Jack Tracy II, Ph.D. Psychological Services, PLLC

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PSYCHOLOGIST-CLIENT SERVICES AGREEMENT **Effective 05/02/2026**

Business Policies and Procedures

Welcome to my practice. This document (the Agreement) contains important information about my professional services and business policies and procedures. It also contains summary information about the Health Insurance Portability and Accountability Act (HIPAA), a federal law that provides privacy protections and patient rights regarding the use and disclosure of your Protected Health Information (PHI) used for the purpose of treatment, payment, and health care operations. HIPAA requires that I provide you with a Notice of Privacy Practices (the Notice) for use and disclosure of PHI for treatment, payment and health care operations. The Notice explains HIPAA and its application to your personal health information in greater detail. The law requires that I provide you with this information.

Although this Agreement is long and sometimes complex, it is very important that you read each section carefully. We can discuss any questions you have about the policies/procedures at that time. When you sign this document, it will represent an Agreement between us. You may revoke this Agreement in writing at any time. That revocation will be binding on me unless I have already taken action based on it; if there are obligations imposed on me by your health insurer to process or substantiate claims made under your policy; or unless you have not satisfied any financial obligations you have incurred.

PSYCHOTHERAPY SERVICES

Psychotherapy is not easily described in general statements. It varies depending on the personality of the psychologist and client, and the specific problems you are experiencing. There are many different methods I may use to deal with the issues you hope to address. Psychotherapy is not like a medical doctor's visit. Instead, it calls for a very active effort on your part for the therapy to be most successful. You may have to work on things we talk about both during sessions and at home.

Psychotherapy can have benefits and risks. Since therapy often involves discussing difficult aspects of your life, you may experience uncomfortable feelings like sadness, guilt, anger, frustration, loneliness, and helplessness. On the other hand, psychotherapy is clearly shown to have many benefits. Therapy often leads to better relationships, solutions to specific problems, and significant reductions in feelings of distress. However, there are no guarantees of what you will experience.

Our first few sessions will involve an assessment of your needs. By the end of the assessment period, we will often establish some goals for your therapy, and I will offer you some first impressions. You should carefully consider this information along with your own opinions to decide if you feel comfortable working with me.

THERAPY SESSIONS

I normally conduct an initial assessment that can last from 2 to 4 sessions. The assessment process involves getting a detailed history from you, obtaining information about the current difficulties that prompted you to

seek therapy, etc. During the initial evaluation, we can both decide if I am the best person to provide the services you need to meet your treatment goals. Once psychotherapy is started, I usually schedule one **50-to-55-minute session** per week. Over time we may spread the sessions out to every two to three weeks as you begin to make progress in therapy and feel better. However, scheduling is flexible, depending on your scheduling and financial needs. If you contact me in advance to cancel an appointment, I will do my best to find another time to reschedule the appointment with you.

MISSED APPOINTMENTS

When an appointment is made, that time is set aside for you and cannot be given to any other client. It is very important that appointments be kept. If an appointment time needs to be rescheduled or canceled, please call the office so that the time may be made available to someone else. We require 24 hours' notice of cancellation. **Once an appointment is scheduled, you will be expected to pay for it unless you provide a minimum of 24 hours' advance notice of cancellation** [unless we both agree that you were unable to attend due to a genuine emergency]. It is important to note that insurance companies do not provide reimbursement for missed sessions, so **you will be responsible for the $60.00 no show / late cancellation fee.** Payments for missed appointments are due with the regular fee by the *next* visit.

After three no-shows or last-minute cancellations, the missed visit charge will increase to my *full hourly fee of $225* for your next missed appointment(s). I also reserve the right to decline to provide you with further services. If this becomes necessary, I will provide you with referrals to other competent mental health providers in the area.

