Psychology and Counseling Associates of Carmel

Client Information and Office Policy Statement
Informed Consent

Welcome!

Thank you for choosing to enter treatment. This is an opportunity to acquaint you with information relevant to treatment, confidentiality and office policies. We will answer any questions you have regarding any of these policies.

I. Aims and Goals:

The major goal is to help you identify and cope more effectively with problems in daily living and to deal with inner conflicts which may disrupt your ability to function effectively. This purpose is accomplished by:

1. Increasing personal awareness.
2. Increasing personal responsibility and acceptance to make changes necessary to attain your goals.
3. Identifying personal treatment goals.
4. Promoting wholeness through psychiatric treatment and/or psychological healing and growth.

Psychotherapy is not easily described in general statements. It varies depending on the personalities of the psychologist and patient, and the particular problems you hope to address. There are many different methods I may use to deal with those problems. 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. Because 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 benefits for people who go through it. Therapy often leads to better relationships, solutions to specific problems, and significant reductions in feelings of distress. But, there are no guarantees as to what you will experience.

Our first few sessions will involve an evaluation of your needs. By the end of the evaluation, your therapist will be able to offer you some first impressions of what our work will include and a treatment plan to follow, if you decide to continue with therapy. You should evaluate this information along with your own opinions about whether you feel comfortable working with your therapist. At the end of the evaluation, your therapist will notify you if she/he believe that they are not the right therapist for you and, if so, they will give you referrals to other practitioners whom they believe are better suited to help you.

Therapy involves a large commitment of time, money, and energy, so you should be very careful about the therapist you select. If you have questions about our procedures, we should discuss them whenever they arise. If your doubts persist, your therapist will be happy to help you set up a meeting with another mental health professional for a second opinion.

II. Appointments:

We normally conduct an evaluation that will last from 2 to 4 sessions. During this time, we can both decide if your therapist is the best person to provide the services you need in order to meet your treatment goals. If we agree to begin psychotherapy, we will usually schedule one 45-minute or 55-minute session per week, at a time we agree on, although some sessions may be longer or more frequent. Once an appointment hour is scheduled, you will be expected to pay for it unless you provide 24 hours advance notice of cancellation [unless we both agree that you were unable to attend due to circumstances beyond your control]. If it is possible, I will try to find another time to reschedule the appointment. You may discontinue treatment at any time, but please discuss any decisions with me. In the event of an emergency, I may be reached by calling 317-983-1119 (You may be charged for telephone consultation in excess of 5 minutes). If you are unable to reach your therapist, you may call your primary care physician or the local emergency room, or a crisis hotline: Ph# 317-574-1252 (1-800-560-4038) or 317-621-5700 (1-800-273-8255).

III. Confidentiality:

Issues discussed in therapy are important and are generally legally protected as both confidential and "privileged." However, there are limits to the privilege of confidentiality. These situations include: 1) suspected abuse or neglect of a child, elderly person or a disabled person, 2) when your therapist believes you are in danger of harming yourself or another person or you are unable to care for yourself, 3) if you report that you intend to physically injure someone the law requires your therapist to inform that person as well as the legal authorities, 4) if your therapist is ordered by a court to release information as part of a legal involvement in company litigation, etc., 5) when your insurance company is involved, e.g. in filing a claim, insurance audits, case review or appeals, etc., 6) in natural disasters whereby protected records may become exposed, or 7) when otherwise required by law. You may be asked to sign a Release of Information so that you therapist may speak with other mental health professionals or to family members.

If your healthcare information is ever released to someone who should not see it and we find out about this we will let you know. We will ask you for your written permission (using an Authorization form) before we do anything that is considered marketing or fundraising with your Protected Health Information. When you pay me for the full cost of any sessions (without using your health insurance to pay part of the cost) you can ask us to not send information about that treatment to your health insurance company and we won't do so. However, if you want to buy life insurance or long term care insurance we will have to send the information about those sessions. We could not cover all the things that could come up about your Protected Health Information. If we want to use or share your information in any way that is not coved by what is written here we will explain this new actions to you and ask your written permission to use your information differently.

