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## **PATIENT SERVICES AGREEMENT**

Effective March 2024

**Welcome to my practice. This document contains important information regarding my professional services and policies. In lieu of spending consultation time on administrative matters, please carefully review this document and keep it for future reference. If you have any questions I am happy to discuss them with you. Please sign the last page and return it to me for my records. When you sign this document, it will serve as an agreement between us.**

### **Psychological Services**

Psychotherapy involves different approaches that vary depending upon the particular issues a patient is experiencing. In order for therapy to be effective, your effort to work on things within and between sessions is essential. Psychotherapy can have benefits, but you may experience uncomfortable feelings (sadness, anger, guilt, etc.) when unpleasant aspects of your life are discussed. On the other hand, you may resolve specific problems, improve your relationships, home or work life, and reduce feelings of distress. Regardless, there are no guarantees of the outcome.

At the initial appointment I will obtain detailed information from you about the issues that you would like to address in psychotherapy. I will discuss my general clinical impressions with you at that time, as well as a plan for your treatment. Please evaluate what we have discussed and if you are comfortable proceeding with treatment. If you ever have any questions about your treatment or its course, please let me know and we will discuss them; since therapy is a partnership, it is important that we are on the same page. If you decide that I am not the right mental healthcare professional for you, I am happy to discuss this with you and suggest other mental health professionals for you to contact.

### **Appointments**

The initial or intake appointment is 75-90 minutes long, in order to provide time for a thorough review of patient and family history, as well as discussion of the presenting issues. Sessions following the initial one are 50 minutes long, unless we have scheduled a longer session.

**In-Office Sessions:** Please have a seat in the waiting area when you arrive and I will get you for your appointment. I do my best for a timely start to your appointment. On occasion I may need to begin your appointment a few minutes after the scheduled time. If I begin your appointment later than scheduled, we will still meet for the full 50 minutes. In the event that you are late to your appointment, we will use whatever time remains. When possible, please call or email to inform me that you are on your way. If you call, please leave a message if I don't answer. Regardless, I will be waiting for your arrival.

Although sessions are 50 minutes in duration, if we are completing a topic or need time to bring a parent into the end of a child's appointment, I may take the liberty to extend the appointment by a few minutes as long as it does not run into my next scheduled appointment (there will be no additional charge for this time). Therefore, please allow for a potential slight fluctuation in appointment time in your planning.

Telehealth/Video Sessions: I use the HIPAA-compliant version of Zoom for video sessions. I will send you the link via email right before your session time. I have noticed variations in transit time to receive the link depending on internet connections, so please allow a few extra minutes for it to arrive if it's not in your inbox exactly at the time of the appointment. I have built-in extra time available at the end of the session to account for this variability, so we can be sure to have our full session time.

### **Payment Responsibility and Patients Seeking Insurance Reimbursement**

**Payment is due at the time of your appointment. Responsibility for full payment is solely yours; I do *not* participate with any insurance plans or with Medicaid, Medicare, or Tricare.**

Although I do not accept any insurance, I am happy to provide you with documentation for you to file in support of insurance claims. I will provide you with a receipt for payment that includes the patient name, date of appointment, type of appointment/procedure code (e.g., individual psychotherapy 90834, or 90834-95 for telehealth), patient's diagnostic code (each diagnosis has its own code), my tax ID number, national provider number, and license number. This is information your insurance company will need if you choose to submit your receipts in order to seek reimbursement. Additionally, your insurer may require a treatment plan or other information about your treatment from me. You will need to determine and inform me of any additional information they require. Prior to me communicating with your insurance company in any way, I will need you to complete a consent form stating that I have your permission to do so. Please be aware that I have no control over what happens with your information once it is given to your insurance company. I am happy to provide you with a copy of the information released to your insurance company if you request it. You can instruct me not to send information to your insurance company if they request it, but this may result in your claims not being paid and you not receiving reimbursement.

**If you are planning to seek reimbursement from your insurance company, I highly suggest that you contact your insurance company prior to engaging in treatment so that you will have a clear understanding of your policy.** Your insurance may not cover this therapy or may only cover a portion of the charges. You may need to pay against your deductible prior to being eligible for reimbursement. Unless a session is cancelled 48 hours in advance, you will be charged the session fee for the missed appointment\* (see below). Please note that insurance companies will not reimburse you for missed sessions since no clinical service was provided. **It is your responsibility to be aware of the specifics of reimbursement according to your policy.** Some important questions may include (but not be limited to): Will your policy reimburse you for these mental healthcare services? How much will they reimburse you and is there a limit to reimbursement? Is there a session limit per year? **Are telehealth sessions reimbursed?** What information is required in order for you to receive reimbursement (e.g., precertification, treatment plan)? Can additional sessions be requested/approved? How are requests for additional sessions made, if needed?

