a "Master Treatment Plan" will be developed. This is a collaborative process—the patient/family, therapist, and Dr. Battocletti working together to make certain that the "Plan" for treatment is evidence-based and meets the individualized needs of the patient. Following the Intake Assessment, subsequent counseling appointments will be made. The Master Treatment Plan will be shared with the patient/family and modified as needed. We will decide, together, how often it would be best to meet for counseling. At least 24 hours prior notification to cancel an appointment is required. Giving 24 hours notice to cancel will not be held against the patient's record. Any appointment cancelled with less than 24 hours notice will be considered a no-show appointment. Not being present for a scheduled appointment is also considered a no-show. Three no-show appointments in one year will result in all future appointments being cancelled. Exceptions will only be considered with a note from a doctor, attorney, or school stating a reason for the missed appointment.

CONTACTING THE THERAPIST OR OTHER STAFF AT INNOVATIVE INTERVENTIONS

Due to work schedules, we are often not immediately available by telephone. You can contact the office between 9:00am and 5:00pm Monday through Friday or leave a message on the cell phone of your therapist. Remember that, in general, telephone calls are not meant to take the place of a counseling session.

EMERGENCIES

In the event of a life-threatening emergency, please call one the following emergency/crisis numbers before calling your therapist:

Emergency Services	911	St. Vincent Crisis	317-338-4800
Community Hospital Crisis	317-621-5700	Valle Vista Crisis	317-883-5289

PROFESSIONAL SERVICES
All records will be kept pursuant to HIPAA. Except in unusual circumstances that involve potential danger to yourself or others, 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. If you wish to see your records, it is recommended that you review them with the therapist so that the contents can be discussed.

Upon request and written (signed) Authorization, you may have a copy of your Clinical Record and/or Psychotherapy Notes forwarded to another mental health professional. The exceptions to this policy are contained in the attached Notice of Privacy.

PROFESSIONAL FEES, BILLING, AND PAYMENT
Our hourly fee for counseling services is $150.00.

Innovative Interventions, LLC is not able to provide services to patients who have both Medicaid and private insurance due to complexity in billing for services when dual insurance is involved. This is especially true when Innovative Interventions, LLC does not have a contract with a private insurance company to be billed.

If your insurance changes in any way, then it is your sole responsibility to notify both your therapist and the administrator of Innovative Interventions, LLC by calling 317-890-5722. This includes if you change insurance companies, add any new policies, or if you lose your Medicaid insurance coverage. When your insurance policy changes and if your Medicaid insurance no longer covers your services with Innovative Interventions, LLC, then you can and will be billed directly for services that are not covered. It is your sole responsibility to pay for Innovative Interventions, LLC services when your insurance will not cover the cost.

If you become involved in legal proceedings that require the participation of anyone through Innovative Interventions, LLC (e.g., giving testimony or depositions), you will be expected to pay for any/all time devoted to such services, including preparation and transportation costs, even if someone through Innovative Interventions, LLC, is called to testify by another party. Because of the complexity of legal involvement, the charge for preparation, transportation, and attendance at any legal proceedings is $200.00 per hour. A retainer fee is charged based on the estimated time involved. This is a minimum charge of $400.00, which is to be paid in advance of any work. THESE LEGAL FEES ARE NOT COVERED BY MEDICAID. The PATIENT is responsible for these fees.

SUPERVISION PROVIDED TO THE THERAPIST BY DR. THOMAS A. BATTOCLETTI
As noted above, all therapists providing counseling services (treatment) through Innovative Interventions, LLC, are supervised by Thomas A. Battocletti, Ph.D., HSPP (Licensed Clinical Psychologist). Dr. Thomas A. Battocletti will securely maintain, pursuant to HIPAA, photocopies of all Clinical Records, Psychotherapy Notes, and Billing Records for services rendered under his supervision. Your signature on this Therapist-Patient Services Agreement constitutes your signed Authorization for the therapist (and Innovative Interventions, LLC) to release information to Dr. Thomas A. Battocletti in order for him to provide supervision to the therapist and obtain photocopies of the aforementioned documentation/records.

