Kathy M. Cosgrove, Ph.D.
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CLIENT/THERAPIST SERVICES AGREEMENT

My approach to treatment is an insight-oriented psychodynamic psychotherapy that utilizes cognitive behavioral techniques and strategies. This calls for an active effort and ongoing commitment from each of us. My role is to help you engage in a relational process involving your thoughts and feelings, life history, relationship patterns, and current symptoms to make meaningful changes in your life. It is important for us to maintain an open dialogue with each other about all aspects of our work together as it progresses.

Since commitment and consistency are so important in psychotherapy, I have developed the following guidelines:

If you need to reach me between regularly scheduled appointments, you can call or text me at (914) 953-1969. I will return all calls and texts within 24 hours. In the case of an emergency, go to the nearest emergency room or call 911 for help.

I will maintain the confidentiality of the content of your sessions with the following exceptions:
If you are having a medical or psychiatric emergency (a danger to yourself or others), I am legally obligated to contact your emergency contact, psychiatrist, or medical provider, or call 911.

If you are a minor (under the age of 18), I am obligated to discuss in general terms the course of your treatment with your guardians. In such situations, I will make every effort not to discuss specific personal matters, unless you pose a risk to yourself or others, and to discuss with you what will be disclosed beforehand.

If you would like me to disclose legal information about your treatment to a specific authority, I will need your written permission.

My services are by appointment only. I normally conduct an evaluation for two to four sessions. During this time, we can both decide if I am the best person to provide the services you need to meet your goals. Sessions are 45-minutes and usually occur once weekly. If you are late to an appointment, the session will still end at its regularly scheduled time.

I will hold a weekly time for you and you are responsible for the fee regularly. I need **48 hours notice** if you must cancel or change an appointment time. With notice, I will try to offer you another time. If you cancel with less than 48 hours, you will be charged the full regular fee for the missed session.

My fee is *TBD* per session. **I require payment at the time of service** via Venmo or Zelle. At the end of the session, I will provide you with a bill detailing the services provided and the total amount paid. I review my fees annually.

If you plan to use mental health coverage through your insurance plan, I will fill out any necessary forms required and provide you with whatever assistance I can in helping you receive the benefits to which you are entitled. However, you (not your insurance company) are ultimately responsible for full payment of fees. It is very important that you find out exactly what mental health services your insurance policy covers.

HIPAA (Health Insurance Portability and Accountability Act) provides you with several new or expanded rights with regard to your clinical records and disclosures of protected health information. The attached form entitled "Notice of Policies and Practices to Protect the Privacy of Your Health Information" lists these rights.

I may recommend that you meet with additional health providers as part of our treatment. This might include physicians, psychiatrists, or nutritionists. In situations where your medical health is at risk, I will trust that you will meet with these providers and follow their recommendations. I will ask you to give me written permission to be in contact with these providers, as collateral contact is in the best interest of your treatment. I will discuss these contacts with you.

I take approximately four weeks of vacation throughout the year and will alert you to my vacation plans ahead of time. During these times, should you need to speak to me and I will be unavailable by phone, Zoom, or FaceTime, I will provide you with the name of a colleague to contact.

Your signature below indicates that you have read this agreement and agree to its terms, and also serves as an acknowledgement that you have received the HIPPA notice form "Notice of Policies and Practices to Protect the Privacy of Your Health Information".

Name of Client: _____

Signature of Client: _____ Date: _____

Guardian's Signature (if minor): _____ Date: _____

Signature of Therapist: _____ Date: _____
Kathy M. Cosgrove, Ph.D.

Please return this signed consent form to me. I will provide you with a copy for your records. Thank you.

NOTICE OF POLICIES AND PRACTICES TO PROTECT THE PRIVACY OF YOUR HEALTH INFORMATION

THIS NOTICE DESCRIBES HOW MENTAL HEALTH AND MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Uses and Disclosures for Treatment, Payment, and Health Care Operation

I may *use* or *disclose* your *Protected Health Information* (PHI) for *Treatment*, *Payment*, and *Health Care Operations* purposes with your *written authorization*. To help clarify these terms, here are some definitions:
"PHI" refers to information in your health record that could identify you.
"*Treatment, Payment, and Health Care Operations"*
Treatment is when I provide, coordinate, or manage your health care and other services related to your health care. An example of treatment would be when I consult with another health care provider, such as your family physician or a psychologist.
Payment refers to reimbursement for your health care. Examples of payment are when PHI is disclosed to your health insurer to obtain reimbursement for your health care or to determine eligibility or coverage.
Health Care Operations are activities that relate to the performance or operation of the practice. Examples are quality assessment and improvement activities, business-related matters (such as audits) and administrative services, case management, and care coordination.
"Use" applies only to activities within the office, such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.
"Disclosure" applies to activities outside of the office, such as releasing, transferring or providing access to information about you to other parties.
"Authorization" is your written permission to disclose confidential mental health information. All authorizations to disclose must be on a specific legally required form.