IV. Professional Fees:

Fee for the initial visit is $250 (45 minutes).
Each individual session thereafter is $150 (45 minutes) or $200 (60 minutes).
We charge this same hourly rate of $200 for other professional services you may need, though we will prorate the hourly cost if we work for periods of less than one hour. Other professional services include report writing, telephone conversations lasting longer than 5 minutes, attendance at meetings with other professionals you have authorized, preparation of treatment summaries, and the time spent performing any other service you may request of me. Fees for other services such as psychological testing are provided upon request.

V. Payments:

BILLING AND PAYMENTS

You will be expected to pay for each session at the time it is held, unless we agree otherwise or unless you have insurance coverage that requires another arrangement. Payment schedules for other professional services will be agreed to when such services are requested.

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. [If such legal action is necessary, its costs will be included in the claim.] In most collection situations, the only information I will release regarding a patient's treatment is his/her name, the dates, times, and nature of services provided, and the amount due.

INSURANCE REIMBURSEMENT

In order for us to set realistic treatment goals and priorities, it is important to evaluate what resources you have available to pay for your treatment. If you have a health insurance policy, it will usually provide some coverage for mental health treatment. We will fill out forms and provide you with whatever assistance I can 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.

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, we will provide you with whatever information we can based on my experience and will be happy to help you in understanding the information you receive from your insurance company. If necessary, we are willing to call the insurance company on your behalf to obtain clarification.

You should also be aware that most insurance companies require that we provide them with your clinical diagnosis. Sometimes we must provide additional clinical information, such as treatment plans, progress notes or summaries, or copies of the entire record (in rare cases). This information will become part of the insurance company files. Though all insurance companies claim to keep such information confidential, we 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. We will provide you with a copy of any records we submit if you request it. ***You understand that, by using your insurance, you authorize your therapist to release such information to your insurance company. We will try to keep that information limited to the minimum necessary.***

Once we have all of the information about your insurance coverage, we will discuss what we can expect to accomplish with the benefits that are available and what will happen if they run out before you feel ready to end our sessions. It is important to remember that you always have the right to pay for our services yourself to avoid the problems described above [unless prohibited by the insurance contract].

I authorize the release or any medical or other information necessary to process my claim. I also request payment of benefits to the party who accept assignment.

Signed:_____ Date: _____

I authorize payment of medical benefits to the Psychology and Counseling Associates of Carmel for the psychological services.

Signed:_____ Date: _____

VI. Cancellations and Missed Appointments:

You will be billed for a sessions that you cancel with less than 24 hours notice. You may leave messages 24 hours per day. You will be billed $150 --not just a co-payment. Insurance companies generally do not reimburse for failed appointments.

VII. Use of Email and text messaging:

No form of client communication is 100 percent guaranteed to be private. Therefore, communication via email and text messages is not encouraged. We use email communication and text messaging only with your permission and only for administrative purposes unless we have made another agreement. That means that email exchanges and text messages with my office should be limited to things like setting and changing appointments, billing matters and other related issues. Please do not email us about clinical matters. Your therapist will not respond to your email with clinical matters. If you need to discuss a clinical matter, please feel free to call us so we can discuss it on the phone or wait so we can discuss it during your therapy session. The telephone or face-to-face context simply is much more secure as a mode of communication.

I would like to use following electronic communication with my therapist (initials below):

___ Email: _____

___ Text: _____

VIII. Complaints:

You have a right to have your complaints heard and resolved in a timely manner. If you have a complaint about your treatment, your therapist, or any office policy please inform us immediately and discuss the situation. If you do not feel the complaint has been resolved, you may also inform your insurance carrier and file a complaint if you so choose.

IV. Consent for Treatment

By signing below, you are stating that you have read and understood this policy statement and you have had your questions answered to your satisfaction. I accept, understand and agree to abide by the contents and terms of this agreement and further, consent to participate in evaluation and/or treatment. I understand that I may withdraw from treatment at any time.