THERAPY VISIT FREQUENCY AND COMPLETION

Many clients choose to begin therapy with weekly or every other week sessions, adjusting frequency as needed. As you begin to feel better, you may choose to change your sessions to once every 3 or 4 weeks. Most clients attend sessions regularly until their treatment goals are met. At that time, when services are no longer needed, your file will be closed, and treatment is ended. If, during your treatment, you do not come in for sessions and do not contact me for a period of 60 days, your file will be closed. Your status will then be considered as "former" patient at that time instead of "current" patient. You are welcome to seek my services again in the future as my schedule allows and if your needs are specific to my areas of treatment.

CONTACTING ME

To make or reschedule an appointment, please call my office number 405-801-2836 to reach a receptionist. If you need to reach me due to a mental health emergency, such as suicidality, (*NOT* a scheduling issue or a non-emergency question) you may call my cell phone: 405-213-6130. If you are unable to reach me and feel that you can't wait for me to return your call, contact your family physician, call 911, or go to the emergency room and ask for the psychiatrist on call. If I am unavailable for an extended time, such as being out of town, my office voicemail will direct you to a colleague who is on call to handle clients in crisis.

CONFIDENTIALITY

The law protects the privacy of all communications between a patient and a psychologist. In most situations, I can only release information about your treatment to others if you sign a written authorization form that meets certain legal requirements imposed by HIPAA. There are other situations that require only that you

provide written consent in advance. Your signature on the Agreement provides consent for those activities, as follows:

- I may occasionally find it helpful to consult other health and mental health professionals about a case. During a consultation, I make every effort to avoid revealing the identity of my patient. The other professionals are also legally bound to keep any information I share confidential. If you don't object, I will not tell you about these consultations unless I feel that it is important in our work together. I will note all consultations in your Clinical Record (which is called "PHI" in my Notice of Psychologist's Policies and Practices to Protect the Privacy of Your Health Information).
- I employ administrative staff to assist me with running my practice. In most cases, I need to share protected information with these individuals for administrative purposes, such as scheduling and billing. All staff members have been given training in protecting your privacy and protected information and have agreed not to release any information outside of my practice without my permission.
- Disclosures required by health insurers or to collect overdue fees are discussed elsewhere in this Agreement.

There are some situations where I am permitted and/or required to disclose information without your consent or authorization:

- If you are involved in legal proceedings and a request is made for information concerning your diagnosis and treatment, such information is protected by the psychologist-patient privilege law. I cannot provide any information without your (or your personal or legal representative's) written authorization, or a court order. If you are involved in or contemplating litigation, you should consult your attorney to determine whether the court would be likely to order me to disclose information. Carefully read the section on court testimony further down in this agreement.
- If a government agency is requesting information for health oversight activities, I may be required to provide it for them.
- If a patient files a complaint or lawsuit against me, I may disclose relevant information regarding that patient to defend myself.
- If a patient files a worker's compensation claim, I may disclose information relevant to that claim to the appropriate parties, including the Administrator of the Workers' Compensation Court.

There are some situations in which I am legally obligated to take actions, which I believe are necessary to protect a patient or others from harm, and I may have to disclose some information about a patient's treatment. These situations are unusual in my practice and are listed below.

- If I have reason to believe that a child under the age of 18 years is the victim of abuse or neglect, the law requires that I report to the appropriate government agency, usually the Department of Human Services. Once such a report is filed, I may be required to provide additional information.
- If I have a reason to believe that a vulnerable adult is suffering from abuse, neglect, or exploitation, the law requires that I report to the appropriate government agency, usually the Department of Human Services. Once such a report is filed, I may be required to provide additional information.
- If a patient communicates an explicit threat to kill or inflict serious bodily injury upon a reasonably identifiable victim and he/she has the apparent intent and ability to carry out the threat, or if a patient

has a history of violence and I have a reason to believe that there is a clear and imminent danger that the patient will attempt to kill or inflict serious bodily injury upon a reasonably identified person, I may be required to take protective actions. These actions may include notifying the potential victim, contacting the police, and/or seeking hospitalization for the patient.

- If a patient threatens to harm himself/herself, I may be obligated to seek hospitalization for him/her, or to contact family members or others who can help provide protection.

If such situations arise, I will make every effort to fully discuss it with you before taking any action and I will limit my disclosure to only what is necessary.

