**Elena Kyrgos, LMFT**
8233 Old Courthouse Rd, Ste 340
Vienna, VA, 22182
Work: 703.981.0870
E-mail: Elena.LMFT@gmail.com

# PSYCHOTHERAPIST-CLIENT SERVICES AGREEMENT

**Confidentiality:**
Everything discussed in session is confidential. I will disclose information about your treatment to others only with your written authorizations. The only exceptions to this are suspected abuse or neglect of a child or an elderly person, the expressed intention to harm yourself or someone else, or an order by a judge. Confidentiality and the above exceptions are determined by federal and state laws and by the ethical practices outlined by the professional licensing board.
If several members of your family attend sessions with me, or when working with partners in couples therapy, information shared with me by one family member is not necessarily confidential from others in treatment. If you are a young adult and your parent(s) is/are financially responsible for therapy, I may share a general treatment plan with them and treatment recommendations as appropriate.

**Health Insurance & Confidentiality of records (DOES NOT APPLY TO CLIENTS PAYING OUT-OF-POCKET):** Disclosure of confidential information may be required by your health insurance carrier or HMO/PPO/EAP in order to process the claims. Elena Kyrgos, M.S., LMFT, LLC has no control or knowledge over what insurance companies do with the information she submits or who has access to this information.

**PAYMENTS & INSURANCE REIMBURSEMENT:** Non-insurance clients are expected to pay the standard fee of $125 per 50-minute session and $210 for 90 minute sessions. Payment is expected to be collected at each session at the time of that session and is accepted in the form of cash or personal check. *There is a $30 charge for returned checks.* At the end of every month, I will provide you with a receipt with the information necessary to submit your claims to your insurance provider if you choose to do so. You are responsible for submitting this paperwork to your insurance provider. It is my policy not to let outstanding bills exceed $250 without payment. Please note that this contract takes precedence over any information provided by your insurance carrier.

If you have an insurance policy and I am a provider for that company, I will bill the company for the sessions. Please be aware that insurance companies reimburse only a percentage of your bill. Before we start therapy, please contact your health insurance provider to determine whether your plan covers clinical services received by me.
You are responsible for all co-pays and/or coinsurance required under your insurance plan and are expected to be collected at each session. *There is a $30 charge for returned checks.* ***Please be advised that insurance companies do not reimburse for missed sessions. In this case you will be responsible for paying your assessed charge ($125), not just your usual insurance co-pay.***
If your account is overdue (unpaid), I may use legal or other means (courts, collection agencies, etc.) to obtain payment.

**Litigation Limitation:** Due to the nature of the therapeutic process and the fact that it often involves making a full disclosure with regard to many matters, which may be of confidential nature, it is agreed that should there be legal proceedings (such as, but not limited to divorce and custody disputes, injuries, lawsuits, etc.) neither you nor your attorney, nor anyone else acting on your behalf will call me to testify in court or at any proceeding, nor will a disclosure of the psychotherapy records be requested unless otherwise agreed upon in advance. If agreed upon, additional fees will apply for testifying in legal proceedings.

**Telephone Calls:** I do not charge for brief telephone conversations to schedule, change, or confirm appointments. Extended phone calls and other services such as preparation of special reports or telephone

consultations are billed at $125.00 per hour. I will return telephone calls as promptly as my schedule allows. Weekend calls will be returned the following business day. If you have an emergency and cannot wait for my return call, go to your nearest emergency room or call 911 or call your local community service board emergency numbers. I do not have the ability to provide 24-hour emergency contact. If you believe that you situation will require a therapist that has a 24-hour support, please discuss this with me as soon as possible.

**Cancellations/weather emergencies:** Continuity is crucial to the effectiveness of therapy. Please notify me as far in advance as possible if you need to cancel a session. ***You will be charged the full fee ($125) for appointments you do not cancel at least 48 hours in advance.*** If you are late for your appointment, you will still be charged for the entire time allotted for the meeting. For weather emergencies/cancellations please call my number: 703-981-0870 to find out if I am canceling sessions.

**The Process of Therapy and Termination:** Participation in therapy can result in a number of benefits to you. Working towards these benefits requires effort on your part. There is no guarantee that psychotherapy will yield positive or intended results and it is normal to experience some unpleasant feelings from therapy. On the other hand, psychotherapy may help you change your unhealthy or maladaptive thoughts and behaviors and give you more rewarding interpersonal relationships. Our collaboration in addressing you problems will be enhanced by the amount of time and effort you devote to our work outside of our therapy sessions as well as during our appointment. During our sessions it is important you are forthcoming with feedback about how you are feeling about our work so that we can decide together if changes in your treatment should be made.