If you stopped attending sessions for one month or more, it will be assumed that you no longer wish to pursue treatment. Your case will be automatically closed. And you will be billed for any remaining outstanding fees.
To reopen your case, you must speak directly to your provider and attend rescheduled session, and only upon such face to face meeting at the scheduled appointment, will your case be reopened, and you will be taken back under the care of your provider.

Name of patient (please print) _____

Signature:_____

Date:_____

*I am the legal guardian or legal representative of the patient and on the patient's behalf legally authorize the practitioner to deliver mental health care services to the patient. I also understand the all policies described in this statement apply to the patient I represent.

Name of parent/guardian (please print) _____

Signature:_____

Relationship to the patient: _____

Date:_____

Minor Only Addendum

Parent Authorization for Minor's Mental Health Treatment

In order to authorize mental health treatment for your child, you must have either sole or joint legal custody of your child. If you are separated or divorced from the other parent of your child, please notify me immediately. I will ask you to provide me with a copy of the most recent custody decree that establishes custody rights of you and the other parent or otherwise demonstrates that you have the right to authorize treatment for your child.

If you are separated or divorced from the child's other parent, please be aware that it is my policy to notify the other parent that I am meeting with your child. I believe it is important that all parents have the right to know, unless there are truly exceptional circumstances, that their child is receiving mental health evaluation or treatment.

One risk of child therapy involves disagreement among parents and/or disagreement between parents and the therapist regarding the child's treatment. If such disagreements occur, I will strive to listen carefully so that I can understand your perspectives and fully explain my perspective. We can resolve such disagreements or we can agree to disagree, so long as this enables your child's therapeutic progress. Ultimately, parents decide whether therapy will continue. If either parent decides that therapy should end, I will honor that decision, unless there are extraordinary circumstances. However, in most cases, I will ask that you allow me the option of having a few closing sessions with your child to appropriately end the treatment relationship.

Individual Parent/Guardian Communications with Me

In the course of my treatment of your child, I may meet with the child's parents/guardians either separately or together. Please be aware, however, that, at all times, my patient is your child – not the parents/guardians nor any siblings or other family members of the child.

If I meet with you or other family members in the course of your child's treatment, I will make notes of that meeting in your child's treatment records. Please be aware that those notes will be available to any person or entity that has legal access to your child's treatment record.

Mandatory Disclosures of Treatment Information

In some situations, I am required by law or by the guidelines of my profession to disclose information, whether or not I have your or your child's permission. I have listed some of these situations below.

Confidentiality cannot be maintained when:

- Child patients tell me they plan to cause serious harm or death to themselves, and I believe they have the intent and ability to carry out this threat in the very near future. I must take steps to inform a parent or guardian or others of what the child has told me and how serious I believe this threat to be and to try to prevent the occurrence of such harm.
- Child patients tell me they plan to cause serious harm or death to someone else, and I believe they have the intent and ability to carry out this threat in the very near future. In this situation, I

must inform a parent or guardian or others, and I may be required to inform the person who is the target of the threatened harm [and the police].

- Child patients are doing things that could cause serious harm to them or someone else, even if they do not intend to harm themselves or another person. In these situations, I will need to use my professional judgment to decide whether a parent or guardian should be informed.
- Child patients tell me, or I otherwise learn that, it appears that a child is being neglected or abused--physically, sexually or emotionally--or that it appears that they have been neglected or abused in the past. In this situation, I am [may be] required by law to report the alleged abuse to the appropriate state child-protective agency.
- I am ordered by a court to disclose information.

<u>Disclosure of Minor's Treatment Information to Parents</u>

Therapy is most effective when a trusting relationship exists between the psychologist and the patient. Privacy is especially important in earning and keeping that trust. As a result, it is important for children to have a "zone of privacy" where children feel free to discuss personal matters without fear that their thoughts and feelings will be immediately communicated to their parents. This is particularly true for adolescents who are naturally developing a greater sense of independence and autonomy.