While this written summary of exceptions to confidentiality should prove helpful in informing you about potential problems, it is important that we discuss any questions or concerns you may have now or in the future. The laws governing confidentiality can be quite complex, and I am not an attorney. In situations where specific advice is required, formal legal advice may be needed and/or sought.

PROFESSIONAL RECORDS

The laws and standards of my profession require that I keep Protected Health Information (PHI) about you in your Clinical Record. EXCEPT in circumstances that involve danger to yourself and / or others, where information has been supplied to me confidentially by others, or if the information has been gathered in a reasonable anticipation of or specifically for use in litigation, you may examine and / or receive a copy of your Clinical Record if you request it in writing. Because these are professional records, they can be misinterpreted, misunderstood, or upsetting to untrained readers. For this reason, I recommend that you initially review them in my presence or have them forwarded to another mental health professional so that you can discuss the contents of the records with them.

I reserve the right to charge a copy fee of $1.00 for the first page and $.50 cents for each additional page.

PATIENT RIGHTS

HIPAA provides you with several rights regarding your Clinical Record and disclosures of protected health information. These rights include requesting that I amend your record; requesting restrictions on what information from your Clinical Record is disclosed to others; requesting an accounting of most disclosures of protected health information that you have neither consented to nor authorized; determining the location to which protected information disclosures are sent; having any complaints you make about my policies and procedures recorded in your records; and the right to a paper copy of this Agreement, the HIPAA Notice Form, and my privacy policies and procedures. I am happy to discuss any of these rights with you.

MINORS & PARENTS

Patients under 18 years of age are not emancipated, and their parents should be aware that the law may allow parents to examine their child's treatment records. Both custodial and non-custodial parents are afforded this right under Oklahoma law. Because privacy in psychotherapy is often crucial to successful outcomes, particularly with teenagers, I may sometimes request an agreement from parents consenting to give up their access to their child's records. If the parent(s) agree to this, during treatment, I will provide them with only

general information about the progress of the child's treatment, and his/her attendance at scheduled sessions. I will also provide parents with a summary of their child's treatment when it is complete.

Any other communication will require the child's Authorization, unless I feel that the child is in danger or is a danger to someone else, in which case, I will notify the parents of my concern. Before giving parents any information, I will discuss the matter with the child, when possible, and do my best to handle any objections he/she may have.

PROFESSIONAL FEES

Payment is due on each visit. For minors, the *parent or guardian who initiates therapy or testing for a child* is the party responsible for the payment at the time that services are rendered. Shared financial arrangements between parents should be worked out between the parents involved *outside of the child's therapy appointments*. If you are doing teletherapy visits with me, you must call in any payment due prior to the time of the appointment. My receptionist will take your payment over the phone.

Your costs for therapy with me will depend on if we are filing with your insurance and if I am an *"in-network"* provider with your insurance. Insurance companies can frequently adjust their reimbursement rates for me and your costs will be adjusted accordingly. I will give you as much advance notice as I get when that happens.

If you have insurance your cost will be your deductible or copay.

If I am an "out-of-network" provider with your insurance, your insurance has out of network benefits and you want me to file with your insurance for therapy sessions, the fees are as listed below**. If you decide to "self-pay" instead of filing with your insurance (whether I am in-network or not) then your self-pay fees will be decided prior to the first appointment.**

What I Bill Your Insurance:

- Initial Diagnostic Interview, 60 minutes (in-person or via telehealth) $250
- Individual, Family Therapy, 45-60 minutes (in-person or telehealth) ..……$225
- Telephone Consultations longer than 5 minutes, per quarter hour (rounded up) $40
- No-shows or appointments cancelled less than 24 hours ahead of time…….$60
- Court Testimony/Legal Involvement…….……..……$450/Hour (4-hour minimum retainer)

I charge $150 per hour for other professional services you may need, though I will prorate the hourly cost if I work for periods of less than one hour. The only exception to this is the "Court Testimony/Legal Involvement fee listed above; Other services include but are not limited to:

- Scoring any testing that was completed as a part of the initial evaluation or ongoing therapy
- Telephone conversations longer than 10 minutes
- Time spent consulting with other professionals at your request
- Preparation of records
- Letters or treatment summaries at your request
- Time spent performing any other service you may request of me

I accept payments by cash, check, and credit card. Payment schedules for other professional services will be agreed to when they are requested.

