Tara M. Files-Hall, Ph.D., P.A.

Stephanie K. Lirio, M.D., P.A.

PATIENT SERVICES AGREEMENT AND INFORMED CONSENT

For Services Rendered to or Regarding:
Name:_____
Date of Birth:_____
Address:_____

INTRODUCTION

WELCOME to Family C.O.P.E., Tara M. Files-Hall, Ph.D., P.A., and/or Stephanie K. Lirio, M.D., P.A. This document is intended to inform you of the conditions governing the psychological/psychiatric services you are requesting. We wish to thank you in advance for your patience regarding all of the paperwork necessary in order to be in compliance with federal laws, state laws and regulations, and professional ethical standards. Also, it is important to clarify all financial matters beforehand, particularly the fact that no matter what you are told by your insurance carrier, their information is ADVISORY and not a guarantee of coverage or payment.

We comply with the Health Insurance Portability and Accountability Act (HIPAA), a recent federal law that provides new privacy protections and new patient rights with regard to the use and disclosure of your Protected Health Information (PHI). HIPAA requires that we provide you with a Notice of Privacy Practices (the Notice) for use and disclosure of PHI for treatment, payment, and health care operations. This Notice, which is attached to this contract, explains HIPAA and its application to your personal health information in detail. The law requires that we obtain your signature acknowledging that we have provided you with this information by the end of this session. Although these documents are long, it is very important that you read them carefully. We are happy to discuss any questions that you have. When you sign this document, it will also represent an agreement between us. You may revoke this Agreement in writing at any time. That revocation will be binding on us unless we have taken action in reliance on it; if there are obligations imposed on us by your health insurer in order to process or substantiate claims made under your policy; or if you have not satisfied any financial obligation you have incurred.

INSURANCE REIMBURSEMENT

Family C.O.P.E., Tara M. Files-Hall, Ph.D., P.A., and/or Stephanie K. Lirio, M.D., P.A. is out-of-network for all insurance plans. Payment is due at the time of service. It is your choice and responsibility to file your own insurance claims independent of these practices. However, we will be happy to provide you with a "super bill" for you to submit to your insurance company for your out-of-network benefits; then, your benefit payments will be mailed directly to you.

PAYMENT METHODS

The preferred methods of payment are cash and check. MasterCard, Visa, Discover, AMEX, and signature Debit/Check cards are also accepted. Please note that even if you choose to pay with cash and/or check, you are required to provide your credit/debit card information in order to guarantee payment of any overdue or unpaid balances

on your account. You understand that your credit/debit card will only be charged if you have not responded within 30 days of being notified, in writing and/or by telephone, of any overdue or unpaid balances on your account.

CONTACTING US

Office hours vary during the week. We are often not immediately available by telephone, as we usually will not answer the telephone when with a patient. Should you need to contact us, please feel free to leave a message with the office manager. Every effort is made to return your call as soon as possible during office hours. If you are a current patient you will be informed of any extended absence from the practice of your clinician and you will be provided with the name of a colleague whom you may contact should the situation present.

Please note that some forms of communication, such as wireless telephones, Skype, FaceTime, web-cameras, and email may not be secure, private, and/or confidential. We have email available for routine NON-EMERGENCY messages (e.g., change of appointment time). As previously mentioned, if you choose to communicate this way, please be aware that email is an insecure form of communication; thus, privacy, security, and confidentiality cannot be guaranteed.

LIMITATIONS OF SERVICES

It is important to note that we provide outpatient services only. This practice is not geared for the provision of crisis or emergency services. Should you find your situation to be one of emergency, please call 911, or go to the local crisis unit or hospital emergency room. (A list of local crisis centers and hospitals has been provided to you.)

PROFESSIONAL RECORDS

The laws and standards of our profession require that we keep Protected Health Information (PHI) about you in your Clinical Record. Your record includes such information as your reasons for seeking treatment, a description of the ways in which your problem impacts on your life, your diagnosis, the goals that we set for treatment, your progress towards those goals, your medical and social history, your treatment history, any past treatment records that we receive from other providers, reports of any professional consultations, your billing records, and any reports that have been sent to anyone, including reports to your insurance carrier. Except in unusual circumstances that disclosure would physically endanger you and/or others or makes reference to another person (other than a health care provider) and we believe that access is reasonably likely to cause imminent harm to such other person, you may examine and/or receive a copy of your Clinical Record, if you request it in writing. Because these are professional records, they may be misinterpreted and/or upsetting to untrained readers. For this reason, we recommend that you initially review them in our presence, or have them forwarded to another mental health professional so you can discuss the contents. Appropriate fees will be charged for professional time spent in responding to information requests. If we refuse your request for access to your records, you have a right of review, which we will discuss with you upon request.