Prior to making this call if you would like to contact me to talk over procedure (CPT) codes that I will use, I am happy to discuss them with you.

In the event that your insurance company errs and sends your reimbursement check addressed to me, I cannot accept it and will need to return it to the insurance company. If this occurs, I will inform you so that you are aware and can follow-up with them to assure that they re-issue the check to you.

## **Fees**

- Intake Appointment or Initial Consultation (75-90 minutes): \$395
- 50 minute session: \$225
- Sessions that are scheduled for longer periods of time may be prorated accordingly.
- Missed Appointment: \$225\*
- Cancellation with less than 48-hour notice: \$225\*

\*If you provide me with less than 48-hour notice that you cannot attend your appointment and I am able to fill your appointment time with another patient, then you will not be charged for this appointment. I often have people waiting for openings, and will make every effort possible to inform them of the opening. This policy allows for a sufficient amount of time for me to reach someone or for that person to make arrangements to attend an appointment.

There may be a charge for other services that I provide related to your treatment. For example, patient-requested meetings with other professionals (e.g., school counselors), extended telephone conversations, or the time required to perform another service you request. There may not be a charge for some of these services if the time involved is minimal, but this determination will need to be at my discretion. Charges for other services are prorated according to the session fee, but I may cap the charge depending upon what is involved. Please inquire about your potential charges at the time you request the service.

If you become involved in litigation that requires my participation, you will be expected to pay for any of my professional time that is required. If you anticipate being involved in litigation, please discuss this with me as soon as possible.

## **Billing and Payment**

Payment can be made in the form of cash, check, credit card or debit card.

I use the MxMerchant system for payment and invoices. I chose this system based on its high level of security and functions. This system allows me to input your credit or debit card information and stores it for future sessions. It meets the data security standards for the payment card industry and HIPAA compliance. After I input your information I no longer have access to your full account number; only the last 4 digits will show. I will shred the written credit card/debit card information you provided.

If you choose to use a credit card, and have previously provided me with that information, you can leave immediately following your session and I will process your payment at the end of my work day or typically within a few days. I can print your receipt for you or email it. *When contacting me for any reason, please do not reply to the email address from which your receipt is generated, as it comes from the payment system and I will not receive your email.*

If you pay by check, please note that there is a returned check fee of \$25. If paying by check for telehealth sessions, you can mail the check to me after receiving the unpaid invoice I send following the session, or make an arrangement to pay ahead for X amount of sessions.

### **Inclement Weather**

Please assume that I am expecting you during inclement weather if you haven't heard otherwise from me. I do *not* automatically close my office along with school- or government-closing schedules. If the weather (e.g., unplowed roads, etc.) has affected your ability to attend your appointment, please call and/or email to let me know. I certainly understand and would not hold you to attending your appointment. Please know that I make every effort to be in the office and will be there unless I inform you that I cannot make it. If you were attending an in-person appointment that is no longer possible and you'd like to change to telehealth that may be possible. Please email me as soon as circumstances dictate and we will make a plan that works for you.

### **Contact Information**

When I am unavailable, you may leave a message on my voicemail, which is private. I check my voicemail during the day once I am in the office. I will make every effort to return your call within 24 hours, with the exception of Fridays, weekends and holidays. If there is an emergency, go to the nearest emergency room or call 911.

You are always welcome to contact me via email, as long as you sign the form that contains consent for us to communicate in that way. I will return these messages in the same manner written above, although I am often able to respond to an email much quicker than a phone call since with email I am not limited to the same time and place constraints. *Please only email me from an email address to which you'd like me to reply.* If you email me from a different email address (e.g., a work address), please understand that there is the possibility that in the future I send an email to this address accidentally, even if it is not the email address you provided on your information form.

### **Privacy**

The confidentiality of your care is of the utmost importance to me. Our sessions and my records about you will be kept secured and private. Email communications may be kept as part of the patient record, in print or electronically in a secured account. In most cases (see below for exceptions) I will only release your information if you provide written authorization by signing my Authorization to Release Patient Information form. In general, the law protects the privacy of communications between a patient and a psychologist, and I can only release information about our work to others with the patient's (or legal guardian's) written permission.

Communication with your other healthcare providers, school personnel, and so forth, will only be done with your written permission via signing my Authorization to Release Patient Information form. Separately, it is common practice for psychologists to consult with other mental healthcare providers about aspects of a patient's treatment when the purpose is to assure that the treatment is being fully conceptualized and done in the most effective way. If I feel that your treatment would benefit from this type of consultation, I will do so without using any type of identifying information.

