WEST COUNTY PSYCHOLOGICAL ASSOCIATES
12125 Woodcrest Executive Dr., Suite 110
St. Louis, Missouri 63141
314-275-8599

Fee Agreement for
Amy Neu, MSW, LCSW

Giving you the best possible service with consideration for your well-being is of utmost importance to us. The following is some information concerning fee schedules and payment procedures.

Initial Consultation	$145.00
Individual session (50 minutes)	$125.00

Payment is due at completion of the session.
A Mastercard or Visa credit card account number and expiration date is required to guarantee payment. *The credit card will not be charged as long as there is no balance on the account.* If the balance has not been addressed, we will notify you that your credit card will be charged. Please fill in your credit card information on the Billing Information sheet.

Also, we offer Mastercard/Visa services to our clients. If you are interested in charging your visits to either your Mastercard or Visa Account, please fill in the space provided on the Billing Information sheet.

If the fees are covered by insurance, we will be happy to furnish you with an itemized statement for you to submit to your insurance company for reimbursement. If Medicare payments are not approved, client will be responsible for payment.

If an appointment must be cancelled for some reason, we require 24 hours notice. **Appointments not cancelled 24 hours in advance will be charged to your account.** If you need to cancel an appointment after 4:00 p.m. or on weekends, we do have an answering service available to take your calls. You can reach them by dialing our daytime number at 275-8599.

I fully understand and agree to the above stated terms.

_____
Please print name here

_____ _____
Signature Date

WEST COUNTY PSYCHOLOGICAL ASSOCIATES

BILLING INFORMATION

Name of Client(s): _____

_____

Person responsible for payment of services:
*Please only include phone numbers where you prefer to be contacted and where we may leave a message.
Name: _____
Address: _____
City: _____State: _____Zip: _____
Home Telephone: _____ Cell Phone: _____
E-mail Address: _____

Employer: _____
Telephone: _____
Social Security Number: _____

Spouse's Name: _____
Spouse's Employer: _____
Spouse's Telephone: _____ Cell Phone: _____
Spouse's Social Security Number: _____
E-mail Address: _____

WCPA offers a variety of seminars and workshops as well as a quarterly newsletter. To receive email notification please check here. ____

Referred by: _____

West County Psychological Associates will provide you with an invoice after each visit which you may mail to your insurance company if you are planning to file.

***Required Information**
Mastercard/Visa Account # _____ Expiration Date: _____
Security Code: _____
I accept financial responsibility for expenses incurred at West County Psychological Associates by the above named client(s).

___ Please charge my credit card for each visit
___ I will pay by check or cash at the time of my visit

_____ _____
Signature of Responsible Party Date

Initial Information Form

Instructions: Please answer the following questions about the client(s).
Note: If you are completing this form for a child or adolescent client, please answer each question in regard to the child, not to yourself. Thank you.

I. Identifying Information

Client's name: _____ Today's date: _____

Date of birth: _____ Age: _____

Marital Status: _____ Occupation: _____

Please note phone numbers and email addresses where we may contact you and leave a message:

Home phone #: _____ Cell #: _____

Email address: _____

Home address & zip code: _____

Person completing this form: _____

Please check one of the following to let us know how you learned of our office:

___ I attended a presentation given by a WCPA therapist
___ Website
___ Referred by a former/current client
___ Internet Search
___ Referred by a friend or family member
___ Email/articles
___ I was referred by a school. School name: _____
Person making referral: _____
___ I was referred by a physician. Physician's name: _____
___ I was referred by an attorney. Attorney's name: _____

II. Reason for coming to therapy at this time:

_____

_____

_____

_____

III. Current Concerns: (please mark all that apply)

Mood:

___ Depressed/Irritable Mood
___ Changes in Sleep
___ Changes in Appetite
___ Crying Spells
___ Fatigue
___ Problems Concentrating
___ Suicidal Thoughts/Attempts
___ Elevated Mood
___ Feeling Restless/Irritable
___ Impulsive Behavior
___ Grandiose Thinking
___ Agitation
___ Rapid Speech
___ Racing Thoughts

Anxiety:

___ Feeling Nervous/Worried
___ Unrealistic Fears
___ Feelings of Panic
___ Social Anxiety/Extreme Shyness
___ Obsessions/Compulsions
___ Nightmares
___ Hair Pulling/Skin Picking

Attention and/or Impulsivity:

___ Difficulty Paying Attention
___ Often Loses Things
___ Doesn't Follow Instructions
___ Difficulty Organizing
___ Easily Distracted
___ Often Forgetful
___ Fidgets
___ Squirms in / Leaves Seat
___ Talks Excessively
___ Runs/Climbs Excessively
___ Difficulty in Playing Quietly
___ Difficulty Awaiting Turn

Eating:

___ Fear of Gaining Weight
___ Recurrent Binge Eating
___ Self-Induced Vomiting
___ Excessive Exercise
___ Loss of Menstrual Periods
___ Unrealistic Body Image

Behaviors:

___ Aggressive toward People
___ Aggressive toward Animals
___ Destructive toward Property
___ Fire Setting
___ Sexual Aggression
___ Cutting or Harming Oneself
___ Social Skill Difficulties
___ Unusual/Odd Behaviors
___ Bed Wetting or Soiling
___ Stealing
___ Alcohol or Drug Abuse
___ Internet/Technology Problems
___ Often Loses Temper
___ Argumentative
___ Breaks Rules
___ Deliberately Annoys Others
___ Seems Angry and Resentful
___ Easily Annoyed/ "Touchy"

Experiences:

___ History of Physical Abuse
___ History of Trauma
___ School Difficulties
___ Grief/Loss
___ Bullying/Harassment
___ History of Sexual Abuse
___ Seizures
___ Lead Exposure
___ Life Transition
___ Sexual Concerns
___ Chronic Pain
___ Parent/Child Relationship Concerns
___ Partner Relationship Concerns
___ Divorce/Remarriage Concerns
___ Child Custody Concerns

Other Current Concerns: _____

IV. Client's Family History

Spouse's Name _____ Age _____

Occupation _____ Health _____

Quality of Relationship _____

If Deceased: Cause of Death _____

Age at Death _____ *Client's Age at the Death* _____

Mother's Name _____ Age _____

Occupation _____ Health _____

Quality of Relationship _____

If Deceased: Cause of Death _____

Age at Death _____ *Client's Age at the Death* _____

Father's Name _____ Age _____

Occupation _____ Health _____

Quality of Relationship _____

If Deceased: Cause of Death _____

Age at Death _____ *Client's Age at the Death* _____

Client's parents are (or were, if deceased):

___ married ___ divorced ___ never married ___ living together ___ separated

Please list step-parents and other parental figures: _____

_____

If not always raised by parents, who provided care and when? _____

_____

Names and ages of client's siblings: _____

_____

Names and ages of client's children: _____

_____

Family history of emotional or behavioral concerns: _____

_____

_____

Other family information: _____

_____

_____

V. If client is still in school, please complete the following:

School: _____

School's phone number: _____

Name of school contact person: _____

Current grade or level: _____

Recent grades/performance: _____

Special services received at school: _____

Behavior problems at school: _____

Extra-curricular involvement: _____

VI. If client is an adult and no longer in school, please complete the following:

Educational level obtained: _____

Current employer and position: _____

Length of current employment: _____

Satisfaction level (circle number): (Low) 1 2 3 4 5 (High)

VII. Client's Medical History

Major illnesses and physical disabilities: _____

_____

Date of last physical exam: _____

Has the client previously seen a professional for counseling / therapy? ___ yes ___ no

If yes, please provide the name of the professional and approximate dates of treatment:

_____

Is substance abuse, alcohol use, or medication management a concern? ___ yes ___ no

Please list any previously diagnosed mental health conditions: _____

_____

Current medications: _____

_____

West County Psychological Associates

Informed Consent for Therapy Services

Welcome to our practice. This document contains important information about our professional services and business policies. Please read it carefully. When you sign this document, it will represent an agreement with West County Psychological Associates (WCPA).

