Kari Lenox, Ph.D.
kari@karilenox.com
Phone: (919) 237-2250
Fax: (919) 251-9660

BUSINESS POLICY AND PATIENT AGREEMENT

This agreement contains information about the professional services and business policies offered at Kari Lenox, Ph.D., PLLC. The purpose of this Business Policy and Patient Agreement is to provide detailed information and avoid misunderstandings regarding the scope of services offered. Please review this document carefully. Please initial where indicated and sign and date the last page. Please raise any questions or concerns you might have with a Kari Lenox, Ph.D. or with an administrative staff member of Kari Lenox, Ph.D., PLLC.

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT

The Health Insurance Portability and Accountability Act (HIPAA) and the Notice of Privacy Practices is a federal law that provides additional privacy protection and explains your rights regarding the release of any Protected Health Information (PHI). The law requires your signature stating you have read or have a copy of Kari Lenox, Ph.D., PLLC's Privacy Practices Agreement. You may request a Notice of Privacy Practices from the office.

SCHEDULE OF FEES FOR GENERAL SERVICES

First Diagnostic Interview (Intake Session)	$225
Subsequent Interviews or Therapy Sessions (standard 45 min)	$195
Extended Therapy sessions (60 min)	$240
Shortened Therapy Sessions (30 min)	$150
Group Therapy Sessions (60 min)	$125
Phone Consultations (5min or longer), per quarter hour increments	$75
Late Cancellation (within 48 hrs of appointment), No Show Fees	$195
Completion of any forms, per quarter hour increments	$75
Emails (send/review) (5min or longer), per quarter hour increments	$75
Additional Services performed on behalf of the client, per hour	$210
Expedited Services requiring delivery at the last minute such as court testimony, document preparation, etc. , per hour	$400

SERVICE OF FEES FOR COURT RELATED SERVICES

Family Therapy (60 min). Requires 10 hour retainer at $200/hr	$250
Co-parenting Consultation (60 min)	$250
Court Preparation and/or Testimony, per hour	$250
Parent Coordinator Fees, per hour (Note: requires a $3000 retainer, split $1500 per parent before services begin unless the Court orders otherwise)	$275
Administrative Fee, per hour	$110
Other services not listed above	Negotiable

LATE CANCELLATIONS AND MISSED APPOINTMENT POLICY

Scheduled appointments are reserved for you and for no one else. Kari Lenox, Ph.D., PLLC, requires a notice of ***2 business days to cancel or change your appointment.*** Please inform the office as soon as you are aware you are unable to keep an appointment. Please note if you do not arrive within 15 mins of your appointment the session will need to be rescheduled.

_____ *Initial* If you cancel or do not show for an appointment within the cancellation policy, you will be charged a late cancellation/no show fee for the time that was reserved for you. This fee is the full rate of the service provided.

PAYMENT POLICY

____*Initial* Payment for all services is due at the time services are provided. If payment is not made, then services will be suspended until the account is current.

____*Initial* I understand that all time spent on my case is billable including, but not limited to telephone calls 5mins or longer, review and responding to emails, collaboration with other professionals, generation of treatment summaries, etc..

____*Initial* Finance charges are added if balance is not paid in full at time of service.. Late charges are computed at 1.5% monthly (18% annually) for any balance over 30 days old.

____*Initial* Final payment is expected on behalf of the client before reports or treatment summaries are released.

____*Initial* If your account has not been paid in over 60 days and arrangements for payment have not been made then legal means can be used to secure payment. This may involve hiring a collection agency or going through small claims court to obtain payment. Your name, address, phone number and the amount due will have to be disclosed if this process becomes necessary. If legal action is necessary, the cost of legal fees will be included in the claim.

____*Initial* A working credit card will be kept on file at all times for session fees and all other services.

HEALTH INSURANCE POLICY

Kari Lenox, Ph.D. is not on any health panels and is considered an "out-of-network provider". You are expected to pay for each office visit at the time services are provided. Kari Lenox, Ph.D. can provide you with the statements that have all necessary information for you to file for insurance reimbursement. The office will do our best to assist you with filing a claim, however, disputed claims cannot be addressed.