If you are involved in legal proceedings, your treatment information and records are almost always secured as confidential. There may be particular proceedings in which a judge mandates a release of information if they determines that treatment information is essential to the legal issue at hand. This request would need to be court-ordered by a judge. Any attorney's request for records will be denied.

There are rare situations in which psychologists are legally obligated to take action to protect a patient or others from harm, even if information about a patient's treatment must be revealed in order to do so. For example, if I believe or learn that a child has been abused, I must file a report with the appropriate state agency, even if the abuse is not currently occurring. If I believe a patient is in danger of committing serious bodily harm to themselves or to another, I am required to take protective actions. These actions may include notifying the potential victim, contacting family members to provide help, contacting the police or protective services, or seeking hospitalization for the patient.

MxMerchant, my payment processing company, will have access to some of your information. This may include the credit/debit card numbers you provide, your payment history, and the information on your invoices/receipts (which includes your name and address, the name of your psychotherapy service and its corresponding code, as well as the ICD diagnostic code number). Your information is provided only for the purpose of processing your payments.

### **Treating Minors**

When treating minors, I communicate regularly with parents. This communication may be done by telephone, written/electronic communication/email, brief meetings during the patient's session time, or within a scheduled parent session. I inform parents of general progress and hear any parent observations or concerns. To protect the minor's privacy and preserve the therapeutic relationship, I do not share specific statements or specific information with parents, unless the minor has granted me permission to do so.

With younger children often parents come into part of the session and we review the child's progress and "homework" together. Treatment of younger children is a team effort between myself and the parents/guardians. I encourage parents to contact me with any concerns that may be pertinent to their child or teenager's treatment.

I inform teenagers of this policy at the beginning of treatment, so that they understand both that there will be some general communication with parents, but also that their privacy is protected (and what the exceptions to that privacy are). Prior to having a parent meeting, I may discuss with a teenage patient the content of the progress to be reported to their parents. Any behaviors that are brought to my attention during therapy and deemed to be unhealthy or potentially unsafe will be discussed with the teenager, and I will carefully consider whether or not it is best practice/helpful/necessary to involve parents. In these situations, if the teen agrees for me to disclose the information to parents, I can do so. Otherwise I must very carefully consider privacy issues and where the clinical needs lie. These matters will also be carefully examined to determine proper course of treatment. Safety contracts and/or agreements for treatment may be devised for a teenager.

During the course of psychotherapy if there are apparent family dynamics that must be addressed for therapeutic progress, I will consult the teenager regarding whether and how to address these issues. Possible arrangements may include: the teenager, outside of a session, speaking with parents about the issues; parents attending a session together with their teenager; or me communicating with parents on their behalf, without the teenager present.

**Additional Considerations for Treating Minors from Divorced Families**

When a minor child with whom I am working has parents who have gone through, or will go through, separation and/or divorce, there are particular considerations of which to be aware. My role is solely as the child's therapist. The rules and ethics of my profession prohibit me from offering opinions regarding custody or visitation. In order to best serve the child and maintain my ethics, I need to maintain neutrality. I will, as always, provide my professional opinion regarding matters specific to clinical issues.

If parents are separated or have joint legal custody, both parents must consent to the treatment of their minor child. If either parent withdraws consent once the child is in treatment with me, I will likely need to end treatment at that time. Please note that ethical decisions and decisions weighing the best course of treatment and best interests of the child are sometimes different than legal decisions/rights.

**Social Media Policy**

Due to confidentiality and privacy concerns, I do not accept contact requests from current or former patients or family members on social networking sites (Facebook, LinkedIn, etc).

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Please keep this literature for future reference, and sign and return the following page.  
I look forward to working with you.

*Stacie B. Isenberg, Psy.D.*

**Signature of Agreement**

It is important that we discuss any questions or concerns that you have about the Office Policies and Patient Services Agreement. Your signature indicates that you have read this agreement and agree to its terms.

If you are the parent or legal guardian of a minor, your signature indicates agreement for your child to participate in psychotherapy sessions with me. If parents are separated or have joint legal custody, both parents must consent to the treatment of their minor child. In the case where only one parent has the right to make healthcare decisions, that parent must be the one to sign this form, even if the other parent brings the minor to sessions. If any of these situations applies to you, please inform me of the situation immediately. Thank you.

\_\_\_\_\_  
**Patient Name**

\_\_\_\_\_  
**Legal Guardian Name (if patient is a minor/under 18)**

\_\_\_\_\_  
**Patient or Legal Guardian Signature**

\_\_\_\_\_  
**Date**