It is my policy to provide you with general information about your child's treatment, but NOT to share specific information your child has disclosed to me without your child's agreement. This includes activities and behavior that you would not approve of — or might be upset by — but that do not put your child at risk of serious and immediate harm. However, if your child's risk-taking behavior becomes more serious, then I will need to use my professional judgment to decide whether your child is in serious and immediate danger of harm. If I feel that your child is in such danger, I will communicate this information to you.

> ***Example***: If your child tells me that he/she has tried alcohol at a few parties, I would keep this information confidential. If you child tells me that he/she is drinking and driving or is a passenger in a car with a driver who is drunk, I would not keep this information confidential from you. If your child tells me, or if I believe based on things I learn about your child, that your child is addicted to drugs or alcohol, I would not keep that information confidential.
>
> ***Example***: If your child tells me that he/she is having voluntary, protected sex with a peer, I would keep this information confidential. If your child tells me that, on several occasions, the child has engaged in unprotected sex with strangers or in unsafe situations, I will not keep this information confidential.

You can always ask me questions about the types of information I would disclose. You can ask in the form of "hypothetical situations," such as: "If a child told you that he or she were doing _____, would you tell the parents?"

Even when we have agreed to keep your child's treatment information confidential from you, I may believe that it is important for you to know about a particular situation that is going on in your child's life. In these situations, I will encourage your child to tell you, and I will help your child find the best way

to do so. Also, when meeting with you, I may sometimes describe your child's problems in general terms, without using specifics, in order to help you know how to be more helpful to your child.

Disclosure of Minor's Treatment Records to Parents

Although the laws of [this State] may give parents the right to see any written records I keep about your child's treatment, by signing this agreement, you are agreeing that your child or teen should have a "zone of privacy" in their meetings with me, and you agree not to request access to your child's written treatment records.

Parent/Guardian Agreement Not to Use Minor's Therapy Information/Records in Custody Litigation

When a family is in conflict, particularly conflict due to parental separation or divorce, it is very difficult for everyone, particularly for children. Although my responsibility to your child may require my helping to address conflicts between the child's parents, my role will be strictly limited to providing treatment to your child. You agree that in any child custody/visitation proceedings, neither of you will seek to subpoena my records or ask me to testify in court, whether in person or by affidavit, or to provide letters or documentation expressing my opinion about parental fitness or custody/visitation arrangements. Please note that your agreement may not prevent a judge from requiring my testimony, even though I will not do so unless legally compelled. If I am required to testify, I am ethically bound not to give my opinion about either parent's custody, visitation suitability, or fitness. If the court appoints a custody evaluator, guardian *ad litem*, or parenting coordinator, I will provide information as needed, if appropriate releases are signed or a court order is provided, but I will not make any recommendation about the final decision(s). Furthermore, if I am required to appear as a witness or to otherwise perform work related to any legal matter, the party responsible for my participation agrees to reimburse me at the rate of $200 per hour for time spent traveling, speaking with attorneys, reviewing and preparing documents, testifying, being in attendance, and any other case-related costs.

Child/Adolescent Patient:

By signing below, you show that you have read and understood the policies described above. If you have any questions as we progress with therapy, you can ask me at any time.

Minor's Signature* _____ Date_____

Parent/Guardian of Minor Patient:

Please initial after each line and sign below, indicating your agreement to respect your child's privacy:

I will refrain from requesting detailed information about individual therapy sessions with my child. I understand that I will be provided with periodic updates about general progress, and/or may be asked to participate in therapy sessions as needed. _____ _____

Although I may have the legal right to request written records/session notes since my child is a minor, I agree NOT to request these records in order to respect the confidentiality of my child's/adolescent's treatment. _____ _____

I understand that I will be informed about situations that could endanger my child. I know this decision to breach confidentiality in these circumstances is up to the therapist's professional judgment, unless otherwise noted above. _____ _____

Parent/Guardian Signature _____ Date_____

Parent/Guardian Signature _____ Date_____

INDIANA NOTICE FORM
Notice of Policies and Practices to Protect the Privacy of Your Health Information
For Psychology and Counseling Associates of Carmel (PCAC)