PATIENT RIGHTS

HIPAA provides you with several new or expanded rights with regard to your Clinical Record and disclosures of PHI. These rights include requesting that we 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 our policies and procedures recorded in your records; and the right to a paper copy of this Agreement, the attached Notice form, and our privacy policies and procedures. We are happy to discuss any of these rights with you.

MINORS AND PARENTS

Patients under 18 years of age who are not emancipated and their parents should be aware that the law may allow parents to examine their child's treatment records. Children between 13 and 17 may independently consent to diagnosis and treatment in a crisis situation.

CHILD THERAPY/PSYCHIATRIC SERVICES IN CASES OF SEPARATED/DIVORCED PARENTS

When separating and/or divorced parents bring their child for treatment, a special risk situation exists regarding the child's treatment.

I recognize that such treatment may be compromised if information revealed therein may subsequently be brought to the attention of the court in the course of litigation. Accordingly, I pledge that I will neither individually nor jointly involve Family C.O.P.E., Tara M. Files-Hall, Ph.D., P.A., and/or Stephanie K. Lirio, M.D., P.A. in litigation. If the services of a mental health professional are considered desirable for the purposes of litigation, the services of another person will be enlisted. Family C.O.P.E., Tara M. Files-Hall, Ph.D., P.A., and/or Stephanie K. Lirio, M.D., P.A. will be happy to provide me with referrals for a forensically trained psychologist with specific training in parenting evaluation, visitation scheduling, family law mediation, expert witness testimony, and/or parenting coordination.

In cases related to consent for psychiatric evaluation and/or consent for psychotropic medications, my signature below confirms that I am a parent who has authority to make medical decisions for my child. In cases in which divorced parents *share* medical decision making responsibilities, I acknowledge that I, as the parent present for the evaluation, have the responsibility to notify the parent who is not present at the evaluation of the nature of the evaluation and/or treatment recommendations, and to provide the psychiatrist with a means to contact the parent who is not present at the evaluation.

There are some situations in which we are legally obligated to take actions, which we believe are necessary to attempt to protect you or others from harm, and we may have to reveal some information about your treatment. These situations are unusual in this practice. They include:

1) If we know, or have reason to suspect, that a child under 18 is abused, abandoned, or neglected by a parent, legal custodian, caregiver, or any other person responsible for the child's welfare, the law requires that we file a report with the Department of Child and Family Services. Once such a report is filed, we may be required to provide additional information.
2) If we know or have reasonable cause to suspect, that a vulnerable adult has been or is being abused, neglected, or exploited, the law requires that we file a report with the central abuse hotline. Once such a report is filed, we may be required to provide additional information.
3) If we believe that there is a clear and immediate probability of physical harm to the patient, to other individuals, or to society, we may be required to disclose information to take protective action, including communicating the information to the potential victim, and/or appropriate family member, and/or the police or seeking hospitalization of the patient.

If any of these situations present themselves, we will make every effort to fully discuss it with you before taking any action and we will limit our disclosure to 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 that you may have now or in the future. The laws governing confidentiality can be quite complex, and we are not attorneys. In situations where specific advice is required, formal legal consultation may be needed.

STATEMENT OF UNDERSTANDING

By signing this treatment contract, the patient and/or other responsible party agree that they have read this Agreement and agree to its terms and also serves as an acknowledgement that they have received the HIPAA notice form described above.

