James Hopper, Ph.D.

Terms of Agreement for Psychological Services

I request psychological services from James Hopper, Ph.D. These services may consist of evaluation, consultation, or a range of therapeutic interventions.

I understand that I may call and leave messages for Dr. Hopper, and that those messages will typically be returned during regular business hours (Monday through Friday, 9am to 6pm). Messages will not usually be returned during weekends or holidays, unless prior arrangements have been made. I also understand that Dr. Hopper may choose to bill for between-session phone calls and other collateral activity.

I understand that if I have an emergency that requires immediate medical or psychiatric attention, I can call 911 or go to the nearest hospital emergency room, and ask for the on-call psychologist or psychiatrist.

I understand that the psychotherapy relationship is a joint process, and that my opinions concerning this process are vital to its success. I also understand that Dr. Hopper always wants to know if, at any time, I have any concerns or questions about any aspect of the treatment process.

_____ _____

Client Signature Date

_____

Street Address

_____

City, State, Zip Code

_____

Daytime (Business) Phone Number

_____

Evening (Home) Phone Number

_____

E-mail address

James Hopper, Ph.D.

Billing Policy

Billing for most services are based on a 50 minute hour rate. The services included are evaluation, psychotherapy, consultation, and EMDR. In situations when I perform any substantive collateral work (e.g. preparation, paperwork, phone calls, meetings, travel time) I will also bill you for this time using the hourly rate. My fees will also be periodically adjusted with advance notice.

Current rate (per 50 minute hour): $125

I request that full payment or co-payments occur at each visit for that visit, except for those whose insurance company requires direct billing. Monthly billing may be available on a per case basis.

Accounts which are 90 days overdue will be subject to referral to a collection agency or attorney. Interest charges of 5% will be added monthly to the unpaid balance.

Missed Appointments & Cancellation Policy

If you need to cancel a scheduled appointment, and the cancellation occurs 24 hours prior to the scheduled appointment, I will not bill you for the appointment. However, if the cancellation occurs less than 24 hours prior to the scheduled appointment, and no other appointment time can be found in the same week or before the next scheduled appointment, I will need to bill you for the cancellation at 50%. Payment will also be expected for a missed session at the next session (nor do insurance companies pay for missed sessions). Exceptions to this policy include the events that are out of your control, such as sudden illness, inclement weather, or car problems.

Signature

I have read these policies, and have received a copy of them. I understand and agree to abide by the terms represented here. I understand that I am ultimately financially responsible for all services rendered me.

_____ _____

Client Signature Date

James Hopper, Ph.D.

Privacy Policies

What you tell me in our work together will remain confidential. I will not share this information with other people, other than with professional colleagues who are serving a consultative or supervisory role in regards to a particular case. I will be keeping a written record of our work as an aid in treatment planning and tracking progress over time. However, I will not release these records to other parties without your specific written permission, or unless I am required to release them by law or under a special circumstance. These circumstances, along with our respective responsibilities and rights and additional relevant information, are outlined on the following five pages, entitled "Notice of Privacy Practices."

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With the exceptions outlined in the Notice of Privacy Practices, your confidentiality and privacy will be strictly maintained. If you have any questions about the information contained in Notice of Privacy Practices, please feel free to ask me now, or at any time in the future, to clarify any of these issues.

I, _____, have read the above statement, the Notice of Privacy Practices, and understand the rules and limits of confidentiality and privacy that have been described.

_____ _____

Client Signature Date

_____ _____

Witness Signature Date

James Hopper, Ph.D.

Notice of Privacy Practices

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

Protecting patient privacy is an important element of the trust between me, James Hopper, Ph.D., and my patients, and an important legal and ethical obligation. I am deeply committed to protecting patients rights to privacy, and to safeguarding patient information.

My Responsibilities:

I am required to maintain the privacy of your Protected Health Information (Health Information). This includes medical information about you that is collected during the course of your treatment, such as your symptoms, examination and test results, diagnoses, treatment, and a plan for future care. Information about care that you have received from other providers may also be included in my medical record. Health Information also includes demographic information and payment information.

I am required by law to provide you with this Notice of Privacy Practices. This Notice describes how I use your Health Information, and disclose (share) it with others. I must abide by the terms of the Notice currently in effect. I reserve the right to change the terms of my Notice and to make the new Notice provisions effective for all Health Information that it maintains. I will post my current Notice in a prominent location in each of my practice sites.

I. Uses and Disclosures of your Health Information:

The following are examples of the types of uses and disclosures of your Health Information that I am legally permitted to make.

A. Uses and Disclosures of Health Information for Treatment, Payment and Operations

Your Health Information may be used and disclosed by me. Your Health Information may also be used and disclosed as necessary for me to obtain reimbursement for care provided to you, and to support the operation of his practice.