Therapy Services

Therapy is a collaborative process between you and a professional therapist to work on areas of dissatisfaction in your life and assist you in creating change. For therapy to be most effective, it is important that you take an active role in the process. Therapy is not an identical process for everyone. There are many different methods your therapist may use to address the problems that you identify together. The type and extent of services that you receive will be determined following an initial assessment and through ongoing discussion between you and your therapist. If you have any questions about therapy procedures, you are always free to discuss them with your therapist.

Benefits and Risks

Therapy has benefits and risks. Since therapy often involves discussing unpleasant aspects of your life, you may experience uncomfortable feelings like sadness, guilt, or anger. Each person's experience and outcomes are unique to their own circumstances.

Fees for Additional Services

If you request that your therapist provide non-therapy services, such as attending meetings with school officials or other professionals, charges for those services will normally be higher than the usual rate for in-office therapy services.

If you become involved in legal proceedings that require your therapist's participation, you will be expected to pay for their professional time even if they are called to testify by another party. Because of the difficulty of legal involvement, charges for such services are higher than those for regular therapy services.

Therapists, at their discretion, may charge for excessive time spent on phone calls between therapy sessions. This includes calls you make to your therapist as well as calls the therapist makes to others at your request, such as to your child's school or to your attorney.

Contacts and Emergencies

You may contact your therapist through the WCPA office phone number, (314) 275-8599. In case of an emergency, please call 911 or go to your nearest emergency room. Your therapist is not on-call at all

times, and may be unreachable. You may leave an emergency message on his or her office voicemail, and your therapist will return your emergency call when they are able.

Confidentiality and Professional Records

The privacy of all records and communications between a patient and a therapist is protected by law. In general, we can only release your information with your written permission. But there are a few exceptions:

- When a valid court order is issued for records and/or testimony on the part of the therapist, the therapist is bound by law to comply with such an order.
- When there is risk of imminent harm to you or to another person, the therapist is ethically bound to take necessary steps to prevent such harm. This notification may include notifying an intended target of violence, notifying the police, informing a family member about the situation, or seeking appropriate hospitalization.
- When there is suspicion that a child has been sexually, physically or mentally abused or neglected, the therapist is legally required to inform the proper authorities.
- Ethical therapists consult with professional colleagues about their cases, in order to provide clients the best possible services. If your therapist consults with a colleague, your therapist will not share your name or identifying information.

Minors

While the law provides parents the right to examine a minor child's treatment records, parents are encouraged to speak to their child's therapist about the risks and benefits of exercising that right. Therapists at WCPA regularly include parents in the therapeutic process with their children. WCPA therapists will notify parents if they believe the minor client is at risk for harm. WCPA therapists do not see minors under age 18 for in-office therapy without parental consent.

In the case of separated or divorced parents, WCPA requires a copy of the legal parenting plan. Unless otherwise stated in the legal parenting plan, both parents must provide signed consent for their minor child to receive therapy services and both parents have the right to exchange information with the therapist about the minor child's therapy.

Electronic Transmissions

WCPA cannot ensure the confidentiality of any form of communication through electronic media. You are advised that any text, email, or internet-enabled communication between you and your therapist involves greater risk to confidentiality than does traditional in-person communication. WCPA strongly discourages any electronic communication between clients and their therapists.

Termination

At any time, you have the right to seek a second opinion with another qualified mental health professional. You also have the right to terminate therapy at any time. If you choose to do so, your therapist may offer to provide you with names of other professionals whose services you might prefer.

Informed Consent for Therapy Services

Consent to Treatment

I voluntarily consent to receive, and/or for my minor child(ren) to receive, mental health assessment, care, and treatment. I authorize my therapist through WCPA to provide such professional services. I understand and agree that I will participate in the planning of my treatment and that I may stop these services at any time. By signing below, I acknowledge that I have both read and understood the information in West County Psychological Associates' *Informed Consent for Therapy Services* document and agree to its terms. This consent ends when I notify my therapist that I am terminating therapy or one year following my last therapy session.

Name of Adult Client(s): _____

Signature of Adult Client(s):

_____ **Date:** _____

_____ **Date:** _____

In the case of a minor client, the signature of a parent is required.

