LUCY T. SMITH, PHD
CLINICAL PSYCHOLOGIST

Adolescent Information Form

Date: ________________

Adolescent Information:

Name: ______________________________ Age: _____ DOB: ______________

Address: ____
Street Apt City State Zip

Phone: Home ___________________________ Is it okay to leave a message? No Yes
Cell ___________________________ Is it okay to leave a message? No Yes
Employment (if any): ____

Mother's Information:
Name: ______________________________ Age: ______
Address: ____
(if different) Street Apt City State Zip

Phone: Home ___________________________ Is it okay to leave a message? No Yes
Cell ___________________________ Is it okay to leave a message? No Yes
Work ___________________________ Is it okay to leave a message? No Yes
E-mail: __________________________________
Highest Grade/Degree: ________________ Employment: ________________________

Father's Information:
Name: ______________________________ Age: ______
Address: ____
(if different) Street Apt City State Zip

Phone: Home ___________________________ Is it okay to leave a message? No Yes
Cell ___________________________ Is it okay to leave a message? No Yes
Work ___________________________ Is it okay to leave a message? No Yes
E-mail: __________________________________
Highest Grade/Degree: ________________ Employment: ________________________

Parents' Marital and Custody Status:

Marital Relationship: married separated divorced never married

If divorced, please describe custody arrangements: ____

____

Sibling Information:

Name: ________________________ Age: ______ Name: ________________________ Age: ______

Name: ________________________ Age: ______ Name: ________________________ Age: ______

Others living in your home? ____

Other Information:

School: ____ Grade: _____

Pediatrician: ____ Phone: _____________________

Other professional: ______________________________________ Phone: _____________________

Emergency Contacts:

Name: ______________________________________ Relationship: _______________________ Phone: ______________________

Name: ______________________________________ Relationship: _______________________ Phone: ______________________

Name: ______________________________________ Relationship: _______________________ Phone: ______________________

Prior Mental Health Treatment:

Has the client ever been hospitalized for a psychological or psychiatric issue? YES NO

If yes, please describe:

Has the client ever received treatment for mental health or substance use concerns? YES NO

If yes, please provide dates, type of treatment, provider information, duration, and helpfulness below.

Any history of suicidal thoughts or attempts? YES NO

If yes, when?

Medical History:

When was the client's most recent physical exam? ______________________ Allergies: __________________________

Please list all current medications: ____

Significant medical concerns or conditions:

____

History of head injury, seizures, or loss of consciousness?

____

Legal History:

Has the client ever been arrested or convicted of a legal violation? YES NO

If yes, please describe:

Referral Source:

Referred to Dr. Lucy Smith by: ____

May I contact your referral source to acknowledge the referral? YES NO

Reason for Visit:

What are the main reasons you are seeking treatment? Please check all that apply.

□ Sadness/Depression
□ Anxiety/Worry
□ Fear
□ Stress
□ Physical Symptoms
□ Grief/loss
□ School Difficulties
□ Social/Family Conflict
□ Other: ______________________
□ Hopelessness
□ Irritability
□ Anger
□ Low Self-Esteem
□ Sleep Difficulties
□ Suicidal Thoughts
□ Self-Harm
□ Thoughts of Harming Others
□ Perfectionism
□ Eating/Weight Concerns
□ Overexercise
□ Body Dissatisfaction
□ Obsessions/Compulsions
□ Panic attacks
□ Loneliness/Isolation
□ Impulsiveness

By signing below, I give permission for the minor named above to participate in evaluation and/or treatment with Lucy Smith, PhD. I certify that as the minor's custodial parent or legal guardian, I have the legal right to give such permission.

____ ________________

Signature Date

____ ____________________

Printed Name Relationship to Minor

LUCY T. SMITH, PHD
CLINICAL PSYCHOLOGIST

12830 Hillcrest Rd, D-114 ▪ Dallas, TX 75230 ▪ 972-386-0511 ▪ lucy@drlucysmith.com

Psychological Services Agreement

Welcome to my private practice. This document contains important information about my professional services and business policies. Please read it carefully and write down any questions you might have so that we can discuss them at our next meeting. When you sign this document, it will represent an agreement between us.

PSYCHOLOGICAL SERVICES
I believe psychotherapy to be a collaborative journey between therapist and client. The therapeutic relationship is essential. Therapy involves a large commitment of time, money, and energy, so it is important that you feel comfortable with the person you select as your therapist. I strive to develop a collaborative partnership characterized by warmth, openness, authenticity, and a nonjudgmental stance. You are a very important and active part of the therapeutic process.

My Orientation
I tend to employ an integrated theoretical orientation, comprised primarily of cognitive-behavioral (CBT), insight-oriented, and experiential perspectives. I believe that individuals are complex and multifaceted beings and that psychological problems are best conceptualized on multiple levels. CBT most strongly targets thoughts and behaviors, insight-oriented processes target increased understanding and insight, and experiential strategies target emotions and body connection. This holistic approach allows for flexibility and thoroughness in working with individuals.

