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POLICIES, PROCEDURES AND PATIENT CONSENT

Psychological Services

Psychotherapy is not easily described in general statements. It varies depending on the personalities of the psychologist and patient, and the particular problems you are experiencing. There are many different methods I may use to deal with the problems that you hope to address. Psychotherapy is not like a medical doctor visit. Instead, it calls for a very active effort on your part. In order for the therapy to be most successful, you will have to work on things we talk about both during our sessions and at home.

Psychotherapy can have benefits and risks. Since therapy often involves discussing unpleasant aspects of your life, you may experience uncomfortable feelings like sadness, guilt, anger, frustration, loneliness, and helplessness. On the other hand, psychotherapy has also been shown to have many benefits. Therapy often leads to better relationships, solutions to specific problems, and significant reductions in feelings of distress. But there are no guarantees of what you will experience.

Meetings

I typically will schedule you for one 45 minute session per week. The first session is an evaluation. I will ask questions about your concerns and other questions that will allow me to determine the issues relevant to your treatment. Once an appointment hour is scheduled, you will be expected to pay for it unless you provide at least 24 hours advance notice of cancellation unless we both agree that you were unable to attend due to circumstances beyond your control. It is important to note that insurance companies do not provide reimbursement for missed or cancelled sessions.

Contacting me

Due to my work schedule, I am often not immediately available by telephone. When I am unavailable, my telephone is answered by voice mail where you can leave a confidential message. I will make every effort to return your call on the same day you make it, with the exception of weekends and holidays. If you are difficult to reach, please inform me of some times when you will be available. If you are unable to reach me and feel that you can't wait for me to return your call, call the University Neuropsychiatric Institute (801) 583-2500 and ask for

the crisis service. They can reach me if I am in town. If I will be unavailable for an extended time, I will leave the name and phone number of a colleague who is providing coverage on my voice mail message.

Confidentiality

The law protects the privacy of all communications between a patient and a psychologist. In most situations, I can only release information about your treatment to others if you sign a written Authorization form. There are other situations that require only that you provide written, advance consent. Your signature on this Agreement provides consent for those activities, as follows:

- I may occasionally find it helpful to consult other health and mental health professionals about a case. During a consultation, I make every effort to avoid revealing the identity of my patient. The other professionals are also legally bound to keep the information confidential. If you don't object, I will not tell you about these consultations unless I feel that it is important to our work together. I will note all consultations in your Clinical Record (which is called "PHI" in my Notice of Psychologist's Policies and Practices to Protect the Privacy of Your Health Information).

- You should be aware that I practice with other mental health professionals and that I employ administrative staff. In most cases, I need to share protected information with these individuals for both clinical and administrative purposes, such as scheduling, billing and quality assurance. All of the mental health professionals are bound by the same rules of confidentiality. All staff members have been given training about protecting your privacy and have agreed not to release any information outside of the practice without the permission of a professional staff member.

- I also have formal business associate contracts with the Utah Health Information Network (UHIN) for purposes of electronic billing and with Bonneville Collections for collecting on delinquent accounts. These contracts require UHIN and Bonneville Collections to maintain the confidentiality of these data except as specifically allowed in the contract or otherwise required by law. If you wish, I can provide you with a model copy of my business associate contract.

- Disclosures required by health insurers or to collect overdue fees are discussed elsewhere in this Agreement.

There are some situations where I am permitted or required to disclose information without either your consent or Authorization:

- If you are involved in a court proceeding and a request is made for information concerning the professional services I provided to you, such information is protected by

the psychologist-patient privilege law. I cannot provide any information without your (or your legal representative's) written authorization, or a court order. If you are involved in or contemplating litigation, you should consult with your attorney to determine whether a court would be likely to order me to disclose information.

- If a government agency is requesting the information for health oversight activities, I am required to provide it for them.

- If a patient files a complaint or lawsuit against me, I may disclose relevant information regarding that patient in order to defend myself.

- If a patient threatens to harm himself/herself, I may be obligated to seek hospitalization for him/her or to contact family members or others who can help provide protection.

- If a patient files a worker's compensation claim, I must, upon appropriate request, provide a copy of the patient's record to the appropriate parties, the patient's employer, the workers' compensation insurance carrier or the Labor Commission.

There are some situations in which I am legally obligated to take actions, which I believe are necessary to attempt to protect others from harm and I may have to reveal some information about a patient's treatment. These situations are unusual in my practice.

- **Child Abuse**: If I have reason to believe that a child has been or is likely to be subjected to incest, molestation, sexual exploitation, sexual abuse, physical abuse, or neglect, the law requires that I immediately notify the Division of Child and Family Services or an appropriate law enforcement agency. Once such a report is filed, I may be required to provide additional information.

- **Abuse of Vulnerable Adult**: If I have reason to believe that any vulnerable adult has been the subject of abuse, neglect, abandonment or exploitation, I am required to immediately notify Adult Protective Services intake. Once such a report is filed, I may be required to provide additional information.

- **Harm to others:** If a patient communicates an actual threat of physical violence against an identifiable victim, I am required to take protective actions. These actions may include notifying the potential victim and contacting the police, and/or seeking hospitalization for the patient.

- **Communicable Disease:** If I have reason to believe that you are suspected of having or are suffering from a disease that is communicable, I am required by law to report this to the local health department.

Professional Records

As of April 14, 2003 I will keep two types of records on you. Your ***clinical record*** contains information such as treatment plans sent to insurance companies and progress notes, along with records of consultations and signed releases of information. This record is available for your review in my presence or in the presence of another professional. The other record contains my ***psychotherapy notes***. These notes are for my own use. These are not available to you or to insurance companies, or anyone else without your written, signed authorization.