IF WE ARE FILING WITH YOUR INSURANCE:

Your costs for my services will depend on your insurance coverage for mental/behavioral health, my contracted rates with your insurance provider, and your required copay and/or deductible as set by your insurance provider. We will do our best to verify what your benefits are and notify you of those benefits prior to our first appointment**.**

We strongly encourage you to call your insurance provider or log in to verify your behavioral/mental health benefits or check with your HR benefits person as we are sometimes given incorrect information and we aren't aware until the first few claims process, which can sometimes take several weeks.

Your insurance card should have a customer/member services number on the back. If you call them and they tell you something different from what we have told you, please get a call reference number and the person you spoke with, give that information to my office staff and then I will have our billing company call the insurance provider again.

Health Insurance Coverage represents a contract between the insurance company and the family. It is the responsibility of the patient and their family to know the benefits and limits of their coverage. Failure to know these limits does not relieve the patient/family of their financial responsibility.

We are not financially responsible for any incorrect information given to our office. You are responsible for any fees or portion of fees not covered by your contract with your insurance company. Determination of benefits by this office is not a guarantee of payment by your insurance company.

COURT TESTIMONY AND LEGAL INVOLVEMENT

I do not provide court testimony, forensic assessment, custody evaluations, letters to attorneys, or any other services for court or legal purposes. My services are limited only to enhancing the mental health and functioning of my clients. If you are seeking a psychologist that can testify on your behalf, such as in custody or criminal cases, I will be happy to refer you to other psychologists who provide that service**.**

By signing this agreement and beginning treatment with me, you agree that none of our conversations, treatment, diagnoses, etc. can be used for any legal purposes, and that my records and/or oral testimony cannot be compelled in any case.

If a subpoena is issued requiring my appearance or for my records and/or oral testimony, you will then be billed for any attorney fees, costs and/or expenses incurred for the time required to comply with or quash the subpoena, and for my time related to dealing with the subpoena. Because of the complexity of legal involvement, **I charge $450.00 per hour of time spent on preparation, travel, consultation, appearance, etc. and require that *a four-hour Retainer be paid in advance*.**

PAST DUE PAYMENTS

If your account has not been paid for more than 60 days and arrangements for payment have not been agreed upon (or if you arrange a payment plan and do not fulfill it), I reserve the option of using legal means to secure the payment. This may involve hiring a collection agency or going through Small Claims court which could

require me to disclose otherwise confidential information. In most collection situations, the only information I release regarding a patient's treatment is their name, contact information on file, the nature of services provided, and the amount due. If such legal action is necessary, those associated costs will be included in the amount of the claim.

INSURANCE REIMBURSEMENTS FOR THERAPY/TESTING

For us to set realistic treatment goals and priorities, it is important we assess and discuss what resources you have available to pay for your treatment. If you have health insurance, it will usually provide some coverage for mental/behavioral health treatment. **However, you *(not your insurance company)* are responsible for full payment of my fees.** Some insurance plans require a copay for each session, and some require a "deductible" to be paid by the patient/guardian before insurance will begin covering services. Some plans do not cover mental health services at all. **It is very important that you find out exactly what mental health services your insurance policy covers prior to your first appointment with me.** You should carefully read the section in your insurance coverage booklet that describes mental health services. If you have questions about the coverage, call your plan administrator or the customer service number on the back of the insurance card inquiring about your mental health benefits. I will provide you with whatever information I can based on my experience and will be happy to help you understand the information you receive from your insurance company.