CONFIDENTIALITY POLICY

The confidentiality of the work conducted by Kari Lenox, Ph.D. will be upheld at all times. By law, there are certain exceptions to this rule and appropriate authorities will be contacted:

1. If Kari Lenox, Ph.D. suspects child abuse or if there is reasonable cause to believe that a disabled adult is in need of protective services.
2. If Kari Lenox, Ph.D. believes that you are a clear and imminent danger to yourself or another person. In this case, others may be notified to prevent the occurrence.
3. If there is need for healthcare oversight, the North Carolina Psychology Board has the power, when necessary, to subpoena relevant records if Kari Lenox, Ph.D. is the focus of an inquiry.
4. If there are legal proceedings, patient/therapist communications are privileged except for the following circumstances:
    a. Your mental status is an issue before the court
    b. If the judge authorizes a court order because he/she feels that communication is necessary to the proper administration of justice
    c. If a government agency is requesting information for health oversight activities, Kari Lenox, Ph.D. may be required to provide it for them.
    d. If a complaint or lawsuit is filed against Kari Lenox, Ph.D., relevant information may be disclosed regarding the patient in order to defend Kari Lenox, Ph.D. and to respond to the inquiry.
    e. If a patient files a worker's compensation claim, Kari Lenox, Ph.D. is required by law to provide mental health information to your employer and the North Carolina Industrial Commission.

5. Services provided will not be audio or video recorded unless discussed prior to and agreed upon by Kari Lenox, Ph.D. and the client. Recording can be grounds for termination of services.

There are instances when confidential issues are not clear cut when working with children and adolescents. In treating your child or adolescent, Kari Lenox, Ph.D. requires your permission to handle confidentially the information shared with us by your child. Kari Lenox, Ph.D. can provide treatment summaries in the event that legal/custody problems arise. Actual communications the child or adolescent have made in therapy will not be provided without the consent of the child unless safety is an issue or unless ordered by a Judge. It is standard practice that parents will be kept informed of general themes or important issues in therapy as they arise. Parents are welcome to share brief updates to inform the treatment process.

READ CAREFULLY AND COMPLETE

____*Initial* I have read the Business Policy and Patient Agreement, understand, and accept the policies above.

____*Initial* I understand that during the course of therapy it may become necessary to increase fees to compensate for increased costs and inflation. Fees will be reviewed periodically and may be increased once a calendar year.

____*Initial* I understand that I am financially responsible for services rendered and that my account is due in full at each session. I understand that Kari Lenox, Ph.D. does not accept assignments of benefits from insurance carriers. I also understand that late charges of 18% annually will accrue on any unpaid portion of my account and there is a $40 service charge for any returned checks.

____*Initial* I agree to pay each visit in full at the time services are rendered.

____*Initial* I understand and accept the confidentiality policy.

____*Initial* I agree that the clinician's role is limited to providing evaluation/ treatment and that I will not involve the clinician in any legal disputes, especially one's involving custody or visitation arrangements.

____*Initial* . If I or my child(ren) are involved in legal proceedings of any kind, I am waiving my rights to access therapy notes, but understand that a treatment summary can be provided at any time. If there is a court appointed evaluator and appropriate releases are signed, or a court order is provided, then general information about my or my child(ren)'s treatment will be shared with the evaluator. This information, however, will NEVER include recommendations regarding custody or custody arrangements.

____*Initial* I will not ask for exact copies of therapy notes. I understand I may be provided a treatment summary if I directly request it.

____*Initial* I understand I will be charged for the time to generate a treatment summary if it is requested.

____*Initial* I will not record or allow anyone else present to record any communications between Kari Lenox, Ph.D. and her client(s). This includes, but is not limited to communications in person, via phone or over the internet.

____*Initial* In legally involved families, a lack of compliance with any treatment recommendations can constitute grounds for termination of services.

____*Initial* I understand all services provided outside of face to face contact (i.e., phone calls, emails, texts, etc.) on my behalf are billable and will be charged to the credit card on file. If there is no card on file, an invoice will be sent via email.
____*Initial* I am aware that email is not a secure or confidential medium of communication. If I send an email, I am granting permission for Kari Lenox, Ph.D. to respond via email and I understand the risks involved in communicating via email. ____*Initial* In addition, I will only use email to handle administrative matters and not for clinical matters. I am aware that emails I send cannot be guaranteed to remain private. For example, in divorced families with joint legal custody, emails sent to me cannot be guaranteed to be kept private from the other parent. Also, I understand any emails I send may not be read before the next session. ____*Initial* No urgent or pressing matters should be sent exclusively via email, as Kari Lenox Ph.D. cannot guarantee how often emails will be checked.
_____ *Initial* Services will be suspended, rescheduled, or refused if there is an outstanding balance on the account. I agree to keep my account current at all times.
_____ *Initial* I understand therapy is a voluntary process and I may communicate my decision to discontinue services at any time. I recognize the billing policies apply to this decision.
Sign: Date:
Note: If the patient is a minor child, then responsible party is to sign and date.
As a patient of Kari Lenox, Ph.D., I acknowledge I had the opportunity to review the HIPAA Notice of Privacy Practices. I understand that if requested, I may have a copy to keep.
Sign: Date:
As a patient of Kari Lenox, Ph.D., I acknowledge I had the opportunity to review the No Surprises Act.
Sign: Date:
As a client of Kari Lenox, Ph.D., I acknowledge I had the opportunity to review the Telepsychology Information and Consent and my signature below provides my consent to participate in telepsychology.
Sign: Date:
Witness Signature: Date:

Kari Lenox, Ph.D.

