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INFORMED CONSENT NOTICE AND FEE AND PAYMENT AGREEMENT

Before we begin psychological services together, there are some things that you ought to know about the process and about my practice. This information contained here will help you understand better what to expect and will explain some limitations about what we will be doing together.

A BRIEF HIPPA OVERVIEW

The Health Insurance Portability and Accountability Act (HIPAA) is 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 health care operations. HIPAA requires that we provide you with our privacy practices for use and disclosure of PHI for treatment, payment or health care operations. The law requires that we obtain your signature acknowledging that we have provided you with this information before this session. 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 any 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 obligations you have incurred.

CONFIDENTIALITY

All of our work together, our conversations, your records and any information that you give us, is protected by legal privilege. This means that the law protects you from having information about you or your child given to anyone. Our office respects your privacy and we intend to honor your privilege. However, there are some exceptions to your privacy that you should understand.

LIMITS OF CONFIDENTIALITY

i. *Uses and Disclosures for Treatment, Payment, and Health Care Operations.*
We may use or disclose your protected health information (PHI) for treatment, payment, and health care operations purposes with your consent. To help clarify these terms, here are some definitions:

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- "PHI" refers to information in your health record that could identify you.
- "Treatment, Payment, and Health Care Operations" – Treatment is when we provide, coordinate, or manage your health care and other services relates to your health care. An example of treatment would be when we consult with another health care provider, such as your family physician, or another psychologist. Payment is when we obtain reimbursement for your healthcare. Examples of payment are when we disclose your PHI 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 and operation of our practice. Examples of health care operations are quality assessments and improvement activities, business-related matters such as audits and administrative services, and case management and care coordination. Disclosure applies to activities outside of our office such as releasing, transferring, or providing access to information about you to others.

ii. *Uses and Disclosures Requiring Authorization.*

We may use or disclose PHI for purposes outside of treatment, payment, and health care operations when your appropriate authorization is obtained. An "authorization" is written permission above and beyond the general consent that permits only specific disclosures. In those instances when we are asked for information for purposes outside of treatment, payment, and health care operations, we will obtain an authorization from you before releasing this information.

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

iii. *Uses and Disclosures with Neither Consent or Authorization.*

We may use or disclose PHI without your consent or authorization in the following circumstances:

- Child Abuse: If we have cause to believe that a child has been, or may be abused, neglected, or sexually abused, we must make a report of such within 24 hours to Social Services or to any enforcement agency.
- Adult and Domestic Abuse: If we have cause to believe that an elderly or disabled person is in a state of abuse, neglect, or exploitation, we must immediately report such to the Social Services Department.
- Judicial or Administrative Proceedings: If you are involved in a court proceeding and a request is made for information about your diagnosis and treatment and the records thereof, such information is privileged under local law, we will not release information, without written authorization from you

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or your personal or 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 ordered. You will be informed in advance if this is the case.

- Serious Threat to Health or Safety: If we determine that there is a probability of imminent physical injury by you to yourself or others, or there is a probability of immediate mental or emotional injury to you, we may disclose relevant confidential mental health information to medical or law enforcement.
- Worker's Compensation: If you file a worker's compensation claim, we may disclose records relating to your diagnosis and treatment to your employer's insurance carrier.

iv. *Patient's Rights and Psychologist's/Clinician Duties:*

Patient's Right:

- Right to Request Restrictions – You have the right to request restrictions on certain uses and disclosures of protected health information about you. However, we are not required to agree to a restriction request.
- Right to Receive Confidential Communications 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 seeing us. Upon your request, we will send your bills to another address).
- Right to Inspect and Copy- You have the right to inspect or obtain a copy (or both) of PHI in our mental health and billing records used to make decisions about you for as long as the PHI is maintained in a record. We may deny access to PHI under circumstances, but in some cases you may have this decision reviewed. You may examine and/or receive a copy of your, or in the case of a minor, the minor client's Psychotherapy Notes unless we determine that release would be harmful to you or the minor's physical, mental or emotional health. On your request, we 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. We may deny your request. On your request, we will discuss with you the details of the amendment process.
- Right to a Paper Copy- You have the right to obtain a paper copy of the notice from us upon your request.

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Psychologist's Duties:

- We are required by law to maintain the privacy of PHI and to provide you with a notice of our legal duties and privacy practices with respect to PHI.
- If we revise our policies and procedures, we will notify you in writing by mail.
- The procedures for selecting, giving, and scoring the tests, interpreting and storing the results, and maintaining your privacy will be carried out in accord with the rules and guidelines of HIPAA, the American Psychological Association and other professional organizations.
- Tests will be chosen that are suitable for the purposes described above. (In psychological terms, their reliability and validity for these purposes and population have been established.
- Tests and tests results will be kept in a locked, safe place for one year and/or at secured location for seven years.

CONSENT TO TREATMENT

I, _____ hereby seek and consent to take part in the psychological treatment and authorize Dr. Marshall's Consulting Services, LLC to perform an initial diagnostic interview, therapy, clinical intervention(s), telehealth, and/or psychological testing/evaluation or any deemed psychological services on _____. (Client's name)

I understand that services may include face-to-face contact, interviewing, and providing therapy and/or testing services with a follow-up appointment to receive the results of testing. Services may also include the psychologist's time required for the reading of records, consultations with other psychologists and professionals, scoring, interpreting the results, report writing and any other activities to support these services. I agree to help as much as I can by supplying full answers, making an honest effort and working as best as I can to make sure that the findings are accurate for psychological testing.

Additionally, I am aware that the practice of psychology or counseling is not an exact science and that the predictions of the effects are not precise nor guaranteed. I acknowledge that no guarantees have been made to me regarding the results of treatment or procedures by this office or treating therapist. Further, I understand that that evaluation and treatment will involve discussion of personal events in my and/or my families own history which, at times, can be discomforting and is at times very personal. I am aware that I may terminate my treatment at any time without consequence, but that I will remain responsible for payment for services that I have received.

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APPOINTMENT POLICY

The frequency and length of appointment scheduled is something that will be decided by us together. Depending on your needs, your age, and therapy goals, appointments are typically between 30 and 50 minutes long and are scheduled from once a week and is based on your psychological needs. If you need to cancel or reschedule an appointment, you are required to give 24-hours notice or will be asked to pay a $25.00 fee. An exception will be made if we both agree you were unable to attend due to circumstance beyond your control.

BILLING AND PAYMENTS

The client assumes 100% responsibility for all services, including any and all balances from pre-approved insurance coverages. I understand that our uninsured fee for individual, couples, and family therapy is $175.00 per session. Uninsured clients are responsible for this fee at the time of service. The rate of insurance reimbursement varies according to individual insurance contracts and I understand that I will only be responsible for my co-pay and any additional fees the insurance will not reimburse for. If I am using my EAP insurance benefits, there will be no fee or copay. If an organization/agency/department or employer has directed you for services you will not be responsible for any fees or if your insurance plan pays 100% for the rendered services. Other than those exceptions just specified, I understand that I am fully responsible for payment of these services.

Your signature below indicates that you have read the information in the Informed Consent to Treatment and agree to abide by its terms during our professional relationship.

_____ _____

Client's Printed Name Client's Date of Birth

_____ _____

Signature of Client Date
(or parent/guardian/state representative if client is a minor)

I, the psychologist or clinician, have discussed the issues above with the client or with the minor client's parent or guardian. My observations of this person's behavior and responses give me no reason, in my professional judgment, to believe that this person is not fully competent to give informed and willing consent of said client or of the minor client's treatment.

_____ _____

Signature of Psychologist/Clinician Date

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