Sara Wye, LMHC
129 East Greenwich Ave., West Warwick, RI 02893
Phone: 401-821-0929; 401-626-2216
Email: Sarap66@verizon.net

Website: sarawyecounseling.com

Welcome to my practice. This document contains important information about my professional services and business policies. Please read it carefully and jot down any questions that you might have so that we can discuss them at our next meeting. Once you sign this, it will constitute a binding agreement between us.

The Treatment Process

I offer individual psychotherapy to adolescents and adults. My orientation is broadly eclectic, which means I draw from a number of different theoretical perspectives.

The goals of therapy are arrived at by mutual agreement. The length of therapy can range from a few sessions to a number of years. It is often hard to realistically assess at the beginning how long therapy will take.

You and I will determine the frequency of our meetings, depending upon your goals, the financial support for your therapy, and our mutual assessment of what frequency is likely to fit your needs best.

Psychotherapy has both benefits and risks. Risks sometimes include experiencing uncomfortable levels of feelings like sadness, guilt, anxiety, anger and frustration, loneliness and helplessness. Psychotherapy often requires recalling unpleasant aspects of your personal history. On the positive side, psychotherapy has been shown to benefit most people who undertake it. It often leads to a significant reduction of feelings of distress, better relationships, and resolutions of specific problems. But there are no guarantees about what will happen.

After our initial one or several evaluation sessions, I will tell you my impressions and make some recommendations, including whether I think I'm the right person to treat you. You need to think carefully about 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, or anything else about our work, we should discuss them whenever they come up. If your doubts persist, I will be happy to help you get a consultation with another mental health professional.

Pandemic note: as people have gotten used to telephone sessions, I've noticed that some clients are multi-tasking. I've gotten call from clients at the grocery store, while driving, waiting for lunch. Please during your session be in a quiet, private place so we can both focus properly.

Fees

My regular fee for a 50 minute session is $100.- after an initial evaluation session which is $150.-. If we meet for longer or shorter periods, the fee is adjusted accordingly. Reduced rates can be negotiated, depending upon my low-fee client load and other circumstances. If your financial circumstances change over the course of treatment, we might renegotiate the fee. Also, I reevaluate fees once a year, and my own fee may go up over the course of a treatment that lasts more than one year. I would prefer you to pay me at the time you are scheduled for your appointment.

I do not charge for telephone contacts that are shorter than 15 minutes, but do charge my usual fee on a prorated basis for calls 15 minutes or longer.

Twenty four hours is requested for cancellations or changes of appointment times, or else you will be expected to pay your full fee for the cancelled session. In the event of illness or

emergency, there will be no charge for a cancellation. Insurance companies do not pay for missed appointments, so you will be expected to make any payment yourself.

Insurance Coverage

In order for us to set realistic treatment goals and priorities, it is important to evaluate what resources are available to pay for your treatment. If you have a health benefits policy, it will usually provide some coverage for mental health treatment. I will help in whatever way I can to insure you receive the benefits to which you are entitled, including filling out forms as appropriate. However you, and not your insurance company, are responsible for full payment of the fee we have agreed to.

You need to be aware that insurance agreements require you to authorize me to provide them with a clinical diagnosis, and sometimes additional clinical information such as a treatment plan or summary, or in rare cases, a copy of the entire treatment record. This information will become part of the insurance company files, and computerized. All insurance companies claim to keep such information confidential, but once it is in their hands, I have no control over what they do with it. I will provide you with a copy of any report which I submit on your behalf.

Telephone Accessibility

You can always call me at 401-821-0929, where you will usually reach an answering machine accessed only by myself. My cell phone is also available to you: 401-621-2216. I will return your call as soon as possible, and usually within the day. I do not carry a beeper and am usually not available during the night. If you cannot reach me and feel you cannot wait for me to return your call, you should call your family physician or the emergency room at the nearest hospital and ask for the psychologist or psychiatrist on call. If I am unavailable for an extended time, and if you feel it would be helpful, I will provide you with the name of a colleague whom you can contact if necessary.

Record

As required by law and professional ethics, I maintain a confidential record of your contacts with me. You are entitled to receive a copy of the records, unless I have reason to believe seeing the records would be emotionally damaging, in which case, I will be happy to provide them to an appropriate mental health professional of your choice. Professional records can be misinterpreted and/or can be upsetting. If you wish to see your records, I recommend that you review them in my presence so that we can discuss what they contain. Clients will be charged an appropriate fee for any preparation time which is required to comply with their information requests.

Confidentiality

Except as described elsewhere in these pages, I will not reveal to anyone any details about your consultations or therapy, or even the fact that you have met with me without your consent. If in the course of our work, we decide to meet with members of your family or with friends, we will discuss the limits and expectations about confidentiality in advance.
There are circumstances under which I am legally obligated to take action, even though that requires revealing some information about a client's treatment. If what you tell me leads me to believe that a child, an elderly person, or a disabled person is being abused, I must file a report with the appropriate state agency. If I believe that a client is threatening serious bodily harm to another, I am required to take protective actions. If a client indicates a serious intent to harm him/herself, I am required to attempt to prevent that harm. These events have rarely occurred in my practice. Should such a situation occur, I will make every effort to fully discuss it with you before taking any action.

