GREENWICH MEDICINE, LLC
38 Lake Avenue
Greenwich, CT 06830

CLIENT AGREEMENT
for
Kasey Spoonamore, MD

Welcome to my practice

This document (the Agreement) contains important information about my professional services and business policies. It also contains summary information about the Health Insurance Portability and Accountability Act (HIPAA), a federal law that provides privacy protections and patient rights with regard to the use and disclosure of your Protected Health Information (PHI) used for the purpose of treatment, payment, and heal care operations. HIPPA requires that Greenwich Medicine provide you with a Notice of Privacy Practices (the Notice) for use and disclosure of the PHI for treatment, payment and health care operations. The Notice, which is attached to this Agreement, explains HIPAA and its application to your personal health information in greater detail. The law requires that your signature is obtained acknowledging that you have been provided with the information at the end of this session.

It is important that you read these documents carefully and advise me if you have any questions. When you sign the 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 me unless I have taken action in reliance on it or if you have not satisfied any financial obligations you have incurred.

The first session will involve a comprehensive evaluation of your needs, though it may extend past the first session. By the end of the evaluation, I will be able to offer you some initial impressions of what your particular treatment plan should include. You should evaluate this information as well as your own assessment about whether you feel comfortable working with me. Psychiatric treatment can involve a large commitment of time, money and energy-so you should be selective about whom you involve in your treatment. If you have any questions about my educational background, experience, procedures, or fees, you should advise me immediately.

APPOINTMENTS and CANCELLATION

Services are most effective when meeting times are regular and consistent. If you need to cancel or reschedule a session it is required that you provide ONE BUSINESS DAY'S notice (24 hour notice during the week, Friday notice for a Monday appointment change; holidays are treated like the weekend). If you miss a session without canceling, or cancel with less than 24hours notice, you will be billed for the full amount of the session. It is important to note that insurance companies do not provide reimbursement for cancelled sessions. In addition, you are responsible for coming to your session on time. If a client misses 2 appointments without providing proper notice, they may be discharged from the practice and provided appropriate referrals for care.

FEES, BILLING AND PAYMENT

Session fees are payable at time of service. I do not participate in any health plans and therefore you will be responsible for paying the entire fee. Moreover, fees for letters and forms are payable prior to release of them.

INSURANCE

I do not participate in any health insurance plans or panels. Insurance is a contract between you and your insurer. Although I will supply factual information when necessary, I do not become involved in disputes between you and your insurance company regarding. An invoice/bill for services with standardized diagnostic codes and procedure codes will be given to you at your request to be used to file for reimbursement from your insurance company.

PROFESSIONAL RECORDS

I am required to keep appropriate records of the psychiatric services I provide. Although psychotherapy, often includes discussions of sensitive and private information, normally very brief records are kept noting that you have been here, what was done in session, and mention of topics discussed. You have the right to a copy of your file to be made available to any other health care provider at any time and can be made available at your written request.

CONFIDENTIALITY

The confidentiality of all communication between a client and a psychiatrist is generally protected by law and I, as your psychiatrist, cannot and will not tell anyone else what you have discussed or even that you are in therapy without your written permission. In most situations, I can only release information about your treatment to others if you sign a written Authorization form. With the exception of certain specific situations described below, you have the right to confidentiality of your therapy. You may, on the other hand, request that information is shared with whomever you choose and you may revoke that permission in writing at any time.

There are, however, exceptions in which I am legally bound to take action even though that requires revealing some information about a patient's treatment. If at all possible, I will make every attempt to inform you when these will have to be put into effect. The legal exceptions to confidentiality include, but are not limited, to the following:

-If there is good reason to believe you are threatening serious bodily harm to yourself or others. If I believe a client is threatening serious bodily harm to another, I may be required to take protective actions, which may include notifying the potential victim, the police, or seeking appropriate hospitalization. If a client threatens harm to him/herself or another, I may be required to seek hospitalization for the client, or to contact family members or others who can provide protection.

-If there is evidence of or good reason to suspect abuse and/or neglect toward children, the elderly or disabled persons. In such a situation, I am required by law to file a report with the appropriate state agency.

-In response to a court order or where otherwise required by law.

-To the extent necessary, to make a claim on a delinquent account via a collection agency.

-To the extent necessary, for emergency medical care to be rendered.

-Finally, there are times when I find it beneficial to consult with colleagues as part of my practice for mutual professional consultation. Your full name and unique characteristics will not be disclosed. The consultant is also legally bound to keep the information confidential.

CONTACTING ME

I am often not immediately available by phone but you can leave a message 24/7 on my office phone at 203.769.5369. I will respond to your message within the next business day. If this is an emergency and you do not hear back from me in short order, please call 911 or proceed to the nearest emergency room. Please note medication refills are not considered urgent.

OTHER RIGHTS

If you are dissatisfied with your treatment for any reason, please do not hesitate to bring up your concerns with me in person. Any criticism will be taken seriously and with care and respect. You may also request that I refer you to another treatment provider and are free to end treatment at any time. You have the right to ask questions about any aspect of the treatment and about my specific training and experience.

CONSENT FOR TREATMENT

I consent to the use or disclosure of my protected health information by GREENWICH MEDICINE, LLC for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of GREENWICH MEDICINE, LLC. I understand that diagnosis or treatment of me by Dr. Spoonamore be conditioned upon my consent as evidenced by my signature on this document.

RESTRICTION

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or health care operations of practice. GREENWICH MEDICINE, LLC is not required to agree to the restrictions that I may request. However, if GREENWICH MEDICINE, LLC agrees to a restriction that I request, the restriction is binding.

PROTECTED HEALTH INFORMATION (PHI)

My PHI means ANY health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

REVOCATION

I have the right to revoke this consent, in writing, at any time, except to the extent that GREENWICH MEDICINE, LLC has taken action in reliance on this consent.

NOTICE OF PRIVACY PRACTICES

I understand I have the right to review GREENWICH MEDICINE, LLC's Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices describes the type of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of GREENWICH MEDICINE, LLC. The Notice of Privacy Practices is also provided on the GREENWICH MEDICINE, LLC website at www.greenwichmedicine.com. The Notice describes my rights and the duties of GREENWICH MEDICINE, LLC with respect to my protected health information. GREENWICH MEDICINE, LLC reserves the right to change the privacy practices that are described in the Notice. I may obtain a revised Notice of Privacy Practices by accessing the website, calling the office and requesting a revised copy be sent by email, or asking for one at the time of my next appointment.

PRINTED NAME:_____

SIGNATURE:_____ DATE_____