After the first few meetings, I will assess if I can be of benefit to you. I do not accept clients who, in my opinion, I cannot help. In such a case, I will give you a number of referrals that you may contact. You have the right to withdraw from therapy at any time. It is expected that you will let me know of your desire to end therapy. I highly recommend that you have a final session with me after you decide to end therapy so that we can review our work together and collaborate in this important stage of therapy.
If you cancel or miss scheduled appointments and do not contact me for more than 30 days, it is understood that you have terminated treatment. Once treatment is terminated, the therapist has no further obligation to the client. If you have completed a course of therapy and wish to resume at some point in the future, I will make every effort to accommodate your scheduling needs.

Your signature below indicates that you understand the above terms. Please ask for clarification of any points.

_____ _____
Printed Name Date

_____ _____
Signature Date

_____ _____
Printed Name (partner or family member) Date

_____ _____
Signature Date

_____ _____
Printed name of Financially Responsible Custodial Parent/Guardian if Applicable Date

_____ _____
Signature of Financially Responsible Custodial Parent/Guardian if Applicable Date

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# Confidential Communications Request Form

You have the right under the HIPAA guidelines to request the type of confidential communications you would like to have with Elena Kyrgos, M.S., LMFT, LLC. To help us get your healthcare information to you in a timely and efficient manner we need you to complete this form identifying your wishes. We will accommodate reasonable requests. As always, Elena Kyrgos, M.S., LMFT, LLC is dedicated to maintaining the privacy of your health care information.

Please select the method(s) by which our office may contact you:

Will you authorize Elena Kyrgos, M.S., LMFT, LLC to leave a message on your phone answering system giving the name Elena Kyrgos, M.S., LMFT, LLC as who is calling, the phone number and a brief description of why we are calling?

Home Phone: _____ OK to leave message here? Y/N

Work Phone: _____ OK to leave message here? Y/N

Cell Phone: _____ OK to leave message here? Y/N

In the event that Elena Kyrgos, M.S., LMFT, LLC would need to email or respond to your email, will you authorize Elena Kyrgos, M.S., LMFT, LLC to send PHI on your email address listed below:

Yes_____ No_____

Email: _____ Initials:_____

Print Name:_____

Client Signature:_____ Date: _____

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# Notice of Therapist's Policies and Practices to Protect the Privacy of Your Health Information

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

## I. Uses and Disclosures for Treatment, Payment, and Health Care Operations

We may *use* or *disclose* your *protected health information* (*PHI*), for *treatment, payment, and health care operations* purposes with your *consent*. To help clarify these terms, here are some definitions:
"*PHI"* refers to information in your health record that could identify you.
*"Treatment, Payment and Health Care Operations"*
– *Treatment* is when we provide, coordinate or manage your health care and other services related to your health care. An example of treatment would be when we consult with another health care provider, such as your family physician or another psychologist.
- *Payment* is when we obtain reimbursement for your healthcare. Examples of payment are when we disclose your PHI to your health insurer to obtain reimbursement for your health care or to determine eligibility or coverage.
- *Health Care Operations* are activities that relate to the performance and operation of our practice. Examples of health care operations are quality assessment and improvement activities, business-related matters such as audits and administrative services, and case management and care coordination.
"*Use*" applies only to activities within our office, clinic, practice group, etc. such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.
"*Disclosure*" applies to activities outside of our office, clinic, practice group, etc., such as releasing, transferring, or providing access to information about you to other parties.

## II. Uses and Disclosures Requiring Authorization

We may use or disclose PHI for purposes outside of treatment, payment, and health care operations only when your appropriate authorization is obtained. An "*authorization"* is written permission above and beyond the general consent that permits only specific disclosures. In those instances when we are asked for information for purposes outside of treatment, payment and health care operations, we will obtain an authorization from you before releasing this information. We will also need to obtain an authorization before releasing your psychotherapy notes. *"Psychotherapy notes"* are notes we have made about conversations during a private, group, joint, or family counseling session, which have been kept separate from the rest of your medical record. These notes are given a greater degree of protection than PHI.
You may revoke all such authorizations of PHI or psychotherapy notes at any time, provided each revocation is in writing. You may not revoke an authorization to the extent that (1) we have previously relied on that authorization; or (2) if the authorization was obtained as a condition of obtaining insurance coverage, and the law provides the insurer the right to contest the claim under the policy.

## III. Uses and Disclosures with Neither Consent nor Authorization

We may use or disclose PHI without your consent or authorization in the following circumstances:

**Child Abuse:** If we have reason to suspect that a child is abused or neglected, we are required by law to report the matter immediately to the Virginia Department of Social Services.

**Adult and Domestic Abuse:** If we have reason to suspect that an adult is abused, neglected or exploited, we are required by law to immediately make a report and provide relevant information to the Virginia Department of Welfare or Social Services.