Consultation with Colleagues

I regularly participate in peer supervision and periodically seek individual consultations from experts about the psychotherapy I provide. The purpose of these consultations is to provide clients with a higher quality of service. Names and identifying information about clients are not revealed, however, in order to better protect confidentiality. If you would like to know the names of the individuals with whom I consult, please let me know and I will be glad to share that information with you. Just as it is helpful to me to talk about my experiences as a therapist, within the bounds of maintaining appropriate confidentiality, so I believe it is helpful for clients to talk with people close with them about their experiences, to help clients keep some perspective on their experiences.

Interruptions in Treatment

When I will be out of town, I will inform you about this several weeks in advance, or longer if I will be away for a week or more. If it seems desirable to both of us, I will provide the opportunity for you to meet with another therapist in the interim.

Your signature below indicates that you have read the information in this document and agree to abide by its terms during our professional relationships.

Name _____Date_____

Sara Wye, MA, LMHC

Phone/Fax: 1-401-821-0929 129 East Greenwich Av

Email: sarap66@cox.net West Warwick, RI 028

AUTHORIZATION FOR RELEASE OF INFORMATION

CLIENT_____
CLIENT'S
ADDRESS_____

DATE OF BIRTH_____TELEPHONE _____

_____I hereby authorize Sara Wye, LMHC to *send* the record of my care to:

____ I hereby authorize Sara Wye, LMHC to *obtain* the record of my care from:

Name:_____

Address:_____

Method of release: ___Telephone/Verbal ___Printed Materials ___Both

The following information contained in the medical record of the above patient pertaining to services provided on or about_____

Please check the information to be released or exchanged:

____ Discharge summary ____ Psychiatric evaluation ____ History and physical

____ Treatment plan ____ Psychological testing ____ Educational information

____
Other:_____
_

This information is needed for the purpose of patient care.

*I understand that my records are protected under federal confidentiality regulations (42 CFR, Part 2), confidentiality of alcohol and drug abuse treatment (if applicable).*

*I have read the above statements carefully and understand, and do herein expressly and voluntarily consent to disclosure of the above information and/or medical records (including alcohol and drug abuse treatment records, or HIV/AIDS data, if relevant) to those persons named above.*

*I further release Sara Wye, LMHC from any liability arising from the release of this information to such persons/agencies, provided that said release of information is done substantially in accordance with applicable law.*

*Information released with this authorization will not be given, sold, transferred, or in any way relayed to another person or party not specified above, without my further written consent.*

*I undestand that I may revoke this consent at any time except to the extent action has been taken in reliance on it, and that in any event this consent expires automatically as follows:*

_____

Specification of the date, event or condition upon which this consent expires (if left blank, will expire 1 year from date below).

_____/_____/_____

Signature of client/legal guardian Relationship to client Date

or parent if client is under 18

Sara Wye, LMHC

# PATIENT ACKNOWLEDGEMENT FORM

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), 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 the treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have been informed by you of your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such *Notice of Privacy Practices* prior to signing this consent. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or healthcare operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

Patient Name:_____

Signature:_____

Relationship to Patient:_____

Date:_____

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# HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

PICA

CARRIER

PATIENT AND INSURED INFORMATION

1. MEDICARE ☐ (Medicare #) MEDICAID ☐ (Medicaid #) TRICARE CHAMPUS ☐ (Sponsor's SSN) CHAMPVA ☐ (Member ID#) GROUP HEALTH PLAN ☐ (SSN or ID) FECA BLK LUNG ☐ (SSN) OTHER ☐ (ID)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M ☐ F ☐

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self ☐ Spouse ☐ Child ☐ Other ☐

7. INSURED'S ADDRESS (No., Street)

CITY | STATE

8. PATIENT STATUS Single ☐ Married ☐ Other ☐ Employed ☐ Full-Time Student ☐ Part-Time Student ☐

CITY | STATE

ZIP CODE | TELEPHONE (Include Area Code) ( )

ZIP CODE | TELEPHONE (Include Area Code) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES ☐ NO ☐

a. INSURED'S DATE OF BIRTH MM DD YY SEX M ☐ F ☐

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M ☐ F ☐

b. AUTO ACCIDENT? YES ☐ NO ☐ PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES ☐ NO ☐

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES ☐ NO ☐ *If yes*, return to and complete item 9 a-d.

**READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.**

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM MM DD YY TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM MM DD YY TO

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES ☐ NO ☐ $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)

1. _____ 3. _____

2. _____ 4. _____

22. MEDICAID RESUBMISSION CODE | ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

PHYSICIAN OR SUPPLIER INFORMATION

| 24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY | B. PLACE OF SERVICE | C. EMG | D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS | MODIFIER | E. DIAGNOSIS POINTER | F. $ CHARGES | G. DAYS OR UNITS | H. EPSDT Family Plan | I. ID. QUAL | J. RENDERING PROVIDER ID. # |
|---|---|---|---|---|---|---|---|---|---|---|
| 1 | | | | | | | | | NPI | |
| 2 | | | | | | | | | NPI | |
| 3 | | | | | | | | | NPI | |
| 4 | | | | | | | | | NPI | |
| 5 | | | | | | | | | NPI | |
| 6 | | | | | | | | | NPI | |

25. FEDERAL TAX I.D. NUMBER SSN ☐ EIN ☐

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES ☐ NO ☐

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. BALANCE DUE $

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH # ( )

a. NPI b.

NUCC Instruction Manual available at: www.nucc.org

***PLEASE PRINT OR TYPE***

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