1. Treatment:

I may use your Health Information to provide and manage your health care. If I refer you for other treatment – for example to another clinician or hospital – I will provide that health care provider with the necessary information to diagnose or treat you. In addition, I may share your Health Information with other health care providers who may consult with me about your care. I believe this is critical to provide you the very best in health care and is necessary given the complexities of various illnesses and health conditions.

2. Payment:

I may use and disclose your Health Information, as needed, to obtain payment for health care services. I may disclose information to your insurance company or third party payer in order to make sure your treatment is approved, to verify eligibility or coverage for insurance benefits, and to permit the payer to review services provided to you for medical necessity. For example, I may need to share relevant Health Information to your health plan to obtain approval for continuing authorizations.

3. Healthcare Operations:

I may use or disclose your Health Information in order to conduct its business of providing health care. These health care operations may include quality assessment, training of students, credentialing and various other activities that are necessary to run my practice and to improve the quality and cost effectiveness of the care that I deliver to you. Some of these business operations may be performed by outside parties (Business Associates) on my behalf. My Business Associates must agree to maintain the confidentiality of your Health Information. In addition, I may also provide you with information about treatment alternatives or other health-related benefits, products and services that may be beneficial to you, again with the hopes of improving your health and welfare.

B. Other Permitted and Required Uses and Disclosures of Your Health Information:

In addition to treatment, payment and healthcare operations, there are other circumstances in which I am either permitted or required to disclose your Health Information, in accordance with applicable law.

1. Involvement of Others in Your Health Care:

I will make an effort to ask you if I may share relevant Health Information about you with family members or any other person you identify. If you are not present, unable to communicate, or in an emergency situation, I may exercise his professional judgment to determine whether to share this information. In addition, I may need to disclose Health Information to notify a family member or any other person responsible for your care of your location, general condition or death. Finally, I may disclose your Health Information to an authorized public or private entity to assist in disaster relief efforts, and to coordinate efforts to notify someone on your behalf. Please be assured I will only do so if absolutely necessary and in the event of an emergency or disaster.

2. Public Health:

I may disclose your Health Information for public health activities, including the following:

- to report Health Information (e.g., infectious diseases, such as chickenpox) to prevent or control
  disease, injury, or disability
- to report births and deaths
- to report reactions to medications or problems with products
- to notify a person who may have been exposed to a communicable disease, or may be at risk for contracting or spreading the disease

3. Victims of Abuse, Neglect or Domestic Violence:

If I reasonably believe that you are a victim of abuse, neglect or domestic violence, I may disclose your Health Information to an appropriate agency authorized by law to receive such reports.

4. Health Oversight:

I may be required to disclose Health Information to a health oversight agency for audits, investigations, inspections, and other health oversight activities. Oversight agencies include government agencies that oversee the health care system, government benefit programs, other government regulatory programs and civil rights laws.

5. Legal Proceedings:

I may be required to disclose Health Information in the course of any judicial or administrative proceeding in response to a legal order or other lawful process, including a subpoena.

6. Law Enforcement:

I may be required to disclose Health Information for law enforcement purposes.

7. Coroners, Funeral Directors, and Organ Donation:

I may be required to disclose Health Information to a coroner or medical examiner to identify a deceased person or to determine the cause of death. I may also disclose Health Information to a funeral director or their designee, as necessary to carry out their duties. Health Information may also be disclosed to organizations that facilitate organ, eye or tissue donation and transplantation.

8. Research:

I may use or disclose Health Information for research that is approved by an Institutional Review Board when written permission is not required by Federal or State law. This may include preparing for research or telling you about research studies in which you might be interested.

9. To avert a serious threat to health or safety:

I may be required to use and disclose Health Information to prevent or lessen a serious threat to a person's or the public's health or safety.

10. Specialized Government Functions:

Under certain circumstances, I may be required to disclose Health Information to units of the government with special functions, such as the U.S. military or the U.S. Department of State.

11. Workers Compensation:

I may use and disclose Health Information as required to comply with workers compensation laws, and other programs that provide benefits for work-related injuries or illnesses.

12. Required by Law:

I may be required to use or disclose your Health Information to the extent that the use or disclosure is required by federal, state or local law. This includes any other law not already referred to in the preceding categories. The use or disclosure will be made in compliance with the law and will be limited to the relevant requirements of the law.

C. Uses and Disclosures of Health Information Based upon Your Written Authorization

Uses and disclosures of your Health Information, other than those described above, will be made only with your written authorization. For example, you will need to sign an authorization form before I can send your Health Information to your life insurance company. I will also obtain your written authorization prior to using your Health Information to send you any marketing materials. You may revoke your authorization at any time, in writing, except to the extent that I have taken any action in reliance on the authorization.