Kari Lenox, Ph.D.
kari_lenox@hotmail.com
Phone: (919) 237-2250
Fax: (919) 251-9660

ADULT PATIENT INFORMATION

DATE: **ACCOUNT NO.:** **DX:**		
ADULT PATIENT INFORMATION		
Last Name:	First Name:	Nickname:
Birthdate: / /	Age:	Gender:
Marital Status: □ Single □ Separated □ Divorced □ Married		Languages spoken at home:
Street Address:	City:	State: Zip Code:
Home Phone:	Cell phone:	Best number to leave messages:
Have you or a family member been seen by Dr. Lenox before? Y or N		
REFERRAL INFORMATION		
Referred by: _____	How did you learn about this practice: □ Doctor □ Lawyer □ Friend □ School □ Co-worker □ Internet search □ Presentation/Talk □ Marketing □ Other	
EMPLOYMENT INFORMATION		
Occupation:		Employer:
Number of years at current position:		Highest Level of Education:
SPOUSE/PARTNER INFORMATION (IF APPLICABLE)		
Name		
Age		
Highest Education Level		
Occupation		
Employer		
Cell Phone		
Work Phone		
Home Phone (if different from patient)		
Email Address		
Address (if different from patient)		

CHILDREN (PLEASE LIST)		
Names: 1-	Gender : Age:	□ Biological □ Step □ Adopted
2-	Gender : Age:	□ Biological □ Step □ Adopted
3-	Gender : Age:	□ Biological □ Step □ Adopted
4-	Gender : Age:	□ Biological □ Step □ Adopted

MEDICAL INFORMATION			
Doctor:	Phone:	Fax:	
Street Address:	City:	State:	Zip Code:
Medical Problems (list):			
Allergies:			
Hospitalizations/Surgeries:			
Medication Name:	Dosage:	X per day:	Reason:
Medication Name:	Dosage:	X per day:	Reason:
Medication Name:	Dosage:	X per day:	Reason:
MENTAL HEALTH HISTORY			

Kari Lenox, Ph.D.

kari_lenox@hotmail.com
Phone: (919) 237-2250
Fax: (919) 251-9660

Mental Health Diagnoses:

Previous Professionals Seen: Name(s): Date(s):

Previous Evaluations: □ Psychological □ Educational □ Speech and Language □ Occupational Therapy
□ Neuropsychological □ Emotional □ Behavioral

FAMILY STRESSORS

□ Abuse □ Deaths □ Job □ Relocation □ Stepchildren □ Trauma
□ Births □ Divorce □ Marriage □ School □ Substance Use □ Other(s):
□ Bullying □ Finances □ Medical □ Separation □ Substance Abuse

FAMILY STRENGTHS

Please Describe:

REASON FOR SEEKING HELP AT THIS TIME:

Please Describe:

FINANCIAL MATTERS

Who is responsible for payment of services?

If the responsible party is someone other than yourself, it is often easiest to ask this person to sign an authorization form to allow their credit card be used each session. Please discuss the Business Policy and Agreement and Authorization for credit card use with this person and return these forms along with the Financial Responsibility form. ***I understand that I give my permission to discuss financial matters with my parents if they are paying for treatment.***

Signature: Date:

Kari Lenox, Ph.D.

kari_lenox@hotmail.com
Phone: (919) 237-2250
Fax: (919) 251-9660

AUTHORIZATION TO RELEASE OR OBTAIN INFORMATION

DATE:	**ACCOUNT NO.:**		
COMPLETION AND SIGNING OF THIS FORM AUTHORIZES ANY CLINICAL OR ADMINISTRATIVE STAFF OF DR. KARI LENOX, PH.D. TO RELEASE, OBTAIN, OR EXCHANGE PROTECTED HEALTH INFORMATION (PHI) FROM PERSON(S) AND/OR AGENCIES YOU DESIGNATE. I AUTHORIZE DR. LENOX TO RELEASE, EXCHANGE, AND/OR OBTAIN INFORMATION FROM THE FOLLOWING:			
PATIENT INFORMATION:			
Patient Last Name:		Patient First Name:	Birth date: / /
Age:	Gender:	Home Phone:	Cell Phone:
Street Address:		City:	State: Zip Code:
PEDIATRICIAN / PHYSICIAN			
Name:		Phone:	Fax:
Street Address:		City:	State: Zip:
PSYCHIATRIST / OTHER THERAPIST			
Name:		Phone:	Fax:
Street Address:		City:	State: Zip:
SCHOOL			
Name:		Phone:	Fax:
Street Address:		City:	State: Zip:
OTHER (ATTORNEY; AGENCIES; ETC.)			
Name:		Phone:	Fax:
Street Address:		City:	State: Zip:

I may limit this exchange of information to:_____ (list content) otherwise only information related to the coordination of care and treatment will be exchanged. This authorization is only for the limited purposes of evaluation and treatment. It shall not be considered a blanket waiver of all privileged and confidential information. I have the right to revoke authorization at any time by sending written notice to Dr. Kari Lenox. Revocation of consent will not be effective to the extent that action based on the consent has already taken place or if this authorization was obtained as a condition of obtaining health insurance coverage and the insurer has a legal right to contest a claim. I understand that information used or disclosed pursuant to the authorization is beyond the control of Dr. Lenox and consequently may be subjected to re-disclosure by the recipient and no longer protected by HIPAA. This authorization will expire in 365 days unless I elect an expiration date of: ___/___/___

Signature:	Witness:	Date:

Kari Lenox, Ph.D.

kari_lenox@hotmail.com
Phone: (919) 237-2250
Fax: (919) 251-9660

CREDIT CARD AUTHORIZATION

DATE :	**PATIENT NAME:**	**OFFICE ACCOUNT NO.:**

CREDIT CARD AUTHORIZATION

Credit Card Holder's Name:
(Please print as it appears on the card)

MAILING ADDRESS WHERE CREDIT CARD STATEMENT IS SENT:

Street Address: City: State: Zip Code:

Home Phone: Email:

_____Initial ***I hereby authorize charges to my credit card for services rendered by Dr. Kari Lenox, Ph.D. that are not paid directly in cash or check.***
_____Initial ***I understand that late or non-cancelled (no show) visits will be charged to my credit card.***
_____Initial ***I understand that it is my responsibility to notify office personnel if I change my credit card companies and/or numbers.***
_____Initial ***I will update the expiration date of my credit card when necessary.***

CREDIT CARD INFORMATION

Credit Card Company:
□ Visa □ Master Card □ Other _____

Credit Card Number:
_____ - _____ - _____- _____

Credit Card Three Digit Security (CCV#):
_____

Expiration Date:
_____ / _____

Signature: Date:

FINANCIAL RESPONSIBILITY

DATE:	ACCOUNT NO.:	DX:
FINANCIAL RESPONSIBILITY		
Client Last Name:	Client First Name:	
Birthdate: / /	Age:	Gender:
Street Address:	City:	State: Zip Code:
Client Home Phone:	Client Cell phone:	Best number to leave messages:
_____Initial ***I agree to be financially responsible for all costs resulting from the treatment and/or evaluation of the above named client.***		
My relationship to the client is: □ Parent □ Spouse □ Partner □ Guardian Ad Litem □ Family Member □ Other		
FINANCIAL PAYOR'S INFORMATION		
Street Address:	City:	State: Zip Code:
Home Phone:	Cell Phone:	Best number to leave messages:
Date of Birth:		
Each session must be paid in full at the time of service. I understand I am accepting responsibility for the cost of treatment and I plan to submit payment by: □ Cash or check sent with the patient □ Completion of the credit card authorization form		

5318 Highgate Dr., Suite 132
Durham NC 27713
Phone: (919) 228-8845
Fax: (919) 251-9660

NO SURPRISES ACT/GOOD FAITH ESTIMATE

This form is being used to comply with the No Surprises Act to ensure clients understand costs associated with health care services. Although all fees are outlined in Kari Lenox, Ph.D., PLLC Business Policy and Outpatient Agreement, this Act requires providers to obtain your signature indicating an understanding of the fees associated with the services you have chosen to pursue at Kari Lenox, Ph.D., PLLC. Unlike typical medical procedures, estimating the cost of therapy and related mental health services services is much more nuanced, however, there are generally no surprises about charges because they are all outlined in the initial paperwork you complete and sign before you receive any mental health services.

