



Mental Health & Substance Abuse Services

CLIENT AND AGENCY AGREEMENT

The following information explains the relationship Fenway Community Health wishes to establish with you once you agree to enter treatment in the Mental Health and Addiction Services Department. Please read the following information carefully and discuss any questions you might have with your therapist. We believe that a relationship based on this information will help you to receive our highest quality of care. We are committed to provide care in a safe, confidential, professional, and supportive environment.

INFORMATION AND CONFIDENTIALITY

In order to make the best assessment of your needs, we will ask you information about yourself, your background, your family and your particular needs.

This may include requiring you to sign a release of information for any of your previous or current service providers. This is so we can provide you with coordinated and effective care.

Any information you provide will be held in strictest confidence and will be disclosed only with your written permission. However, please be aware of the following exceptions to this basic rule.

1. Your FCH therapist is **REQUIRED** to disclose information if:
 - a. you present a danger to yourself and refuse to accept appropriate treatment;
 - b. you present an actual threat to harm another person;
 - c. you have a history of violent behavior and your therapist believes that you are a threat to another person;
 - d. you report child abuse, elder abuse, disabled abuse, or physician misconduct.
2. In certain legal proceedings a court officer may require the release of confidential information about treatment.
3. FCH can release appropriate information in order to collect debts or to protect itself in a court action.

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If you anticipate issues around child custody, divorce proceedings or other possible court involvement, please inform your evaluator. This may determine your therapist assignment, due to variations in the law based on a particular therapist's license.

Federal Regulations 42 CFR, Part 2, protects the confidentiality of data related to substance abuse treatment. Any disclosure of information, which is not authorized by these regulations, is subject to a fine of not more than \$5,000 in the case of subsequent offenses.

ACCESS TO RECORDS WITHIN FCH

Within the FCH system, access to records is provided only to those professionals who have a "need to know". This includes your therapist's supervisor, our staff psychiatrist and the clinical team, which reviews each case seen at FCH. In addition, the Medical Clinic and the Mental Health and Addiction Services Department work closely together to ensure coordinated care within FCH. Your medical provider can access your mental health record as needed.

Except as provided above, no one will be allowed to see your records without your signed authorization to release the information.

PSYCHIATRIC MEDICATIONS

If psychiatric medications are recommended and accepted by you, regular physical exams and blood monitoring may be required.

EMERGENCY SERVICES

FCH provides 24-hour mental health emergency phone service for all Fenway clients. To access this service, dial the main number (617.267.0900) and ask to speak to the mental health provider on-call. While the health center is open during business hours, we also provide crisis coverage on site. Additional back-up mental health emergency services are provided by the Beth Israel Deaconess Medical Center emergency ward.

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CANCELLATIONS AND NO-SHOWS

Psychotherapy is most effective when sessions are attended on a regular, consistent basis. Given our commitment to providing the most effective care, as well as the time limitations of our staff, it is very important that you keep your appointments and come on time.

Cancellation of or not coming to more than three sessions will result in review of your treatment plan, which may result in termination of services.

If you are unable to keep your appointment, please call your therapist in advance of the appointment. A minimum notice of 48 hours is required or you will be billed directly for the missed session at your established self-payment fee. Public grants and insurance will not cover this charge.

Clients who are receiving group services are responsible for payment of ALL group sessions, regardless of cancellation. This policy is reviewed prior to joining any of our groups.

FEE POLICY

In order for us to provide quality services at fair and reasonable rates, we rely on direct payment for our services. Payment may be arranged through third party (insurance coverage), first party (self-payment), or a combination of the two. Payment for services is expected at the beginning of each session. You may pay by cash, credit card (Visa or MasterCard) or personal check.

Our service charges are:

Individual Mental Health Evaluation	\$175.00
Couple/Family Evaluation	\$175.00
Psychiatric Medication Evaluation	\$175.00
Individual Psychotherapy Session	\$135.00
Couple/Family Therapy Session	\$140.00
Group Therapy Session	\$60.00
Psychiatric Follow-up (medication)	\$80.00

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INSURANCE COVERAGE

Insurance policies vary in how they provide mental health coverage. Some policies have deductibles, while others pay only a part of the fee. **It is your responsibility to know the details of your coverage and provide FCH with the appropriate information and completed forms, so that we can bill your insurance company. Otherwise, you will be billed directly at our full fee.**

If your insurance only partially covers each session, you will be billed directly for the remainder of the fee, unless otherwise prohibited. In the event that your insurance company does not reimburse us, you will be billed your self-payment fee that was determined during your initial call.

You should be aware that when billing your insurance company, we will need to supply them with a diagnosis to receive reimbursement and in some cases, additional information that supports the diagnosis and need for therapy. If you have any questions or concerns about this, please discuss it with your therapist.

Please be aware that not all insurance companies, including Medicare, will reimburse for your therapy with all of our providers. You will be assigned to the appropriate provider. However, if your insurance changes, or you become covered by Medicare after you begin therapy, you might have to transfer your care to another provider.

REVIEW OF FEES

Your self-payment fee was set relative to your current financial resources. Should your resources change, we expect that you will inform your therapist so that a new fee is negotiated.

UNPAID BILLS

In order to receive mental health services at FCH, clients must commit to keeping their bills up to date. Unpaid bills will result in a review of your treatment plan and may result in termination of services. If you are returning to FCH for services, balances must be paid before re-engaging in treatment

NON-DISCRIMINATION POLICY

It is the policy of Fenway Community Health to provide services without discrimination on the basis of race, color, religion, gender, sexual orientation, gender identification, age, marital status, disability or veteran status. If you feel you have been discriminated against in the provision of any services, you may file a complaint with our Patient Care Assessment Coordinator or the Department Director.

YOUR RIGHT TO AN ADMINISTRATIVE REVIEW AND HEARING OF YOUR GRIEVANCE

If, at any time, you are dissatisfied with any action taken by FCH in furnishing or denying Mental Health and Addiction Services Department services to you, you have the right to file a formal complaint with our Patient Care Assessment Coordinator or the Department Director. Complaint forms are available at the reception desk.

Fenway Community Health is committed to providing the highest quality care to its clients. If there is any way that we may assist you to achieve your goals, or if you have any questions about this information, please do not hesitate to speak to your therapist.

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- I have read, and understand, and agree to abide by Fenway Community Health's Client/Agency Agreement.
- I am aware that payment is due at the time of each session and I will be billed directly for all sessions canceled with less than 2 full business days' notice.
- I am aware of the limits of Confidentiality and Grievance Procedures as discussed in the agreement.
- I have received information about HIV transmission and risk reduction practices.

Client Signature Date

Witness Signature Date