Sometimes insurance companies require additional clinical information such as treatment plans or summaries, or copies of your entire Clinical Record. In these situations, I will make every effort to release only the minimum amount of information about you that is necessary for the purpose requested. This information will become part of the insurance company files and will probably be stored on a computer/server. Though all insurance companies claim to keep such information confidential, I have no control over what they do with the information once it is given to them and how they secure it. In some cases, they may share the information with a national medical information databank. Upon your request I will provide you with a copy of any report I submit to them. If your insurance company denies reimbursement, you will be responsible for paying for the services I provided for you.

It is important to know that you always have the right to "self-pay" for my services and not file with your insurance(s) to avoid the situations described above.

IMPAIRMENT FROM ALCOHOL OR OTHER SUBSTANCES

I respectfully request that you be free of alcohol or other intoxicants prior to coming in for therapy so that we can have the best chance of being successful in our work together. If, during the session, I come to believe that your senses are impaired in some way because of substances, then I will address that concern to determine if we can continue. If in fact you are "intoxicated" for whatever reason, then we will stop your session, and I will make any arrangements necessary for you to get back to your residence "safe and sound". This may involve calling a friend, relative, or calling a cab. I will also request your car keys so you will not be tempted to continue driving while impaired. If, for some reason, you refuse to cooperate, then I could be forced to call the authorities to ensure your safety and the safety of others. While such circumstances are extremely rare, you need to be informed about what could happen if you were to come to therapy "impaired" any way.

PRACTICE STATEMENT:

My office is in the "Norman Psychology" building with several other mental health professionals. This group is an association of independently practicing professionals, which share certain expenses and administrative functions. While members share office space and expenses, my practice is completely independent in providing you with clinical services. I alone am fully responsible for those services. My professional records are separately maintained, and no member of the group can have access to them without your specific, written permission or in the case of emergency coverage which you request during my absence. You should be aware that I employ administrative office staff to assist me with running my practice, and I also employ a billing service. In most cases, I need to share protected information with these individuals for administrative purposes, such as scheduling and billing. All staff members have been given training in protecting your privacy and have agreed not to release any information outside of my practice.

BREACH NOTIFICATION

As required under the September 2013 Privacy Rule of HIPAA, I must notify you of the following policy. A "breach" is defined as the acquisition, access, use or disclosure of PHI in violation of the HIPAA Privacy Rule.

1. When the Practice becomes aware of or suspects a breach in your PHI, the Practice will conduct a Risk Assessment and will keep written record of that Risk Assessment. This will include reviewing the nature and extent of the PHI involved, to whom the PHI may have been disclosed, whether the PHI was actually acquired or viewed, and the extent to which the patient has been mitigated.
2. Unless the Practice determines that there is a low probability that PHI has been compromised, the practice will give the notice of the breach as described in the breach notification overview in my Privacy Notice.
3. The risk assessment can be done by a business associate if it was involved in the breach. While the business associate will conduct a risk assessment of a breach of PHI in its control, the Practice will provide any required notice to patients and HHS.
4. After any breach, particularly one that requires notice, the Practice will re-assess its privacy and security practices to determine what changes should be made to prevent the re-occurrence of such breaches.

DR. TRACY PSYCHOLOGIST-CLIENT SERVICES AGREEMENT SIGNATURE PAGE

CONSENT FOR TREATMENT

Your signature on this form indicates that you have read the information in this Agreement and agree to its terms. This also serves as an acknowledgement that you have reviewed the HIPAA Privacy Notices form described herein and received a copy. If you are the guardian of a minor child who is the patient, you are giving legal consent for services for that minor and attest that you have the legal authorization to give consent for the clinical evaluation or treatment for that child.

X_____ _____ _____

Signature of Adult Patient / Guardian | Print name of Adult Patient/Guardian | Date

_____ _____

Printed name of minor child (if patient is a minor) | Date of Birth of Child

CONSENT FOR INSURANCE BILLING

I give permission to Dr. Tracy, his staff, and/or his medical billing company to release medical information to my or my child's (if patient is a minor) insurance company or managed care company contracted by the insurance company, if necessary, in order for the insurance company to pay their portion of the services provided by me. I further agree to pay for any services the insurance does not cover and will not pay for.

_____ _____

Signature of Adult Patient / Guardian | Date