If parents are divorced or legally separated, the signatures of both parents are required unless otherwise stated in the legal parenting plan.

Name /Age of Minor Client(s): _____

Signature: _____ **Date:** _____

Signature: _____ **Date:** _____

NOTICE OF PRIVACY PRACTICES

The privacy of your personal information is important to West County Psychological Associates (WCPA). WCPA will maintain the privacy of your information and will not disclose your information to others unless you tell WCPA to do so, or unless the law authorizes or requires WCPA to do so.

A federal law commonly known as HIPAA requires that WCPA take additional steps to keep you informed about how WCPA may use information that is gathered in order to provide health care services to you. As part of this process, WCPA is required to provide you with the attached Notice of Privacy Practices and to request that you sign the written acknowledgement that you received a copy of the Notice. The Notice describes how WCPA may use and disclose your protected health information to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. This Notice also describes your rights regarding personal information WCPA maintains about you and a brief description of how you may exercise these rights.

If you have any questions about this Notice please contact WCPA's Director, Dr. Mary Fitzgibbons, at (314) 275-8599.

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.

WCPA is required by applicable federal and state law to maintain the privacy of your health information. It is also required to give you this Notice about privacy practices, legal obligations, and your rights concerning your health information ("Protected Health Information" or "PHI"). It must follow the privacy practices that are described in this Notice (which may be amended from time to time).

For more information about privacy practices, or for additional copies of this Notice, please contact WCPA using the information listed in Section II G of this notice.

I. USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION (PHI)

A. Permissible Uses and Disclosures without Your Written Authorization

WCPA may use and disclose PHI without your written authorization, excluding Psychotherapy Notes as described in Section II, for certain purposes as described below. The examples provided in each category are not meant to be exhaustive, but instead are meant to describe the types of uses and disclosures that are permissible under federal and state law.

1. Treatment: WCPA may use and disclose PHI in order to provide treatment to you. For example, WCPA may use PHI to diagnose and provide counseling service to you. We may also disclose your information in order to remind you of appointment times. We may disclose your information to any family members or significant others that you voluntarily decide to bring to and include in a therapy session. We may disclose your PHI, with the exception of identifying information, during professional clinical supervision and/or consultation, in order to ethically provide you the highest quality services.

2. Payment: WCPA may use or disclose PHI so that services you receive are appropriately billed and payment is collected. By way of example, it may disclose PHI to permit your health plan to take certain actions before it approves or pays for treatment services.

3. Health Care Operations: WCPA may use and disclose PHI in connection with our health care operations, including quality improvement activities, training programs, accreditation, certification, licensing or credentialing activities.

4. Required or Permitted by Law: WCPA may use or disclose PHI when it is required or permitted to do so by law. For example, it may disclose PHI to appropriate authorities if it reasonably believes that you or a child are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. In addition it may disclose PHI to the extent necessary to avert a serious threat to your health or safety or the health or safety of others. Other disclosures permitted or required by law include the following: disclosures for public health activities; health oversight activities including disclosures to state or federal agencies authorized to access PHI; disclosures to judicial and law

enforcement officials in response to a court order or other lawful process; disclosures for research when approved by an institutional review board; and disclosures to military or national security agencies, coroners, medical examiners, and correctional institutions or otherwise as authorized by law.

B. Uses and Disclosures Requiring Your Written Authorization

1. Psychotherapy Notes: Notes recorded by your clinician documenting the contents of a counseling session with you ("Psychotherapy Notes") will be used only by your clinician and will not otherwise be used or disclosed without your written authorization.

2. Marketing Communications: WCPA will not use your health information for marketing or fundraising communications without your written authorization. You have the right to opt out of any marketing or fundraising communications that you choose not to receive.

3. Other Uses and Disclosures: Uses and disclosures other than those described in Section I.A. above will only be made with your written authorization. For example, you will need to sign an authorization form before WCPA can send PHI to your life insurance company, to a school, or to your attorney. You may revoke any such authorization at any time.