In addition, federal and Massachusetts laws require that I obtain your specific written authorization for the use or disclosure of certain information about you. This information includes psychotherapy process notes as defined by federal law; communications with certain behavioral health professionals; communications between domestic violence victims and domestic violence counselors, and between sexual assault victims and sexual assault counselors; and information related to substance abuse treatment, HIV testing or test results, treatment of sexually transmitted diseases, and genetic testing or test results.

II. Your Individual Rights

Although your medical record at my office is my property, the Health Information it contains belongs to you. The following is a statement of your rights with respect to your Health Information, and a brief description of how you may exercise these rights.

A. You have the right to inspect and copy your Health Information.

At any time, you may inspect and obtain a copy of Health Information about you, including your medical and billing record, which may be used to make decisions about your care. Under limited circumstances I may limit your access to all or certain portions of your record. This includes, but is not limited to, psychotherapy process notes, or information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding. If you are denied access to portions of your record, in some circumstances you may have a right to have this decision revised. All requests to access your record must be made to me in writing, and will be processed within 30 days. If you request a copy of your records, I may charge you a fee to cover the copying and mailing costs.

B. You have the right to request an amendment of your Health Information.

You may request that I amend your treatment and billing information if you think the information is incorrect or incomplete, for as long as he maintains the information. If for some reason I deny your request, I must give you a written statement with the reasons for the denial, and what other steps are available to you. Please don’t hesitate to contact the Medical Records

department if you have questions about amending your medical record, or any registration staff to discuss amendments to your billing records.

C. You have the right to request a restriction of your Health Information.

You have the right to ask for restrictions on the use and sharing of your health information for treatment, payment, or health care operations. I am not required to agree to your request. If I do, I must put the restriction in writing and abide by it, except if you need to be treated in an emergency. You may not ask me to restrict uses and sharing of information that I am legally required to make. All requests must be in writing to me.

D. You have the right to request to receive communications from me **by alternative means or at an alternative location.**

I will make every effort to accommodate requests, provided you supply a valid alternative address or other method of contact. In certain cases I may need to contact you and may do so at the original address or phone number if attempts to contact you at the alternative locations are not successful.

E. You have the right to receive an accounting of certain disclosures I have made, if any, of your Health Information.

This right applies to disclosures for purposes other than treatment, payment or healthcare operations as described in this Notice. It does not apply to disclosures I may have made to you, that Ire authorized by you, information provided to family members or friends about your care, or for notification purposes. You have the right to receive specific information regarding disclosures made by me that occurred after April 14, 2003. You can request an accounting of disclosures for a period up to six years, but only for disclosures made after April 14, 2003. The right to receive this information is subject to certain exceptions, restrictions and limitations. Requests must be made to my office in writing (on paper, not electronic), and I will respond to your request within 60 days.

F. You have the right to obtain a paper copy of this notice.

I will provide a paper copy of this Notice to you, upon request, even if you have agreed to accept this notice electronically.

III. Effective Date: This Notice is effective on April 14, 2003.

IV. Complaint Process:

If you believe I have violated your privacy rights, please communicate your concerns to me at the site where you receive treatment. You may also send a written complaint to the Director, Office for Civil Rights of the U.S. Department of Health and Human Services. I will not retaliate against you if you file a complaint about my privacy practices, nor will it affect your rights or status as a patient with me. I will make every effort to respond to your concerns immediately and professionally.

You may contact me for further information about the complaint process or my privacy practices.

James Hopper, Ph.D.
Massachusetts General Hospital
149 13th Street - 2nd Floor
Charlestown, MA 02129
eFax: 440 445-1414

Authorization to Obtain/Release Information

Client: _____ Date of Birth: _____

Address: _____

_____

I authorize James Hopper, Ph.D. to:

( ) Obtain from ( ) Release to

Name: _____

Facility: _____

Address: _____

_____

Phone: _____

The following information contained in the record of the client named above concerning services provided on or about _____.

Please check the appropriate information to be released:

( ) Verbal communication about ongoing or prior treatment
( ) Admission Note
( ) Discharge Summary
( ) Psychological Testing
( ) Treatment Plans/Summaries
( ) Consultations
( ) Notification of the primary care physician that I have requested behavioral health services
( ) Other: _____
( ) I agree that a copy of this form is valid as the original.

I have carefully read and understand the above statements and expressly and voluntarily consent disclosure of information or records about my condition and treatment.

I understand this consent can be revoked at any time unless action based on it has already begun. The authorization expires one year from the date written below:

Date: _____ Signature of Client: _____

Date: _____ Signature of Witness: _____