THIS NOTICE DESCRIBES HOW PSYCHOLOGICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

I. Uses and Disclosures for Treatment, Payment, and Health Care Operations

Psychology and Counseling Associates of Carmel (PCAC) may *use* or *disclose* your *protected health information* (*PHI*), for *treatment, payment, and health care operations* purposes with your *written authorization.* To help clarify these terms, here are some definitions:

• "*PHI*" refers to information in your health record that could identify you.
• "*Treatment, Payment, and Health Care Operations*"
– *Treatment* is when PCAC provides, coordinates, or manages your health care and other services related to your health care. An example of treatment would be if
PCAC consulted with another health care provider, such as your family physician or another psychologist.
– *Payment* is when PCAC obtains reimbursement for your healthcare. Examples of payment are when PCAC discloses 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 this practice. Examples of health care operations are quality assessment and improvement activities, business-related matters such as audits and administrative services, and case management and care coordination.
• "*Use*" applies only to activities within the office such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.
• "*Disclosure*" applies to activities outside of the office, such as releasing, transferring, or providing access to information about you to other parties.
• "*Authorization*" is your written permission to disclose confidential mental health information. All authorizations to disclose must be on a specific legally required form.

II. Other Uses and Disclosures Requiring Authorization

PCAC may use or disclose PHI for purposes outside of treatment, payment, or health care operations when your appropriate authorization is obtained. In those instances when PCAC is asked for information for purposes outside of treatment, payment, or health care operations, PCAC will obtain an authorization from you before releasing this information.
PCAC will also need to obtain an authorization before releasing your Psychotherapy Notes.

"*Psychotherapy Notes*" are notes made during a private, group, joint, or family counseling session, which may be kept separate from the rest of your medical record.
These notes are given a greater degree of protection than PHI.
You may revoke all such authorizations (of PHI or Psychotherapy Notes) at any time, provided each revocation is in writing. You may not revoke an authorization to the extent that (1) PCAC has relied on that authorization; or (2) if the authorization was obtained as a condition of obtaining insurance coverage, and law provides the insurer the right to contest the claim under the policy.

III. Uses and Disclosures with Neither Consent nor Authorization

PCAC may use or disclose PHI without your consent or authorization in the following circumstances:
• *Child Abuse* – If PCAC believes that a child is a victim of child abuse or neglect, PCAC must report this belief to the appropriate authorities.
• *Adult and Domestic Abuse* – If PCAC believes or has reason to believe that an individual is an endangered adult, PCAC must report this belief to the appropriate authorities.
• *Health Oversight Activities* – If the Indiana Attorney General's Office is conducting an investigation into PCAC's practice, then PCAC is required to disclose PHI upon receipt of a subpoena.
• *Judicial and Administrative Proceedings* – If the patient is involved in a court proceeding and a request is made for information about the professional services PCAC provided you and/or the records thereof, such information is privileged under state law, and PCAC will not release information without the written authorization of you or your 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 you communicate to PCAC that an actual threat of violence to cause serious injury or death against a reasonably identifiable victim or victims or if you present evidence, conduct or make statements indicating an

imminent danger that you will use physical violence or use other means to cause serious personal injury or death to others, PCAC will take the appropriate steps to prevent that harm from occurring. If PCAC has reason to believe that you present an imminent, serious risk of physical harm or death to yourself, PCAC will need to disclose information in order to protect you. In both cases, PCAC will only disclose what PCAC feels is the minimum amount of information necessary.

• *Worker's Compensation* – PCAC may disclose protected health information regarding you as authorized by and to the extent necessary to comply with laws relating to worker's compensation or other similar programs, established by law, that provide benefits for work-related injuries or illness without regard to fault.

