PRACTICE AGREEMENT
Jaclyn Starritt, Ph.D, PLLC
Office within Triangle Center for Behavioral Health Cary

A NOTE ABOUT COLLEAGUES IN THIS OFFICE

The clinicians in 539 Keisler Dr. Suite 201 Cary, NC and I work together as a group for the purpose of sharing office space and necessary support and equipment to facilitate our ability to practice our professions independently. At times, we may consult with one another for the purpose of treatment coordination and routine peer supervision. However, we are not otherwise bound to one another. Jaclyn Starritt operates as the independent business owner of Jaclyn Starritt, PhD, PLLC and has no legal or business relationship with any therapist working in this location. In addition TCBH Cary, LLC (Triangle Center for Behavioral Health) is a business entity for the purpose of renting space and advertising, no one who subleases space in this office is an employee of TCBH Cary, LLC and TCBH Cary, LLC does not practice psychology.

WELCOME TO MY PRACTICE

This document contains important information about my practice and its business policies. It also contains summary information about the Health Insurance Portability and Accountability Act (HIPAA), a federal law that provides privacy protections and patient rights with regard to use and disclosure of your Protected Health Information (PHI) used for the purpose of treatment, payment, and health care operations. The Notice explains HIPAA and its application to your protected health information in greater detail. The law requires that I obtain your signature acknowledging that I have provided you with this information at the beginning of your treatment. Please read it carefully and make note of any questions you may have. After reading this and discussing your questions, please sign and date the form. Once you sign this document, it will represent an agreement between us.

PSYCHOLOGICAL SERVICES

Psychological evaluation and therapy are not easily described in general statements. They vary depending on the methods of the psychologist and the particular concerns of the patient. My services vary depending on your needs. There are many available methods used to help us reach your treatment goals.

Evaluation and therapy 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, it often leads to better relationships, solutions to problems and significant reductions in feelings of distress over time. 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. 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 careful about the therapist you select. If you have questions about my procedures, we should discuss them whenever they arise.

APPOINTMENTS & CANCELLATION POLICY

Keeping regular session is essential to treatment success. You are therefore strongly encouraged to keep appointments unless it is absolutely necessary to cancel or reschedule. Your appointment time is reserved exclusively for you. If you are unable to keep your appointment, please notify me as soon as possible. In order to avoid being charged for the

session, you should notify me at least 24 hours in advance that you will not be keeping the appointment. Fees are assessed for late cancellations (less than 24 hours advance notification) and no-shows (failing to notify me in advance that you will not be keeping the appointment).

PRACTICE FEE SCHEDULE

The following fee schedule outlines the services available and the current fees associated with those services. Please note that these fees are reviewed periodically and subject to revision. Existing patients will receive a grace period and sufficient notice before their fees are adjusted.

Intake Appointment

60 minutes	$225

Therapy Sessions

60 minutes	$225
45 minutes	$165
30 minutes	$120
Extended Session	Prorated

Testing Services (Psychological,Psychoeducational, Neuropsychological)

Step 1: Intake Appointment (60 minutes) $225

Step 2: Testing procedures: The total cost of testing varies based on factors such as the nature of your concerns, the actual testing procedures, and the extent of documentation (i.e. report) prepared. I will provide you with an estimate of your testing and documentation fees at the conclusion of the intake appointment. Please be advised that testing typically takes two plus hours. The estimated cost may be different than the actual cost. The services and their corresponding fees are indicated below:

Face-to-face testing (per hour)	$250
Scoring/Interpretation/Comprehensive Report (per hour)	$150
Classroom Observations (per hour)	$250
Consultation with teacher(s), etc (per hour, prorated)	$200
Attendance at school/IEP meeting (per hour, prorated):	$250

Step 3: Appointment to review test results and recommendations

45 minutes	$165
60 minutes	$225

Early Kindergarten Testing

IQ only	$200
IQ & Achievement	$400
Full evaluation with report	$650

Other Fees

Communications (email, phone)	15 minutes	$55
Document preparation	15 minutes	$55
Late cancellations (less than 24 hours notice)		$75
No show/missed appointment without notification		$165