Other Uses and Disclosures Requiring Authorization

I may use or disclose PHI for purposes outside of treatment, payment or health care operations when your appropriate authorization is obtained. In those instances when I am asked for information for purposes outside of those outlined above, I will obtain authorization from you before releasing that information. I will also need to obtain authorization before releasing your *Psychotherapy Notes*. Those are notes I have made about our conversation during a private, group, joint, or family counseling session, which I have kept separate from the rest of your record. These notes are given a greater degree of protection than PHI.

You may revoke all such authorizations (of PHI or Psychotherapy Notes) at any time, provided each revocation is in writing. You may not revoke an authorization to the extent that (1) I have relied on that authorization; or (2) if the authorization was obtained as a condition of insurance coverage, the law provides the insurer with the right to contest the claim under the policy.

Uses and Disclosures Without Authorization

I may use or disclose PHI without your consent or authorization in the following circumstances:
Child Abuse – If I know or have reasonable cause to suspect that a child known to me in my professional capacity has been or is in immediate danger of being mentally or physically abused or neglected, I must immediately report such knowledge or suspicion to the appropriate authority.
Adult and Domestic Abuse – If I believe that an adult is in need of protective services because of abuse or neglect by another person, I must immediately report this belief to the appropriate authorities.
Health Oversight Activities – If the NY Board of Psychology is investigating me or my practice, I may be required to disclose PHI to the Board.
Judicial and Administrative Proceedings – If you are involved in a court proceeding and a request is made for information about the professional services I have provided you and/or the records thereof, such information is privileged under NY law, and I will not release information without the written authorization of you or your legally appointed representative or a court order. The privilege does not apply when you are being evaluated for a third party or where the evaluation is court offered. You will be informed in advance if this is the case.
Serious Threat to Health or Safety – If I believe disclosure of PHI is necessary to protect you or another individual from a substantial risk of imminent and serious physical injury, I may disclose the PHI to the appropriate individuals.

Worker's Compensation – If I am treating you for Worker's Compensation purposes, I must provide periodic progress reports, treatment records, and bills (upon request) to you, the NY office of Hearings and Adjudication, your employer, or your insurer (or their representatives).

Patient's Rights and Provider's Duties

Patient's Rights:

Right to Request Restrictions – You have the right to request restrictions on certain uses and disclosures of PHI. However, I am not required to agree to a restriction you request.

Right to Receive Confidential Information by Alternative Means and at Alternative Locations – You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations. (For example, you may not want a family member to know that you are in treatment with me. Upon your request, I will send bills to another address.)

Right to Inspect and Copy – You have the right to inspect or obtain a copy (or both) of PHI in my mental health and billing records used to make decisions about you for as long as the PHI is maintained in the record. I may deny your access to PHI under certain circumstances, but in some cases you may have the decision reviewed. You may be denied access to Psychotherapy Notes if I believe that a limitation of access is necessary to protect you from a substantial risk of imminent psychological impairment or to protect you or another individual from a substantial risk of imminent and serious physical injury. I shall notify you or your representative if I do not grant complete access. Upon your request, I will discuss with you the details of the request and denial process.

Right to Amend – You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. I may deny your request. Upon your request, I will discuss the details of the amendment process.

Right to an Accounting – You generally have the right to receive an accounting of disclosures of PHI. Upon your request, I will discuss with you the details of the accounting process.

Right to a Paper Copy – You have the right to obtain a paper copy of the notice from me upon request, even if you have agreed to receive the notice electronically.

Provider's Duties:

I am required by law to maintain the privacy of PHI and to provide you with a notice of my legal duties and privacy practices with respect to PHI.

I reserve the right to change privacy policies and practices described in this notice. Unless I notify you of such changes, however, I am required to abide by the terms currently in effect.

If I intend to revise my policies and procedures, I must describe in the notice to patients how I will provide patients with a revised notice of privacy policies and procedures (e.g., by mail, e-mail).

Questions and Complaints

If you have questions about this notice, disagree with a decision I make about access to your records, or have other concerns about your privacy rights, you may contact me (Kathy Cosgrove, PhD). If you believe that your privacy rights have been violated and wish to file a complaint with me, you may send your written complaint to me at: 280 Madison Avenue Suite 1004 New York New York 10016. You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services. I can provide you with the appropriate address upon request. Please note: you have specific rights under the Privacy Rule. I will not retaliate against you for exercising your right to file a complaint.

Effective Dates, Restrictions and Changes to Privacy Policy

This notice will go into effect on January 1, 2009. I reserve the right to change the terms of this notice and to make the new notice provisions effective for all PHI that I maintain. I will provide you with a revised notice by mail or in person.

Initials: _____