IV. Patient's Rights and Psychologist's Duties

Patient's Rights:
• *Right to Request Restrictions* – You have the right to request restrictions on certain uses and disclosures of protected health information. However, PCAC is not required to agree to a restriction you 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 being seen in this practice. On your request, PCAC 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 your mental health and billing records used to make decisions about you for as long as the PHI is maintained in the record. PCAC may deny your access to PHI under certain circumstances, but in some cases you may have this decision reviewed.
On your request, PCAC 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. PCAC may deny your request. On your request, PCAC will discuss with you the details of the amendment process.
• *Right to an Accounting* – You generally have the right to receive an accounting of disclosures of PHI. On your request, PCAC will discuss with you the details of the accounting process.
• *Right to a Paper Copy* – You have the right to obtain a paper copy of the notice from PCAC upon request, even if you have agreed to receive the notice electronically.
For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html**.**

Psychologist's Duties:
• PCAC is required by law to maintain the privacy of PHI and to provide you with a notice of PCAC's legal duties and privacy practices with respect to PHI.
• PCAC reserves the right to change the privacy policies and practices described in this notice. Unless PCAC notifies you of such changes, however, PCAC is required to abide by the terms currently in effect.

• If PCAC revises policies and procedures, PCAC will provide you with a revised notice at your next session in this office.

V. Complaints

If you are concerned that PCAC has violated your privacy rights, or you disagree with a decision made about access to your records, you may contact Momi Yamanaka, Ph.D. HSPP @ (317) 517-8817 or momi.yamanaka@gmail.com.
You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services. The person listed above can provide you with the appropriate address upon request.

VI. Effective Date, Restrictions, and Changes to Privacy Policy

This notice will go into effect on March 1, 2017.
Psychology and Counseling Associates of Carmel reserves the right to change the terms of this notice and to make the new notice provisions effective for all PHI that we maintain.
The notice will be available upon request in the office.
We never market or sell personal information.

Psychology and Counseling Associates of Carmel
Momi Yamanaka, Ph.D. HSPP
Robert Morales, Ph.D. HSPP
PO Box 1064 Carmel, IN 46082-1064
317-983-1119

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

By signing this form, you acknowledge receipt of the Notice of Privacy Practices that I have given to you. Our Notice of Privacy Practices provides information about how I may use and disclose your protected health information. I encourage you to read it in full.
Our Notice of Privacy Practices is subject to change. The most recent version will always be available at the office upon request. If we change our notice, you may obtain a copy of the revised notice from us by contacting us at the phone number above.
If you have any questions about our Notice of Privacy Practices, please contact us at the address and /or phone number above
I acknowledge receipt of the Notice of Privacy Practices of Psychology and Counseling Associates of Carmel (DBA).

Signature: _____Date:_____
(patient/parent/conservator/guardian)

Signature: _____Date:_____
(patient/parent/conservator/guardian)

INABILITY TO OBTAIN ACKNOWLEDGEMENT OF RECEIPT OF NOTICE
OF PRIVACY PRACTICES
I made good faith attempts to obtain my patient's acknowledgement of his or her receipt of our Notice of Privacy Practices, including _____.
However, because of _____ I was unable to obtain my patient's acknowledgement.

Signature of provider:_____Date:_____

Psychology and Counseling Associates of Carmel

Consent for Returning to In-Person Psychological Services

This Consent for Returning to In-Person Psychological Services is a supplement to the general informed consent that we agreed to at the outset of our clinical work together. Please read this document carefully, and let me know if you have any questions.

The threat of COVID-19 is ongoing throughout the United States. As a way to mitigate the risk of exposure to COVID-19, our practice has transitioned to providing most services via telecommunications technology**.** Use of telecommunications technology reduces the need for persons to come into close contact with each other or to be in areas where exposure to COVID-19 may occur. However, in some situations, teletherapy services may not be adequate, and in-person services may be more appropriate.

We have determined that in-person services are appropriate at this time for your situation for the following reason(s): □ Limited contacts with others outside of families, □ without any symptoms for over the past week, □ no travel outside of the country in the past 2 weeks, □ Intake/other assessments benefit of in-person contacts/observation,

_____

_____

_____

The decision about whether to engage in in-person services is based on current conditions and guidelines, which may change at any time. It is possible that a return to remote services will be necessary at some point based on consideration of health and safety issues. Such a decision will be made in consultation with you, but I will make the final determination based on a careful weighing of the risks and applicable regulations.