CONFIDENTIALITY
The law protects the privacy of all communication between a patient and a therapist. 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. There are other situations that require only that you provide written, advance consent. Your signature on this Therapist-Patient Services 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 will avoid revealing the identity of the 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 Protected Health Information [PHI] in the attached Notice of Policies and Practices at Innovative Interventions, LLC, to Protect the Privacy of Your Health Information).

- If a patient seriously threatens to harm himself/herself, I may be obligated to seek hospitalization for him/her, or contact family members or others who can help provide protection. I may disclose confidential information only to medical or law enforcement personnel if I determine that there is a probability of imminent physical injury by the patient to himself/herself or others.

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 your diagnosis and treatment, such information is protected by privilege/confidentiality laws. I cannot provide any information without your (or your legal representative's) written/signed Authorization, or a court order. If you are involved in or contemplating litigation, you should consult with your attorney to determine whether court action 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 you file a worker's compensation claim, I may be required to disclose PHI, such as diagnosis and treatment records, to relevant parties or officials.

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

- If I have cause to believe that a child under 18 has been or may be abused or neglected (including physical injury, substantial threat of harm, or any kind of sexual contact or conduct), or that a child is a victim of a sexual offense, or that an elderly or disabled person is in a state of abuse, neglect or exploitation, I must report that belief, as required by law, to the appropriate authorities. Once such a report is filed, I may be required to provide additional information.

- If I determine that there is a probability that the patient will inflict imminent physical injury to another, or that the patient will inflict imminent physical harm upon himself/herself, I will be required to take protective action by disclosing information to medical or law enforcement personnel or by securing hospitalization of the patient.

If such a situation arises, I will make every effort to fully discuss it with you before taking 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 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.

PATIENT'S RIGHTS
HIPAA provides you with several new or expanded rights with regard to your Clinical Record and disclosures of protected health information (PHI). 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 disclosures of PHI; determining the location that protected information disclosures are sent; having any complaints you make about my policies and procedures recorded in your records; and the right to have a paper copy of this Agreement, the attached Notice of Privacy Practices form, and the privacy policies and procedures at Innovative Interventions, LLC. I am happy to discuss any of these rights with you.

MINORS AND PARENTS
Patients under 18 years of age who are not emancipated and their parents should be aware that the law allows parents to examine their minor-aged child's treatment records, unless I believe this review would be harmful to the patient and his/her treatment. Because privacy in psychotherapy is often crucial to successful progress, particularly with teenagers, it is my policy to request an agreement from parents that they give consent to give up their access to their child's record. If they agree, I will provide them only with general information about the progress of the child's treatment, 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 make every effort to discuss the matter with the child, if possible, and do my best to handle any objections he/she may have with what I am prepared to discuss.

ADDITIONAL INFORMATION
You have the right to choose not to receive therapy from me, at any time. If you choose this, I will provide you with names of other qualified professionals whose service you might prefer. You also have the right to ask any questions about the procedures used in therapy/treatment. I encourage you to ask questions about my therapy/treatment methods as they arise. I encourage you to ask me any questions you may have about the structure of our therapist-patient relationship or the nature of treatment, at any time. Please feel free to discuss with me any problem that may arise regarding any of these policies. I look forward to a successful and beneficial therapist-patient relationship with you.

AGREEMENT AND CONSENT FOR TREATMENT

[PLEASE PRINT]

_____	_____	_____
Patient Name	Date of Birth	Age
_____	_____	_____
Address	City/State	Zip Code

_____
Primary: Home/Cell Phone

Permission to leave message at this number (with person answering the phone, answering machine, and/or voice mail) and/or to send text messages: ☐ Yes ☐ No _____ (Initials)

_____
Secondary: Phone Number

Permission to leave a message at this number (with person answering the phone, answering machine, and/or voice mail) and/or to send text messages: ☐ Yes ☐ No _____ (Initials)