Signatures:	Relationship:
_____	_____
_____	_____
_____	_____
_____	_____
Witness	Date

Please be aware that it is your right to revoke any consent forms (including this form) at any time. This revocation of consent must be provided in written form.

family C.O.P.E.
Center Of Psychotherapy/Psychiatry & Evaluation

BACKGROUND INFORMATION

TODAY'S DATE _____ 1st APPOINTMENT DATE _____

YOUR NAME _____ NICKNAME_____

DATE OF BIRTH _____ AGE _____

WHO REFERRED YOU FOR EVALUATION? _____

PREFERRED PHARMACY NAME AND LOCATION? _____

BRIEFLY DESCRIBE THE NATURE OF THE PROBLEM YOU ARE HAVING

_____

_____

NAME OF PERSON COMPLETING THIS FORM_____ _____

_____

_____

WITH WHOM DO YOU LIVE?

_____

_____

_____

PLEASE DESCRIBE ANY LEGAL PROBLEMS YOU HAVE HAD_____

_____

_____

HAVE YOU EVER USED TOBACCO, if yes (circle one) past or present ? How much per day? _____

_____

_____

_____

HAVE YOU EVER USED ALCOHOL, if yes (circle one) past or present? How Much? _____

_____

HAVE YOU EVER USED DRUGS, if yes (circle one) past or present? Type: _____

WHAT CHALLENGES IS YOUR FAMILY FACING (DIVORCE, JOB LOSS, DEATH, ETC) _____

_____

_____

HAVE YOU BEEN EVALUATED BY A MENTAL HEALTH PROFESSIONAL BEFORE? IF SO, TELL ME ABOUT THAT_____

_____

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ARE YOU TAKING ANY MEDICATIONS, SUPPLEMENTS, OR REMEDIES AT THIS TIME? IF SO, PLEASE LIST THE NAMES, DOSES, REASON FOR TAKING, AND HOW LONG TAKING_____

MORE MEDICAL AND DEVELOPMENTAL INFORMATION

PLEASE LIST THE NAMES OF ALL TREATING PHYSICIANS/MEDICAL PRACTITIONERS_____

DESCRIBE ANY MEDICAL PROBLEMS OR UNEXPLAINED MEDICAL SYMPTOMS_____

LIST SURGERIES, HOSPITALIZATIONS, INJURIES _____

HAVE YOU EVER HAD A HEAD INJURY? (CONCUSSION, LOSS OF CONSCIOUSNESS, OR SEIZURE) _____

LIST ANY ALLERGIES TO MEDICATIONS, FOODS, OR OTHER THINGS_____

FAMILY HISTORY

DESCRIBE EMOTIONAL/BEHAVIORAL PROBLEMS IN ANY BLOOD RELATIVES_____

DESCRIBE ANY MEDICAL PROBLEMS THAT SEEM TO RUN IN THE FAMILY_____

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YOUR EXPECTATIONS

WHAT SORTS OF THINGS HAVE YOU ALREADY TRIED TO REMEDY YOUR PROBLEMS? _____

_____

_____

_____

ARE YOU WILLING TO CONSIDER INDIVIDUAL OR FAMILY COUNSELING? _____

ARE YOU WILLING TO CONSIDER MEDICATION IF INDICATED? _____

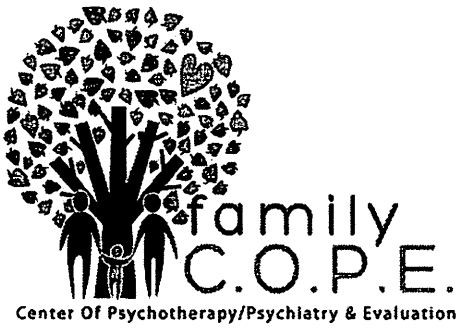
ARE THERE ANY OTHER CONCERNS OR ISSUES WHICH WOULD BE IMPORTANT FOR ME TO KNOW ABOUT AS I MEET WITH YOU AND MAKE DECISIONS REGARDING TREATMENT?

_____

_____

_____

THANK YOU FOR COMPLETING THIS QUESTIONNAIRE. IT WILL MAKE OUR FIRST VISIT MUCH MORE PRODUCTIVE AND ASSIST ME IN MAKING IMPORTANT DIAGNOSTIC AND TREATMENT DECISIONS. THIS FORM WILL BECOME PART OF YOUR MEDICAL RECORD AND IS COMPLETELY CONFIDENTIAL.



Tara M. Files-Hall, Ph.D., P.A.

Stephanie K. Lirio, M.D., P.A.