It is also important to consider that, although insurance reimbursement for teletherapy services may have been mandated during the COVID-19 pandemic, such mandates may no longer be in effect, and teletherapy may no longer be reimbursed by your insurance company.

In order for me to provide you with in-person services, the following protocols must be followed by patients/clients and providers:

- Social distancing requirements must be met, meaning that you must maintain a six-foot distance from others while in offices, waiting rooms, and other areas.
- Patients/clients and providers may wear face coverings or masks while in the office.
- Hand sanitizer will be provided at the office entrance and must be used upon entering the office.
- There will be no physical contact with others in the office.

- You agree not to present for in-person services if you have a fever, shortness of breath, coughing, or any other symptoms associated with COVID-19 or if you have been exposed to another person who is showing signs of infection or has confirmed COVID-19 within the past two weeks.
- If you are bringing a child or other dependent in for services, you agree to ensure that both you and your child/dependent follow all of these protocols.

As COVID-19 regulations continue to evolve, I may become legally required at some point to disclose that you and I have been in contact, especially if either of us were to test positive or show signs of COVID-19 infection. If I am legally compelled to disclose information, I will inform you and will only provide the minimum necessary information (e.g., your name and the dates of our contact) required by law.

We remain committed to following state and federal guidelines and to adhering to prevailing professional healthcare standards to limit the transmission of COVID-19 in our offices. Despite our careful attention to sanitization, social distancing, and other protocols, there is still a chance that you will be exposed to COVID-19 in our office. If, at any point, you prefer to stop in-person services or to consider transitioning to remote services, please let me know.

By signing below, you acknowledge that you understand that there is still a potential risk of exposure and that you agree to follow the safety protocols outlined above in order to engage in in-person services.

_____ _____

Patient/Client Date

_____ _____

Psychologist Date

Psychology and Counseling Associates of Carmel

INFORMED CONSENT FOR TELEPSYCHOLOGY

This Informed Consent for Telepsychology contains important information focusing on doing psychotherapy using the phone or the Internet. Please read this carefully, and let me know if you have any questions. When you sign this document, it will represent an agreement between us.

Benefits and Risks of Telepsychology

Telepsychology refers to providing psychotherapy services remotely using telecommunications technologies, such as video conferencing or telephone. One of the benefits of telepsychology is that the client and clinician can engage in services without being in the same physical location. This can be helpful in ensuring continuity of care if the client or clinician moves to a different location, takes an extended vacation, or is otherwise unable to continue to meet in person. It is also more convenient and takes less time. Telepsychology, however, requires technical competence on both our parts to be helpful. Although there are benefits of telepsychology, there are some differences between in-person psychotherapy and telepsychology, as well as some risks. For example:

- Risks to confidentiality. Because telepsychology sessions take place outside of the therapist's private office, there is potential for other people to overhear sessions if you are not in a private place during the session. On my end I will take reasonable steps to ensure your privacy. But it is important for you to make sure you find a private place for our session where you will not be interrupted. It is also important for you to protect the privacy of our session on your cell phone or other device. You should participate in therapy only while in a room or area where other people are not present and cannot overhear the conversation.

- Issues related to technology. There are many ways that technology issues might impact telepsychology. For example, technology may stop working during a session, other people might be able to get access to our private conversation, or stored data could be accessed by unauthorized people or companies.

- Crisis management and intervention. Usually, I will not engage in telepsychology with clients who are currently in a crisis situation requiring high levels of support and intervention. Before engaging in telepsychology, we will develop an emergency response plan to address potential crisis situations that may arise during the course of our telepsychology work.

- Efficacy. Most research shows that telepsychology is about as effective as in-person psychotherapy. However, some therapists believe that something is lost by not being in the same room. For example, there is debate about a therapist's ability to fully understand non-verbal information when working remotely.

Electronic Communications
We will decide together which kind of telepsychology service to use. You may have to have certain computer or cell phone systems to use telepsychology services. You are solely responsible for any cost to you to obtain any necessary equipment, accessories, or software to take part in telepsychology.

