D. Russell Bishop, Psy. D.
Clinical Psychologist
4700 N. Cloverdale Road, Boise, Idaho 83713
(208) 999-0785

PSYCHOLOGIST-PATIENT SERVICES AGREEMENT

Patient Name: ___________________________ Date of Birth: _________________

Address: ____
(Street) (City) (State) (Zip)

Best Day Time Phone Number: (____)_____________________

Guarantor Name: ________________________ Social Security #: _____________ Phone: (___)_________________

Address: ____
(Street) (City) (State) (Zip)

I am delighted to have the opportunity to work with you. This form contains important information about my policies and procedures that have been established as part of my commitment to excellence in providing psychological services.

The Health Insurance Portability and Accountability Act (HIPAA), requires that I provide you with a Notice of Privacy Practices for use and disclosure of Private Health Information (PHI) for treatment, payment and health care operations. The Notice explains HIPAA and its application to your personal health information in greater detail. In addition to your control over "Authorization" allowing me to communicate with others, you may request additional confidential handling of your PHI. Patients under 14 years of age and their parents should be aware that the law allows parents to examine their child's treatment records. Parents are entitled to information concerning their child's current physical and mental condition, diagnosis, treatment needs, services provided, and services needed. I may occasionally consult with other health and mental health professionals in order to provide ongoing high quality services. Be assured that I will maintain confidentiality of personal identifying information in accordance with existing legal requirements as well as ethical principles and standards.

Appointments are to be scheduled in advance in person or by phone. Typical appointments last 45 minutes. Other evaluation and/or testing sessions are scheduled to address individual needs. You will be informed of the nature of the evaluation procedures and treatment recommended, including potential benefits, limitations and alternatives. These issues are reviewed as needed on an ongoing basis. I strive to be punctual. If you are late for any reason, you will receive the remainder of your scheduled time. If you need to cancel an appointment, a minimum of 24 hours notice is required; otherwise, you are subject to a full charge for the appointment—missed appointments result in the same fee assessment. Payment is due in full at the time of service. Exact charges will depend upon the services rendered and will be discussed as soon as they may be accurately determined. Please make checks payable to D. Russell Bishop, Psy. D. A $25 service fee is assessed for checks returned as non-sufficient or non-payable. If your account has not been paid for more than 60 days and arrangements for payment have not been agreed upon, your account will be turned over to a collection agency, which will require me to disclose some confidential information. If such action is necessary, the costs will be your responsibility.

You may choose to submit claim forms to your insurance company for reimbursement. At the time of service, I will give you a billing form detailing the service provided, payment, and other relevant information. If you ask me to communicate with your insurance company, I will ask you to complete an "Authorization" form first.

Emergencies are to be directed to the emergency room at the local hospital nearest you. Please call the office for non-emergency or scheduling concerns. If I am not directly available, I will return your call as soon as possible.

YOUR SIGNATURE BELOW INDICATES THAT YOU HAVE READ AND UNDERSTAND ALL OF THIS AGREEMENT AND AGREE TO ITS TERMS.

____ ____
Patient Signature (if 14 years of age or older) Date Parent or Legal Representative Signature Date

____
Witness Signature Date