Legal Proceedings
Per hour $500

LEGAL PROCEEDINGS
I require a subpoena for deposition and testimony. Should I be subpoenaed for deposition and testimony, I may also object on the grounds of statutory privilege and may request a court order and a Qualified Protective Order in order to adhere to HIPAA and maximize the protection of patient confidentiality. There may be other reasons for objecting to a subpoena, depending on the details of the case. I will provide an estimate of the total number of hours the depositions and testimony will take and will track my time. Should the case take less time than estimated, I will immediately return funds for hours unused, and should the case take additional time, I will bill the patient for the balance, with the balance due within 15 days of billing. The fee for depositions and testimony as a fact or expert witness is $500 per hour. I will estimate time at court or depositions in hourly increments and additional time will also be estimated and billed at the same $500 per hour rate to account for preparation. I will provide a comprehensive estimate of time to the subpoenaing attorney and/or party. If my attorney reviews any subpoena or has involvement in the process, you agree to pay 100% of all attorney's fees incurred by me. IMPORTANT: Should you attempt to subpoena me without paying my usual and customary fees (i.e., the full estimate) in advance, and refuse to rescind the subpoena, I will move to quash and/or file counter complaint for abuse of process, and you agree to pay 100% of attorney fees incurred by me, said fees to be rolled into your estimate.

To guarantee availability I require a minimum of two weeks notice for depositions or testimony. I will make every effort to be available if less than two weeks notice is given, but I may have scheduling conflicts with too little notice. I require 1⁄2 of the hourly estimate to hold the date; this holding fee is fully refundable if I am notified five full business days prior to said date that my services will not be needed. The remaining 1⁄2 of the estimate is due in full five full business days prior to the date. Should cancellation occur less than five full business days in advance, the money will be returned minus an hourly fee of $225 for the time held (which covers time lost with patients in the office that day), and minus any preparation hours that have already been spent on the case (billed at the $500/hr). After the deposition or testimony has taken place I do not offer refunds for any reason. Attorneys may pay by any form of check, credit card (or cash); parties must pay by cashier's check, credit card, or cash.

Late Fees & Returned Checks: If a balance accrues for any reason, it is due within 14 days of the invoice date. I will inform you of your balance. If for some reason there is an outstanding balance after 14 days a finance charge of 10% will be added for each two weeks of outstanding balance. A collection agency will be notified if the bill has not been paid within 30 days. If an attorney must be hired to collect the past due balance, all fees for this service will be charged to you as well. Regarding returned check fees, you will owe any fees the bank charges me for the bounced check, any fees for time I must spend talking with the bank or you to rectify the situation (billed at $225/hour in 15-minute increments), plus any late fees that apply. Regarding delinquent accounts, you are responsible for, in full, and will be charged for, in full, any and all time I spend trying to collect on the account (billed at $225/hour), and/or any and all fees of any outside services, such as an attorney or credit collector, hired to collect the debt.

BILLING AND PAYMENTS
You will be expected to pay for each session at the time it is held, unless we agree otherwise. I accept the following methods of payment: credit card, check, and cash. Checks need to be

made out to me. 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, I 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 patient's treatment is his/her name, the nature of services provided, and the amount due. (If such legal action is necessary, the costs will be included in the claim.)

INSURANCE REIMBURSEMENT

In order for us to set realistic goals and priorities, it is important to evaluate what resources you have available to pay for your treatment because I am an out-of-network provider for all insurance companies. As a courtesy, I can electronically submit a claim form on your behalf; however, I strongly encourage you to contact your insurance company prior to services to determine your out-of-network benefits and for you to request pre-authorization if necessary. I cannot guarantee reimbursement from your insurance company.

You should also be aware that if you request reimbursement from your insurance carrier, your contract with your health insurance carrier requires that I provide them with information relevant to the services that I provide to you. I am required to provide a clinical diagnosis and a service code. 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 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 electronically. 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.

COMMUNICATION

Due to the nature of my work, I am often not immediately available. Please leave a message for me if you get my voicemail and I will make every effort to respond within 24 hours (with the exception of holidays). Should you decide to contact me 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. While my email is HIPAA compliant, it is not encrypted and there is inherent risk in loss of confidentiality in transmitting information in this manner. In addition, I may not perform thorough assessments and provide appropriate clinical care via email or SMS. For these reasons, I prefer using email and/or SMS only to arrange or modify appointments. Please do not email or text me content related to your therapy sessions. Should you elect to communicate with me via email or SMS, you are effectively opting out of encrypted forms of communication and accept the potential risk of loss of confidentiality assumed by using these methods. If you cannot reach me and feel that you have an emergency, call 911 or go to the nearest emergency room and ask for the psychiatrist on call.