For communication between sessions, I only use email communication and text messaging with your permission and only for administrative purposes unless we have made another agreement. This means that email exchanges and text messages with my office should be limited to administrative matters. This includes things like setting and changing appointments, billing matters, and other related issues. You should be aware that I cannot guarantee the confidentiality of any information communicated by email or text. Therefore, I will not discuss any clinical information by email or text and prefer that you do not either. Also, I do not regularly check my email or texts, nor do I respond immediately, so these methods **should not** be used if there is an emergency.

Treatment is most effective when clinical discussions occur at your regularly scheduled sessions. But if an urgent issue arises, you should feel free to attempt to reach me by phone. I will try to return your call within 24 hours except on weekends and holidays. If you are unable to reach me and feel that you cannot wait for me to return your call, contact your family physician or the nearest emergency room and ask for the psychologist or psychiatrist on call. If I will be unavailable for an extended time, I will provide you with the name of a colleague to contact in my absence if necessary.

Confidentiality
I have a legal and ethical responsibility to make my best efforts to protect all communications that are a part of our telepsychology. However, the nature of electronic communications technologies is such that I cannot guarantee that our communications will be kept confidential or that other people may not gain access to our communications. I will try to use updated encryption methods, firewalls, and back-up systems to help keep your information private, but there is a risk that our electronic communications may be compromised, unsecured, or accessed by others. You should also take reasonable steps to ensure the security of our communications (for example, only using secure networks for telepsychology sessions and having passwords to protect the device you use for telepsychology). The extent of confidentiality and the exceptions to confidentiality that I outlined in my Informed Consent **Client Information and Office Policy Statement** still apply in telepsychology. Please let me know if you have any questions about exceptions to confidentiality.

Appropriateness of Telepsychology
From time to time, we may schedule in-person sessions to "check-in" with one another. I will let you know if I decide that telepsychology is no longer the most appropriate form of treatment for you. We will discuss options of engaging in in-person counseling or referrals to another professional in your location who can provide appropriate services.

Emergencies and Technology

Assessing and evaluating threats and other emergencies can be more difficult when conducting telepsychology than in traditional in-person therapy. To address some of these difficulties, we will create an emergency plan before engaging in telepsychology services. I will ask you to identify an emergency contact person who is near your location and who I will contact in the event of a crisis or emergency to assist in addressing the situation. I will ask that you sign a separate authorization form allowing me to contact your emergency contact person as needed during such a crisis or emergency.

If the session is interrupted for any reason, such as the technological connection fails, and you are having an emergency, do not call me back; instead, call 911, ***[include any local hotlines or other resources]***, or go to your nearest emergency room. Call me back after you have called or obtained emergency services.

If the session is interrupted and you are not having an emergency, disconnect from the session and I will wait two (2) minutes and then re-contact you via the telepsychology platform on which we agreed to conduct therapy. If you do not receive a call back within two (2) minutes, then call me on the phone number I provided you (XXX-XXX-XXXX).

If there is a technological failure and we are unable to resume the connection, you will only be charged the prorated amount of actual session time.

Fees

The same fee rates will apply for telepsychology as apply for in-person psychotherapy. However, insurance or other managed care providers may not cover sessions that are conducted via telecommunication. If your insurance, HMO, third-party payor, or other managed care provider does not cover electronic psychotherapy sessions, you will be solely responsible for the entire fee of the session. Please contact your insurance company prior to our engaging in telepsychology sessions in order to determine whether these sessions will be covered.

Records

The telepsychology sessions shall not be recorded in any way unless agreed to in writing by mutual consent. I will maintain a record of our session in the same way I maintain records of in-person sessions in accordance with my policies.

Informed Consent

This agreement is intended as a supplement to the general informed consent that we agreed to at the outset of our clinical work together and does not amend any of the terms of that agreement. Your signature below indicates agreement with its terms and conditions.

_____	_____
Client	Date
_____	_____
Therapist	Date