Please know that you are under no obligation to continue in therapy. You are free to discontinue therapy services at any time. Please give us as much notice as possible if you plan to discontinue treatment so your reserved appointment times can be offered to other clients waiting to receive services. Please be advised that services terminated within 48 hours of an already scheduled appointment will incur the late cancellation charge as outlined in the Business Policy. You may avoid this charging by communicating your desire to end services at least 48 hours before your next scheduled appointment.

FEES:

Kari Lenox, Ph.D., PLLC fees are outlined below. These rates are the same as outlined in the Business Policy and Outpatient Agreement:

Intake session	60 min $225
Psychotherapy sessions	45 min $195* 30 min $150 60 min $240
Group therapy sessions	60 min $115
Telephone consultations >5 minutes, prorated in 15 min increments	$300/hr
Other professional services, prorated in 15 min increments (collateral contacts, reading/sending emails, phone calls, etc.)	$300/hr
No Show or Late cancellation (less than 48 hours' notice)	Full cost of service

*45 minutes is the length of a standard therapy appointment

In addition to appointments, charges for other professional services you request such as report writing, telephone conversations lasting more than 5 minutes, reading and/or composing emails, composing letters, scoring tests, attendance at meetings or consultations with other professionals, travel time to meetings, preparation of records or treatment summaries, or the time required to perform any other service you request will be charged on a prorated basis of $300 per hour. When crisis intervention is necessary, such as contacting other pertinent people involved

in your case (e.g., school personnel, caregivers, medical professionals), charges will be based on the $300 per hour rate.

Some families or individuals may become or are already involved in litigation. Please note that **I am unable to become involved in court-related matters and/or litigation under any circumstance,** as it poses significant issues related to ethics, confidentiality, conflict of interest, and my ability to be effective in treatment. You and/or your attorney are not to ask me to testify in court or participate in a deposition, either in person, by affidavit, or through any other means. You are to instruct your attorney not to subpoena me, my records, or to refer in any court filing to anything that has been said in our therapy work. If you or your child believe I will be sharing details from sessions with attorneys and/or the court system, the effectiveness of therapy and your confidentiality will be greatly compromised. In addition, treating psychologists are ethically bound not to make recommendations to the court regarding custody.

While I do not participate in court-related matters under any circumstance, I am required to disclose charges for any court-related involvement. You are billed for all clinical time regardless of who initiated and requested or required my participation. A $3,000 retainer is required for any court-related matter of which **$1500 is non-refundable**. The hourly rate for all court related matters is $300/hour. Charges are prorated based on actual time (although a $1500 minimum will be charged for court/deposition) and may exceed the $3000 retainer amount. Please note that there are no refunds of the non-refundable retainer, or any other hourly charges incurred even if the case is settled, canceled, postponed, or continued.

Any preparation of records that requires administrative time will be billed at $110/hour. Any preparation/review of records that requires my professional time is billed at $300/hour. Any expedited services needed are charged at $500/hour.

Your appointment time is reserved exclusively for you. **You must provide at least 48 hours' notice to cancel an appointment and avoid charges.** You will be billed the full amount of the session scheduled (e.g., $195 for a 45- minute session) if you do not provide 48 hours' notice or if you fail to arrive for your scheduled appointment. I will wait 15 minutes for you past your scheduled appointment time, but if you do not arrive within 15 minutes of your scheduled appointment time then I will assume you are not coming. It is important to note that I cannot provide paperwork for insurance claims for missed sessions. Please provide as much advance notice as possible if you are unable to keep your appointment.

Fees will be periodically reviewed and may be increased during at some point during your therapy services. Fees will be increased no more than once during any calendar year. There will be a **$40.00 service charge for all returned checks.**

BILLING & PAYMENT

5318 Highgate Dr., Suite 132
Durham NC 27713
Phone: (919) 228-8845
Fax: (919) 251-9660

Payment for all services is due in full at each session. In separated or divorced families, payment is due at the time of service regardless of payment agreements made between separated or divorced parents. Services will be suspended if there is an unpaid balance on your account until the amount due is paid in full. Overdue payments will be charged a 12% interest rate after 30 days. Final payment is expected on behalf of the client before summaries or other reports, including psychological evaluations, are released. **Please note that evaluation reports, treatment summaries, letters, or other requested documents will not be written or provided until the patient account has been paid in full.** 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 payment. This may involve hiring a collection agency or going through small claims court, which will require me to disclose your name, address, phone number, and the amount due. If legal action is necessary, the total cost of collection, including attorneys' fees, will be included in the claim.

CODES

The No Surprises Act/Good Faith Estimate requires that providers outline information such as diagnoses, common/expected codes, etc. Kari Lenox, Ph.D. does not diagnose individuals she has not yet met (new clients/patients). If you are not sure what diagnosis you or your child have (current clients), please ask and we will provide you with that information. Commonly used CPT codes are listed below. It is possible that other codes will be used during care.