7345 International Place #109 Sarasota, FL 34240
2620 S. Tamiami Trail Sarasota, FL 34239
941-702-9978

GUARANTEE OF PAYMENT FORM

PATIENT NAME: _____

I, _____, hereby *guarantee full payment* of any and all charges and fees incurred for the account of the above-named patient from the initial interview/session through the termination of treatment by Family C.O.P.E., Tara M. Files-Hall, Ph.D., P.A., and/or Stephanie K. Lirio, M.D., P.A. I also understand that Family C.O.P.E., Tara M. Files-Hall, Ph.D., P.A., and/or Stephanie K. Lirio, M.D., P.A. does NOT accept insurance and/or assignment for any insurance plans and that I am fully responsible for making all payments directly at the time of service. *I accept full and complete responsibility for any and all charges and balances on this accoun*t as noted in the "PATIENT SERVICES AGREEMENT AND INFORMED CONSENT".

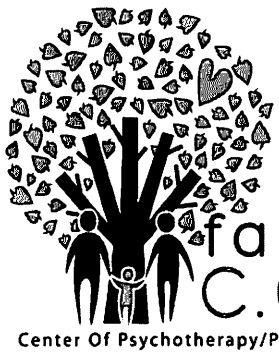
I also agree to make any and all final payments within 30 days of the final billing invoice/statement. In addition, I agree to provide my valid Credit/Debit Card information in order to guarantee payment on this account. I understand that my credit/debit card will *only* be charged the amount of any overdue or unpaid balances on this account, if I have not responded within 30 days of being notified, in writing and/or by telephone.

In addition, I understand that I am completely and fully responsible for any and all charges, fees, or costs involved in collecting any overdue payments or unpaid balances on this account, including but not limited to; interest charges, late fees, collection and/or court fees, and any reasonable attorney fees. I understand that if collection, court, or legal action becomes necessary to secure such overdue payments or unpaid balances that any and all costs involved for this will be passed onto to me, directly, and those fees will be included in that claim. I also agree to hold Family C.O.P.E., Tara M. Files-Hall, Ph.D., P.A., and/or Stephanie K. Lirio, M.D., P.A. harmless for any adverse consequences that may occur as a result of the assignment of this account to a collection agency and/or an attorney.

My signature below indicates that I have read and understand the information contained in this document and agree to all of its terms, in its entirety. My signature also indicates that this information has been reviewed with me and I have had the opportunity to discuss any concerns or questions I had.

_____ _____
Parent/Guardian/Responsible Party/Patient's Signature Date

_____ _____
Witness Date



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Payment Consent Form

PATIENT Name _____
First *Middle* *Last*

Name (as it appears on the card) if different than Patient's Name above:

_____
First *Middle* *Last*

I authorize Family C.O.P.E., Tara M. Files-Hall, Ph.D., P.A., and/or Stephanie K. Lirio, M.D., P.A. to charge my Credit/Debit Card for Professional Services and Fees as follows:

Please INITIAL all that apply:

_____ If there is ever an overdue and/or unpaid balance on my account for over 30 days and I have not paid this amount after being notified, in writing and/or by telephone, my credit/debit card will be charged that amount in full to bring my account up-to-date. (**ALL Patients**)

_____ I wish to use my credit/debit card to pay for any and all charges, fees, and amounts for services on my account.
(I understand that all charges, fees, and amounts will be made to my credit/debit card as they occur.)

_____ I prefer to pay for some or all charges, fees, and amounts occurring on my account in advance and/or at the time of service by Cash or Check. However, there may be times when I wish to use my credit/debit card to pay for some or all of the charges, fees, and amounts that have occurred on my account. At those times, I understand that my Verbal Authorization will be accepted to process that payment using my credit/debit card.

Type of Credit Card: □ Visa □ MasterCard □ Discover □ AMEX □ Flexible Spending Account
(Please check if the card is also a bank Check/Debit Card) □

Card Number: _____ - _____ - _____ - _____ Expiration Date _____ /_____

SECURITY CODE # (three-digit # on back of card) _____

Card Holder's Billing Address for Credit Card Statements:

_____
Street Address

_____
City *State* *Zip*

My signature below indicates that I understand and agree with the payment option(s) as selected above.

Card Holder's Signature _____, Date ____ /_____ /____

*Please be aware that revocation of this consent must be provided in written form.