Minors and Parents

Patients under 14 years of age who are not emancipated and their parents should be aware that the law may allow parents to examine their child's treatment records unless I decide that such access is likely to injure the child, or we agree otherwise. Since parental involvement in therapy is important, it is my policy to request an agreement between a child patient between 14 and 18 and his/her parents allowing me to share general information about the progress of the child's treatment and his/her attendance at scheduled sessions. Any other communication will require the child's authorization, unless I feel that the child is in imminent danger to self or other, in which case, I will notify the parents of my concern. Before giving parents any information, I will discuss the matter with the child, if possible, and do my best to handle any objections he/she may have.

Professional Fees

My fee for a 45 minute evaluation is $175. My fee for subsequent 45 minute psychotherapy sessions (individual, couple or family) is $140. In addition to weekly appointments, I charge this amount for other professional services you may need, though I will prorate the hourly cost if I work for periods of less than one hour. Other services include letter or report writing, telephone conversations with you or on your behalf, consulting with other professionals, preparation of records or treatment summaries, and the time spent performing any other service you may request of me. If you become involved in legal proceedings that require my participation, you will be expected to pay for all of my professional time, including preparation and transportation costs, even if I am called to testify by another party. Because of the difficulty of legal involvement, I charge $175 per hour for preparation and attendance at any legal proceeding.

Insurance Reimbursement

If you have a health insurance policy, it will usually provide some coverage for mental health treatment. I will fill out forms and provide you assistance in helping you receive the benefits to which you are entitled; however, you (not your insurance company) are responsible for full payment of my fees. **It is very important that you find out exactly what mental health services your insurance policy covers, and comply with any requirements of your plan (e.g., getting preauthorization, physician referral, determining that I am on your plan's provider list, notifying me of changes in your health coverage).** Be aware that some services may be deemed "non covered" services because of diagnosis, modality of treatment, or for other reasons. **You will be responsible for payment whether or not your health plan allows the service.**

You should carefully read the section in your insurance coverage booklet that describes mental health services. If you have questions about the coverage, call your plan administrator. Of course, I will provide you with whatever information I can based on my experience and will be happy to help you in understanding the information you receive from your insurance company.

You should also be aware that your contract with your health insurance company requires that I provide it with information relevant to the services that I provide to you. I am required to provide a clinical diagnosis. Sometimes I am required to provide additional clinical information such as treatment plans or summaries, or copies of your entire clinical record. In such situations, I will make every effort to release only the minimum information about you that is necessary for the purpose requested. This information will become part of the insurance company files and will probably be stored in a computer. Though all insurance companies claim to keep such information confidential, I have no control over what they do with it once it is in their hands. In some cases, they may share the information with a national medical information databank. I will provide you with a copy of any report I submit, if you request it. **By signing this Agreement, you agree that I can provide requested information to your health insurance plan.**

Billing and Payments

I require payment at the time of service if you do not want to use health insurance. I accept cash, check, Mastercard and Visa. If you choose to use your health insurance, you will be expected to pay any amounts not covered by your health plan (e.g., copayments, unpaid deductibles, missed appointment fees) at the time of service. If you do not know the actual amount covered by your health plan, you will be expected to pay 50% of the session charge at the time of service, and any adjustments will be reflected on your monthly statement. You will be expected to pay any outstanding amounts on your statement within 30 days.

If your account has not been paid for more than 60 days and arrangements for payment have not been agreed upon, I have the option of using legal means to secure the payment. This may involve hiring a collection agency or going through small claims court which will require me to disclose otherwise confidential information. In most collection situations, the only information I release regarding a patient's treatment is his/her name, the nature of services provided, and the amount due. If such legal action is necessary, you will be charged a collection fee of 50%, plus any attorney's fees, court costs, and filing fees. You will be charged interest of 1.5% per month on any balance over 30 days that is owed. You will be changed $20 for checks returned unpaid by your bank.

I have read and understand the procedures for emergencies, confidentiality, billing, and insurance, and I consent to treatment under the conditions described. I authorize the release of information to my insurance company (if applicable). I understand that I am ultimately responsible for the balance due, regardless of how my health insurer may respond to claims. I agree to the above described terms regarding interest, collections charges, charges for appointments missed or cancelled late, fees for checks returned unpaid, and payment of costs of collecting delinquent accounts.

I HAVE READ THE INFORMATION IN THIS DOCUMENT AND CONSENT TO ABIDE BY ITS TERMS DURING OUR PROFESSIONAL RELATIONSHIP.

Client Signature	**Date**
Legal Guardian (if client is a minor)	**Date**
Financially Responsible Party (if different)	**Date**

Information Sheet

PATIENT

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: Home _____ Work: _____ Mobile: _____ Email:_____

Sex:(M : F) Date of Birth: _____ Age: _____ SSN: _____

Person to contact in case of emergency: _____ Phone:_____

Physician: _____ Phone: _____

RESPONSIBLE PARTY (Statements will be sent to)
This must be the person signing fee agreement as responsible party

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____ (Home) Phone: _____ X ____ (Work)

INSURANCE INFORMATION:

Primary Insurance Carrier: _____

Subscribers Birth date: _____ Employer: _____

A photocopy of your card will be taken. Only complete below if you do not have a copy of your card(s).

Address: _____

City:_____ State:_____ Zip:_____ Phone: ( )_____

Subscriber's Name: _____

SS #: _____ Subscriber's ID: _____

Secondary Insurance Carrier: (Please list on back)

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