**Health Oversight:** The Virginia Board of Psychology has the power, when necessary, to subpoena relevant records should we be the focus of an inquiry.

**Judicial or Administrative Proceedings:** If you are involved in a court proceeding and a request is made for information about your diagnosis and treatment and the records thereof, such information is privileged under state law, and we will not release such information without the written authorization of you or your legal representative, or a subpoena (of which you have been served, along with the proper notice required by state law). However, if you move to quash (block) the subpoena, we are required to place said records in a sealed envelope and provide them to the clerk of court of the appropriate jurisdiction so that the court can determine whether the records should be released. The privilege does not apply when you are being evaluated for a third party or where the evaluation is court ordered. You will be informed in advance if this is the case.

**Serious Threat to Health or Safety:** If we are engaged in our professional duties and you communicate to me a specific and immediate threat to cause serious bodily injury or death, to an identified or to an identifiable person, and we believe you have the intent and ability to carry out that threat immediately or imminently, we must take steps to protect third parties. These precautions may include (1) warning the potential victim(s), or the parent or guardian of the potential victim(s), if under 18; or (2) notifying a law enforcement officer.

IV. Patient's Rights and Therapist's Duties

Patient's Rights:
*Right to Request Restrictions* –You have the right to request restrictions on certain uses and disclosures of protected health information about you. However, we are not required to agree to a restriction you request.
*Right to Receive Confidential Communications by Alternative Means and at Alternative Locations* – You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations. (For example, you may not want a family member to know that you are seeing us. Upon your request, we will send your bills to another address.)
*Right to Inspect and Copy* – With some exceptions, you have the right to inspect or obtain a copy (or both) of PHI about you. You will be charged one dollar per page for any PHI that I copy for you. I may deny your access to PHI under certain circumstances, but in some cases you may have this decision reviewed. Upon your request, I will discuss with you the details of the request and denial process. There are certain situations in which I am not required or permitted to comply with your request.
*Right to Amend* – You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. We may deny your request. On your request, we will discuss with you the details of the amendment process.
*Right to an Accounting* – You generally have the right to receive an accounting of disclosures of PHI . On your request, we will discuss with you the details of the accounting process.
*Right to a Paper Copy* – You have the right to obtain a paper copy of this notice from us upon request, even if you have agreed to receive the notice electronically.

Therapist's Duties:

We are required by law to maintain the privacy of PHI and to provide you with a notice of our legal duties and privacy practices with respect to PHI. We reserve the right to change the privacy policies and practices described in this notice. Unless we notify you of such changes, however, we are required to abide by the terms currently in effect. If we revise our policies and procedures, we will provide our patients with a notice at their next scheduled session.

V. Complaints

If you are concerned that we have violated your privacy rights, or you disagree with a decision we have made about access to your records, you may file a complaint with Elena Kyrgos, M.S., LMFT, LLC or with the Secretary of the Department of Health and Human Services. To file a complaint with our office, please send a written complaint to Elena Kyrgos, M.S., LMFT, LLC at 8233 Old Courthouse Rd, Suite 340, Vienna, VA 22182. Upon your request, we will provide you with the appropriate address if you choose to send a written complaint to the Secretary of the U.S. Department of Health and Human Services. You will not be penalized for filing a complaint.

VI. Effective Date, Restrictions and Changes to Privacy Policy

This notice went into effect on January 3, 2012. We reserve the right to change the terms of this notice and to make the new notice provisions effective for all PHI that we maintain. We will provide you with a revised notice at the first scheduled treatment visit after any revisions occur.

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# Notice of Privacy Practices Acknowledgement

I understand that, under the Health Insurance Portability and Accountability Act of 1996 (HIPPA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly or indirectly.
- Provide information to a third party for the patient to be reimbursed.
- Conduct normal healthcare operations. For example, to evaluate the quality of care you receive from us.

I acknowledge that I have received a copy of Elena Kyrgos', M.S., LMFT, LLC's Privacy Practices containing a more complete description of the uses and disclosures of my health information. I have been given the right to review Elena Kyrgos', M.S., LMFT, LLC's Notice of Privacy Practices prior to signing this consent. I understand that Elena Kyrgos, M.S., LMFT, LLC has a right to change its Notice of Privacy Practices from time to time and that I may contact Elena Kyrgos, M.S., LMFT, LLC at any time to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that Elena Kyrgos, M.S., LMFT, LLC restrict how my private information is used or disclosed to carry out treatment, payment, or health care operations. I also understand Elena Kyrgos, M.S., LMFT, LLC is not required to agree to my requested restrictions.

Client Name:_____

Relationship to Client of Person Signing:_____

Signature:_____ Date:_____