In-person office visits: 90791 - 60 min intake code; 90834 - 45 min standard therapy code

Telehealth codes: 90791 95 - 60 min intake via telehealth; 90834 95 - 45 min standard therapy via telehealth

Testing Codes: 96136 (first 30 minutes) + 96137 (for each additional 30 minutes)

ESTIMATED TOTALS

The No Surprises Act/Good Faith Estimate requires providers to give examples of totals for services.

Estimated total cost of treatment: As mentioned above, you are under no obligation to commit to a particular course of treatment. Dr. Kari Lenox works with some clients for a short duration and others on a longer basis. Length of treatment is complex and depends largely on the referral concern. We will make these decisions as we work together. Please ask if you are ever uncertain about what the costs will be for your care. Next Step Psychology, PLLC strives to be very clear about charges so there are no surprises.

Therapy total cost estimate example: If you attend therapy twice a month for 6 months, you will take the therapy cost and multiply it by the number of weeks to determine the total anticipated cost. For 13 weeks at $185 each, the cost would be $2405. This cost plus the intake appointment ($215) would bring the total to $2620.

5318 Highgate Dr., Suite 132
Durham NC 27713
Phone: (919) 228-8845
Fax: (919) 251-9660

For psychological evaluation services, the charges are $375 per hour and most evaluations take roughly 6 hours. Testing is largely dependent on the referral reason, which greatly impacts time and cost. For a basic evaluation, including the intake session ($205) and the feedback session ($205), the estimated total cost would be $2660.

DISCLAIMER

This Good Faith Estimate shows the reasonably expected costs for your health care needs. The estimates included here are based on information known at the time the estimate was created. The Good Faith Estimate does not include any unknown or unexpected costs that may arise during treatment. You could be charged more if any complications or special circumstances arise. If this happens, federal law allows you to dispute (appeal) the bill. Also, you may seek reimbursement for the upfront costs spent by filing the claims with your insurance provider.

DISPUTE

You may dispute your invoice if you are charged more than the Good Faith Estimate for the exact same services rendered. You may contact the health care provider to let them know the billed charges are substantially higher than the Good Faith Estimate. You can ask for an updated bill to match the Good Faith Estimate, you may ask to negotiate the bill, or ask if financial assistance is available. You may also start a dispute resolution process with the U.S. Department of Health and Human Services (HHS). If you choose to use the dispute resolution process, you must start the dispute process within 120 calendar days of the date on the original invoice. There is a $25 fee to use the dispute process. If the agency reviewing your dispute agrees with you, then you will have to pay the price(s) reflected on the Good Faith Estimate. If the agency disagrees with you then you will have to pay the higher amount as invoiced. To learn more and get a form to start the process, go to www.cms.gov/nosurprises. For questions or more information about your right to a Good Faith Estimate or the dispute process, visit www.cms.gov/nosurprises

The issue of dispute should not come up during typical care. Again, all fees are listed here in this No Surprises Act/Good Faith Estimate form and in the Business Policy and Outpatient Agreement. You may discontinue services at any time (but with no less than 48 hours' notice to avoid charges), and fees for services already incurred must still be paid in full.

ACKNOWLEDGEMENT

I have read and understand Kari Lenox, Ph.D., PLLC charges for services. If I have any questions, I can ask at any time. I understand these are estimates and my actual costs may be higher or lower. I also understand that I am free to discontinue services at any time (with no less than 48 hours notice before scheduled appointments). I understand that if I request other/additional services (i.e., therapy services plus an evaluation, or therapy plus phone calls with other providers, a school observation, etc.) and/or my situation requires emergency services then I am still responsible for those charges and these extra services will increase the total amount of the services.

Kari Lenox, Ph.D.
5318 Highgate Dr. Suite 132
Durham, NC 27713

This notice describes how psychological medical information about you may be used and disclosed and how you can get access to this information please review carefully.

We take seriously a patient's privacy and strive to protect the confidentiality of your psychological medical information at this practice federal legislation (HIPPA) requires at all healthcare providers issue an official notice of one's privacy practices. Private health information (PHI) is a term that will be used throughout this document refers to information your health records that could identify you.

How we may use and disclose psychological medical information about you with your advance consent:

The following categories describe the different ways that we may use and disclose information about you with your consent which is provided by signing the Notice of Privacy Practice Patient Acknowledgment Agreement.