TCBH and myself have a presence on certain social media venues so that individuals can access information regarding services provided and helpful information. However, I practice a strict policy of not "friending" and/or communicating with current or previous patients or their families through social media (e.g., Facebook, LinkedIn, etc.). I enforce this policy to protect your privacy and to keep the boundaries of our therapeutic relationship clear.

CONFIDENTIALITY

In general, the law protects the privacy of all communication 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 document 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.

- My practice maintains its own secure patient records, stored separately from those of the other providers within Triangle Center for Behavioral Health. Your confidential information may not be accessed by other providers without your written authorization. However, in the event of my death or incapacitation, a representative I have designated will oversee the short-term clinical operations of my practice. By signing this form, you are consenting to allow that individual access to your records in order to contact you regarding my status and to assist you with seeking alternative clinical services as needed. If ever I am unable to access your records or communicate with you during a clinical emergency, a representative may access your records in my absence. By signing this form, you are consenting to allow this individual to contact you during an emergency and assist you with accessing emergency services, as well as contact other parties involved in the emergency situation, including law enforcement, in order to ensure your safety and that of others.

- You should also be aware that I have a contract with My Clients Plus, LLC, a web-based company that provides billing, clinical documentation, credit card merchant, and calendar/patient scheduling services. As required by HIPAA, I have a formal business associate contract with My Clients Plus, LLC, in which it promises to maintain the confidentiality of your protected health information, except as specifically allowed in the contract or otherwise required by law.

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

There are some situations in which 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 that I provided you, such information is protected by the psychologist-patient privilege law. I cannot provide any information without your 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 a patient files a worker's compensation claim, and my services are being compensated through workers compensation benefits, I must, upon appropriate request, provide a copy of the patient's record to the patient's employer or the North Carolina Industrial Commission.

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 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 patient presents an imminent danger to the health and safety of another, I may be required to disclose information in order to take protective actions, including initiating hospitalization, warning the potential victim, and/or calling the police.

MINORS AND PARENTS
Parental involvement is essential to the successful treatment of minors and this may require that some private information be shared with parents. It is my policy only to share information that is considered necessary with a minor patient's parents, this does not include information regarding substance use, sexual preference, etc. It does include 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 consent.

It is important that any questions or concerns that you may have about confidentiality, either now or in the future, be discussed immediately with me.

PROFESSIONAL RECORDS
You should be aware that, pursuant to HIPAA, I keep protected health information about you in two sets of professional records. One set constitutes you Clinical Records. It includes information about your reasons for seeking therapy, a description of ways in which you problem impacts you 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 received from other providers, reports of any professional consultations, your billing records and any reports that have been sent to anyone, including those sent to your insurance

carrier. Except in unusual circumstances that involve danger to yourself and/or others 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. If I refuse your request to access to your records, you have a right of review, which I will discuss with you upon request. There is a fee for copies of your records.

PATIENT 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 I 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. I will be happy to discuss any of these rights with you. These rights are explained further in the Privacy Notice.

Jaclyn Starritt, Ph.D., PLLC Psychologist-Patient Services Agreement
Effective January 1, 2018

By signing below I, _____, acknowledge that I
Patient's Full Name (Print)

understand and accept all the terms in the above agreement for services provided my clinician.

I also acknowledge that I have received the HIPAA Privacy Notice Form described above.

_____ _____
Signature (required for patients 18 years or older) Date

_____ _____
Parent or Legal Guardian's Signature Date (required for minors) Date

Please initial and complete the following information:

____ I authorize the release of relevant information to my insurance company should they request information to aid in the processing of claims or the extension of treatment.

____ I acknowledge that email (although HIPAA compliant) and SMS communication are not encrypted and consent to communicating with Dr. Starritt via these methods. My email is

_____.

____ I am aware that all emails are retained in the logs of the Internet Service Providers.

____ If providing Dr. Starritt information via text or email, I understand that providing clinical judgements on that basis is limited and imperfect.

____ I understand that Dr. Starritt does not accept, friend or follow requests from current or previous patients or their family members on social media websites

____ A detailed voicemail can be left at the following phone number(s)_____

_____
Patient Name

_____ _____
Patient or Responsible Party's Signature Date