Benefits and Risks of Therapy
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. It is normal for people to feel worse before they feel better. Therapy is undoubtedly hard work and is truly a process – it is hard to predict how quickly it will "work" or what specific effects it will have. However, psychotherapy has also been shown to have benefits for people who go through it. Therapy often leads to reduced stress and anxiety, improved self-esteem, better relationships, solutions to specific problems, and significant reductions in feelings of distress. It is important to note that there are no guarantees of what you will or will not experience.

Appointments
Your appointment time is reserved for you. Therapy sessions normally last 45-50 minutes, and we normally meet 1x/week. Sessions may be longer or more frequent if we decide this would be useful for you. In addition, sessions may occur less frequently (every 2-4 weeks) as we near the end of treatment. Regular attendance is recommended to ensure continuity and to enhance the effectiveness of therapy.

Cancellation Policy and Charge for Missed Appointments
I ask for 48 hours notice if you need to cancel or reschedule your appointment. **I charge the regular fee for clients who miss appointments or who cancel appointments with less than 48 hours notice.**

Charge for Phone Consultations
There is a charge at the agreed upon session fee for all phone conversations that exceed ten minutes. The charge is pro-rated.

Telephone Accessibility and Emergencies
I monitor my messages frequently and will make every effort to return your call within 24 hours of when you make it. If you are difficult to reach, please leave me some times when you will be available. **Should you have a true clinical emergency that requires immediate attention or action, you will need to call 911 or go to the nearest emergency room.** If I will be unavailable for an extended time, I will provide you with the name of a colleague to contact, if necessary.

Other Forms of Communication
At times clients prefer to communicate between sessions via e-mail or text messaging. This information exchange generally involves logistical matters such as scheduling and appointment changes. It might also be used for scheduled, brief check-ins during the week (e.g., regarding homework assignments). **E-mail or text messaging should not be used as a means to contact me in an emergency.** In addition I do not conduct therapy via e-mail or text messaging. These mediums are less secure; therefore privacy and confidentiality may be compromised. *Please see the Communications and Social Media Policy for more information.*

Professional Fees and Payments
My standard fee for psychological services is $200.00 per 45/50-minute session. This fee covers telephone consultations with other professionals, such as dieticians, physicians, and psychiatrists. In addition to psychotherapy sessions, I charge this amount for other services you may need or request, such as report writing, telephone conversations lasting longer than 10 minutes, session time beyond the standard 45/50 minutes, preparation of records or treatment summaries, and any other service you may request of me. Fees for these services are prorated based on your normal session fee.

Payment is due in full at each session. For your convenience, I accept cash, checks, or credit cards. **There will be a $30 administrative fee for all returned checks.** If your account has not been paid for more than 60 days and arrangements for payment have not been agreed upon, I reserve the option of using legal means to secure the payment. This may involve hiring a collection agency or going through small claims court. 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, its costs will be included in the claim. By signing this agreement, you authorize me to employ the services of an outside collection agency or attorney to seek payment of all unpaid fees.

Legal action
If legal actions occur in which I am requested or subpoenaed to provide testimony (either by you or another party), you will be responsible to pay me directly for the following services: (a) the time spent preparing for court, (b) the time spent for transportation to/from court, and (c) the time spent in court. Because of the difficulty of legal involvement, I charge **$400.00 per hour** for preparation and attendance at any legal proceedings. Payment for the estimated number of hours is due 10 days prior to the court date and must be paid in the form of a cashier's check.

Insurance and Managed Care
If you have insurance coverage and plan to file for reimbursement, you will be given a detailed statement that contains my provider information and your relevant diagnostic code(s). The statement may then be attached to one of your insurance claim forms, which you may file for reimbursement. If you are relying on your insurance company to reimburse you for part or all of the charges for therapy, it is important that you have thoroughly reviewed and understand your insurance company's reimbursement policies, the amount of your deductible, the percentage your company will reimburse you for outpatient psychotherapy, and any limitations to treatment that may be a dimension of your policy. The contract for reimbursement is between you and the insurance company, rather than between the insurance company and me.

Client Rights
You have several important rights as a client.

1. You have the right to ask questions about the process and course of therapy.
2. You have the right to voice any concerns or complaints about our work together. I truly welcome your feedback directly. In addition, you are welcome to contact the Texas State Board of Examiners of Psychologists with any concerns about unethical or unfair treatment by me or any other psychologist. My Texas license number is 34601.
3. You have the right to decide not to receive therapeutic assistance from me. If you wish, I will provide you with the names of other qualified professionals whose services you might prefer.
4. You have the right to end therapy at any time. I ask you to contact me by phone or in person to let me know of your decision. And if possible, it is often helpful to discuss this decision within the context of therapy to process the closure of our relationship.
5. You have the right to expect that I will maintain professional and ethical boundaries by not entering into other personal, financial, or professional relationships with you, all of which would greatly compromise our work together.