II. YOUR INDIVIDUAL RIGHTS

A. Right to Inspect and Copy. You may request access to your medical record and billing records maintained by WCPA in order to inspect and request copies of the records. All requests for access must be made in writing. Under limited circumstances, WCPA may deny access to your records. WCPA may charge a fee for the costs of copying and sending you any records requested. If you are a parent or legal guardian of a minor, please note that certain portions of the minor's medical record may not be accessible to you, in accordance with state law. You have the right to an electronic communication of any records that WCPA keeps electronically.

B. Right to Alternative Communications. You may request, and WCPA will accommodate, any reasonable written request for you to receive PHI by alternative means of communication or at alternative locations.

C. Right to Request Restrictions. You have the right to request a restriction on PHI used for disclosure for treatment, payment or health care operations. You must request any such restriction in writing addressed to the Privacy Officer as indicated below. WCPA is not required to agree to any such restriction you may request. One exception is that, if you self-pay at WCPA, you may request that we not disclose these services to your health insurance company and WCPA is obligated to honor that request.

D. Right to Accounting of Disclosures or Breaches. Upon written request, you may obtain an accounting of disclosures of PHI made by WCPA after October 1, 2003. This right is subject to restrictions and limitations. You also have the right to be notified by WCPA if a privacy breach of your PHI has occurred. If such a breach occurred, you would be notified within a reasonable time.

E. Right to Request Amendment. You have the right to request that WCPA amend your health information. Your request must be in writing, and it must explain why the information should be amended. WCPA may deny your request under certain circumstances.

F. Right to Obtain Notice. You have the right to obtain a paper copy of this Notice by submitting a request to the Privacy Officer at any time.

G. Questions and Complaints. If you desire further information about your privacy rights, or are concerned that WCPA has violated your privacy rights, you may contact the **Privacy Officer,** Director Mary Fitzgibbons, Ph.D., at (314) 275-8599. You may also file written complaints with the

Director, Office for Civil Rights of the U.S. Department of Health and Human Services. WCPA will not retaliate against you if you file a complaint with the Director or the Privacy Officer.

III. EFFECTIVE DATE AND CHANGES TO THIS NOTICE

A. Effective Date. This Notice is effective on October 1, 2013.

B. Changes to this Notice. WCPA may change the terms of this Notice at any time. If WCPA changes this Notice, it may make the new notice terms effective for all PHI that it maintains, including any information created or received prior to issuing the new notice. If WCPA changes this Notice, it will post the revised notice in the waiting area of the office and on our website. You may also obtain any revised notice by contacting the Privacy Officer.

This Form is educational only, does not constitute legal advice, and covers only federal, not state, law.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

By my signature below I, _____, acknowledge that I received a copy of the Notice of Privacy Practices for West County Psychological Associates.

_____ _____

Signature of client (or personal representative) Date

If this acknowledgment is signed by a personal representative on behalf of the client, complete the following:

Name of Client: _____

Personal Representative's Name: _____

Relationship to Client: _____

Authorization to Release Health Care Information

IN CASE OF EMERGENCY

Client name: _____ Date of birth: _____

West County Psychological Associates has my permission to contact the following person in case of emergency:

Name(s): _____

Address: _____

City, State, Zip: _____ Phone Number: _____

WCPA will only exchange information pertinent to the emergency.

This authorization ends: _____ on _____ (date); or

_____ when the following occurs:

_____

I may cancel this authorization in writing as allowed by law. This would not affect any actions already taken based upon my original request. There are three ways to cancel this authorization:

1) Sign and date a revocation form. This form is available from WCPA; or
2) Write, sign and date a letter to WCPA to cancel the authorization; or
3) Sign, date and write "CANCEL" on this original form

I understand that once WCPA gives out information, WCPA has no control over it. The recipient might re-disclose it. Privacy laws may no longer protect it.

I understand that I am agreeing to the exchange of health care information regarding receiving testing and/or treatment for psychiatric disorders, mental health, behavior, and/or drug and/or alcohol use.

_____ _____ _____

Patient or legally authorized individual signature Date Time

_____

Relationship to patient if signed on behalf of the patient by parent, legal guardian, personal representative, etc.