- **Treatment** is when we provide and coordinate services related to your healthcare examples of treatment would be when we consult with another healthcare provider such as a family physician or another mental health professional who is providing treatment.
- **Payment** is when we retain reimbursement from you. Examples include when we disclose PHI to your health insurance carrier so that you may get reimbursed. However, you may have the right to restrict certain disclosures a PHI information to a health plan if you pay out-of-pocket info for healthcare services. We may need to send a PHI such as your name address office visit dates in codes identifying your diagnosis and treatment to your insurance company. Also, we may need to supply basic identifying information such as your name address phone number to an attorney or billing service collection of any outstanding payment.
- **Healthcare operations** refer to activities that relate to the performance and operation of our practice. For example healthcare operations include a administrative services, scheduling appointments, business related matters, case management and coordination of care.

Uses and disclosures requiring written authorization:

You must sign an authorization before we can release your PHI for any other issues and disclosures not described in the Privacy Notice. When appropriate written authorization is obtained, Kari Lenox PLLC may use her disclose PHI and to others whom you designate. An authorization is permission above and beyond the general consent noted in the prior section that permits only disclosures in treatment, payment and healthcare operations. When we ask for information outside of these parameters, we will attend an authorization from you before releasing information. For example, you may ask us to contact a school, release a report to someone or send records after you no longer are a patient within our practice.

If you give us authorization to use or disclose information about you may revoke that authorization in writing at any time.

However, we are unable to retract any disclosures that I've already been made in good faith with any previous written authorization that you gave us. Also, if authorization is obtained from you as a condition of your obtaining insurance coverage, the law provides ensure the right to contest the claim under the policy.

When psychotherapy notes (if kept) separately are requested which would require an authorization or a court order. You have the right to request a copy of the records in electronic format. Additionally you may request a copy of the records to the patient's designee, for example, the patient's attorney.

We are not allowed to charge a fee for providing access in electronic format.

Uses in disclosures of medical information not requiring consent or authorization:
We may use or disclose PHI without your consent or authorization in the following circumstances:

1. If the therapist suspects child abuse or if there's a reasonable cause to believe they disabled adult is a need a protective services, then appropriate authorities are contacted.
2. If a therapist believes that you are a clear eminent danger to yourself or another person, the therapist may notify appropriate others to prevent the occurrence.
3. If there is a need for health oversight, the North Carolina Psychology Board has the power when necessary to subpoena relevant records should we be the focus of an inquiry.
4. If there are legal proceedings patient therapist communications are privilege except for the following:
    - If your mental health status is an issue before the court.
    - If the judge authorizes a court order because he or she feels that communication is necessary to the proper administration of justice.
    - If a government agency is requesting information for health oversight activities we may be required to provide it for them.
    - If a complaint or lawsuit is lodged against us we may disclose relevant information regarding that patient in order to defend our practice

Kari Lenox, Ph.D.
5318 Highgate Dr. Suite 132
Durham, NC 27713

- If a patient files of Worker's Compensation claim we are required by law to provide mental health information to your employee and the North Carolina Industrial Commission

Patient rights:

- **Right to request restriction**. You have the right to request restrictions on certain uses and disclosures of PHI to you we are not required to agree to the restriction request but if we do agree we will comply with your request unless information is needed to provide you with emergency treatment.
- **Right to request different ways to communicate with you**. You have the right to request how and where we contact you about PHI for example you may wish to be contacted at work or utilize a different address or phone number.
- **Right to inspect and copy**. You have the right to see and copy both the PHI in our records and billing information that we used to make the decisions about you for as long as the PHI is maintained in that record. We may deny your access to PHI under certain circumstances but you may have this decision reviewed.
- **Right to amend**. If you feel that information we have about you is incorrect or incomplete you may ask is it any time to take a look at the issue you have the right to request an amendment of PHI for as long as the pH is maintained in the record we may deny your request. Upon your request we will discuss the details of the amendment process.
- **Right to accounting**. You generally have the right to request a list of disclosures of medical information about you. To request this list you must submit a written request and we will discuss with you the details of the accounting. The first time you ask in a 12 month period for us to release or disclose PHI this is considered a courtesy and no charges are levied. If there is an inquiry for additional records within the 12 month, additional fees are levied.
- **Right to a paper copy**. You do have the right to obtain a paper copy of the notice from us upon request, even if you have agreed to receive the notice electronically or other means by which the information is sent to you.
- **Right to be notified of breach**. You have the right to be notified if there is a breach of unsecured Protected Healthcare Information.

Psychologist's duties:
Kari Lenox, PLLC is required by law to maintain the privacy of the PHI and 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. We will post a notice of any changes of our Notice of Privacy Practice with the effective date and are waiting rooms and on our website. You may request a paper copy at any time.