*** Please know that text messages are not always secure or confidential. It is for this reason that text messages will be brief and limited to arranging, modifying, or confirming appointments. ***

IF PATIENT IS MINOR-AGED CHILD:

_____ _____
Parent/Legal Guardian/ Representative/ (Responsible Party) [PLEASE PRINT]
Relationship to Child

_____ _____
Parent/Legal Guardian/ Representative [PLEASE PRINT]
Relationship to Child

_____ _____ _____
Address City/State Zip Code

_____
Primary: Home/Cell Phone

Permission to leave message at this number (with person answering the phone, answering machine, and/or voice mail) and/or to send text messages: ☐ Yes ☐ No _____ (Initials)

_____
Secondary: Phone Number

Permission to leave a message at this number (with person answering the phone, answering machine, and/or voice mail) and/or to send text messages: ☐ Yes ☐ No _____ (Initials)

_____
If applicable, Non-Custodial Parent [PLEASE PRINT]

_____ _____ _____
Address City/State Zip Code

_____
Primary: Home/Cell Phone

Permission to leave message at this number (with person answering the phone, answering machine, and/or voice mail) and/or to send text messages: ☐ Yes ☐ No _____ (Initials)

_____
Secondary: Phone Number

Permission to leave a message at this number (with person answering the phone, answering machine, and/or voice mail) and/or to send text messages: ☐ Yes ☐ No _____ (Initials)

In the event of an emergency, permission to contact next of kin: Yes No

If yes, Name: _____ Phone Number: _____

Who Referred You to My Practice: _____

Patient's Pediatrician or Family Physician: _____

I, _____, have read this
(Parent/Legal Guardian/Representative/Responsible Party) [PLEASE PRINT]

Therapist-Patient Services Agreement and the attached Notice of Policies and Practices at Innovative Interventions, LLC, to Protect the Privacy of Your Health Information fully and completely, I have discussed any questions I had about the information, and I understand the information. I understand that there are no guarantees stated or implied, and I accept the risks inherent in the course of therapy/treatment. I understand the payment, charges, and fees for services provided by Innovative Interventions, LLC. I agree to hold Innovative Interventions, LLC, harmless for any injury or claim of damages arising from release of records or information to my insurance company/managed care company, Medicaid, or collection agency.

_____ _____
Patient Signature Date

_____ _____
Parent/Guardian/ Date
Representative Signature

_____
Legal Authority of
Representative

_____ _____
Witness/Therapist Signature Date

_____
Print: Therapist Name and Credentials

I, _____, have read and I understand that
(Parent/Legal Guardian/Representative/Responsible Party) [PLEASE PRINT]
this Therapist-Patient Services Agreement will constitute a binding agreement between Innovative Interventions, LLC, and I and that Innovative Interventions, LLC, and I agree to abide by its terms during our professional relationship. I agree and consent to participate in mental health services (for myself or my minor-aged child) offered through Innovative Interventions, LLC. I understand that I am consenting and agreeing only to those mental health services that the therapist through Innovative Interventions, LLC, is qualified to provide within the scope of his/her certification and training—under the supervision of Thomas A. Battocletti, Ph.D., HSPP (Licensed Clinical Psychologist). I understand that my signature below constitutes written permission—signed Authorization—for Dr. Thomas A. Battocletti to obtain any/all information disclosed by the patient, legal guardian, or others to the therapist during the course of treatment, contained within the Clinical Record, Psychotherapy Notes or otherwise, for counseling services provided by the therapist under the supervision of Dr. Thomas A. Battocletti (This includes permission for Dr. Thomas A. Battocletti to securely maintain, pursuant to HIPAA, photocopies of all Clinical Records, Psychotherapy Notes, and Billing Records for services rendered under his supervision).

_____ _____
Patient Signature Date

_____ _____
Parent/Guardian/ Date
Representative Signature

_____
Legal Authority of
Representative

_____ _____
Witness/Therapist Signature Date

_____
Print: Therapist Name and Credentials