Complaints:
If you believe your privacy rights have been violated or you disagree with the decision that we made about the access to your records, you may contact the privacy officer Kari Lenox, PLLC or our office for further information. You may also file a complaint with the US secretary of Department of Health and Human Services.

Who will follow this notice:

Any healthcare professional authorized to enter information into your medical record, all employees, staff, and personnel Kari Lenox, PLLC. who may need access to your information must abide by this notice. All subsidiaries and business associates of this practice must agree to maintain the privacy of any patient information they may come in contact with either advertently or in advertently. Except when necessary only essential medical information will be released about you.

KARI LENOX, PH.D.

5318 Highgate Dr., Suite 132
Durham, NC 27713

Phone: (919) 237-2250
Fax: (919) 251-9660

TELEPSYCHOLOGY INFORMATION AND CONSENT

Telepsychology is the delivery of psychological services using interactive audio and visual electronic systems where the psychologist and the patient are not in the same physical location.

The interactive electronic systems used in telepsychology incorporate network and software security protocols to protect confidentiality of patient information and audio and visual data. These protocols include measures to safeguard the data and to aid in protecting against intentional or unintentional corruption.

Potential Benefits

- Increased accessibility to psychological treatment
- Patient convenience

Potential Risks

- As with any therapy, there may be potential risks associated with use of telepsychology. I understand these risks include, but may not be limited to:
- Information transmitted may not be sufficient (e.g., poor resolution of video) to allow for appropriate mental health decision making by Dr. Lenox
- A lack of access to all the information that might be available in a traditional face to face visit, which may result in errors in mental health treatment.
- Telepsychology care may not be as complete as face to face care.
- Telepsychology does not decrease or minimize the risks that might be present in a mental health condition.
- The possibility (despite best efforts to prevent this) that the transmission of mental health information could be disrupted or distorted by technical failures in transmission.
- The possibility that electronic transmission of mental health information could be interrupted or even accessed illegally by unauthorized persons.
- Delays in mental health treatment may occur due to deficiencies or failures of the equipment.
- Dr. Lenox may not be able to provide mental health treatment to me using interactive electronic equipment (such as completing rating forms in office).
- Dr. Lenox may not be able to provide or arrange for emergency mental health care that I may require.

Access to Information

- I have the right to inspect all information and this includes telepsychology visits.
- I may obtain copies of this therapy record information for a reasonable fee.

Confidentiality

- I understand the laws which protect the confidentiality of therapy information apply to telepsychology.
- My video telepsychology visits will not be recorded and all identifying information in the interaction will be kept secure in the same manner as any other private mental health information.

My Rights

I understand that:

- The software technology used by Kari Lenox, Ph.D. is encrypted per the software company's explanation of services to prevent the unauthorized access to my private mental health information.
- I have the right to withhold or withdraw my consent to the use of telepsychology during the course of my care at any time.
- The withdrawal of my consent will not affect any future care or treatment.
- Dr. Lenox has the right to withhold or withdraw consent for the use of telepsychology during the course of my care at any time.
- I understand that all rules and regulations, which apply to the practice of psychology in the state of North Carolina, also apply to telepsychology.
- Dr. Lenox will inform me if any other person can hear or see any part of our session before the session begins.
- Dr. Lenox will sign the credit card receipt on my behalf since I am not physically present but I am responsible for all payments related to the service.

<u>My Responsibilities</u>

- I will not record any therapy sessions without written consent from Dr. Lenox.
- I will inform Dr. Lenox if any other person can hear or see any part of our session before the session begins.
- I understand that I, not Dr. Lenox, am responsible for the configuration of any electronic equipment used on my computer, which is used for telepsychology sessions.
- I understand that it is my responsibility to ensure the proper functioning of all electronic equipment before my session begins.
- I understand that I must be a resident of the state of NC to be eligible for telepsychology services from Dr. Lenox.
- I understand that my initial intake session will not be done by telepsychology except in special circumstance under which I will be required to verify my identity to the satisfaction of Dr. Lenox before the intake.
- I will cancel telepsychology appointments in accordance with office policies (48 business hours) or I will be charged the late cancellation fee.
- I will remit payment at the time of service, as I usually do in an in-office appointment.

I have read and understand the information provided above regarding telepsychology. All of my questions have been answered to my satisfaction, and I am aware of the alternatives to telepsychology including traditional face to face sessions. I hereby give my informed consent for the use of telepsychology in my mental health care and authorize Kari Lenox, Ph.D. to use telepsychology in the course of my diagnosis and treatment.