Confidentiality

In general, law protects the privacy of all communications between a patient and a psychologist, and I can only release information about our work to others with your written permission. But there are a few exceptions:

1. Instances of active or suspected abuse (physical, emotional, or sexual) or neglect of a child, an elder, or a dependent adult must be reported to the appropriate protective services.
2. If I believe that a client is threatening serious bodily harm to another, I may be required to take protective actions. These actions may include notifying the potential victim, contacting the police, or seeking hospitalization for the patient.
3. If a client reveals a serious intent to harm himself/herself, I am ethically bound to take steps to help maintain his/her safety. I may be obligated to seek hospitalization for the client or to contact family members or others who can help provide protection.
4. If a judge orders my testimony/records or, in the context of a legal proceeding, a client raises his/her own psychological state as an issue, I may be required to release the client's confidential information to the court.
5. When a client reports that a previous counselor or therapist has sexually abused the client, the current psychologist has a legal duty to report that abuse to the proper authorities. Such a report need not include the client's name.
6. I may occasionally find it helpful to consult other professionals about a case. During a consultation, I make every effort to avoid revealing the identity of my client. The consultant is 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.

Professional Records

The laws and standards of my profession require that I keep treatment records. These records include information about your reasons for seeking treatment, relevant diagnoses, treatment goals, progress towards those goals, medical and social history, treatment history, any past treatment records I receive from other treatment providers, documentation of any professional consultations, billing records, and copies of any professional documents generated during the course of treatment (e.g., informed consent forms, release of information forms, letters sent at your request). Except in unusual circumstances that involve danger to yourself and/or others, you may examine and/or receive a copy of your clinical record if you request it in writing. Because these are professional records, they can be misinterpreted and/or upsetting to untrained readers. I recommend that you review them in my presence so that we can discuss the contents or that you have them forwarded to another mental health professional. Patients will be charged an appropriate fee for any professional time spent in responding to information requests.

Minors and Parents

Patients under 18 years of age who are not emancipated should be aware that the law may allow parents to examine their child's treatment records. Privacy in psychotherapy is often critical to building rapport with the therapist, and this therapist-client rapport is crucial for successful progress. Because of this, when working with adolescents, I will discuss beforehand with the client and his/her parents the nature of our communication and how confidentiality will work in our relationship. Typically, I will provide parents with general information about treatment progress, and I wholeheartedly welcome parents' feedback and insight regarding their adolescent. I immediately inform parents of serious safety issues (if the adolescent is in imminent danger of harming himself/herself or someone else) or issues related to abuse. Other than the above-stated topics, I protect the confidentiality of the adolescent with whom I am working. *Please see the Parent Agreement for Therapy with Children and Adolescents for additional information about my guidelines in working with minors.*

Unexpected Therapist Absence

In the event of my unplanned absence from practice, whether due to injury, illness, death, or any other reason, I maintain a detailed Professional Will. As part of this, I have designated trusted colleagues who will manage my practice and act as an Emergency Response Team (ERT) for clients with whom I have been working. If such an emergency arises, one of these colleagues will contact you to inform you of my situation/status and to help ensure you receive competent care during my absence. Signing this document indicates that you authorize the ERT to access your treatment and financial records only in accordance with the terms of my Professional Will and only if I experience an event that has caused or is likely to cause a significant unplanned absence from practice.

Consent for Services

Please initial by each item below.

_____ I understand the nature of the proposed treatment, and I give my informed consent for psychological treatment by Lucy Smith, PhD.

_____ I understand that the fee for service is $200 per 45-50 minute therapy hour.

_____ I understand that the counseling session is 45-50 minutes in length.

_____ I agree to pay for any missed appointments or late cancellations. To avoid a fee, please give at least 48 hours advanced notice if you need to cancel or reschedule an appointment.

_____ I agree to pay for any phone conversations that exceed 10 minutes. I understand that the fee will be prorated based on my normal session fee. I also agree to pay for other services I might need or request, such as report writing, session time beyond the standard 45/50 minutes, and preparation of records or treatment summaries. I understand that fees for these services will be prorated based on my normal session fee.

_____ I understand that if I am experiencing a medical or psychiatric emergency, I have been advised to dial 911 or go to the nearest emergency room, and I agree to abide by these instructions.

I have read and understand the contents of this Psychological Services Agreement. My questions about these policies have been answered. I agree to the professional and financial terms described above, as indicated by my signature below.

____ ______________________

Signature of Client or Authorized Representative Date Signed

____

Printed Name of Client or Authorized Representative

LUCY T. SMITH, PHD
CLINICAL PSYCHOLOGIST
12830 Hillcrest Rd, D-114 ▪ Dallas, TX 75230 ▪ 972-386-0511 ▪ lucy@drlucysmith.com

Parent Agreement for Therapy with Children and Adolescents

Prior to beginning treatment, it is important for you to understand my approach to child/ adolescent therapy and agree to some rules about your child's confidentiality during the course of his/her treatment. The information herein is in addition to the information contained in the Psychological Services Agreement. Under HIPAA and the APA Ethics Code, I am legally and ethically responsible to provide you with informed consent. As we go forward, I will try to remind you of important issues as they arise.

One risk of child therapy involves disagreement among parents and/or disagreement between parents and therapist regarding the best interests of the child. 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, you will decide whether therapy will continue. If either of you decides that therapy should end, I will honor that decision; however, I ask that you allow me the option of having a closing session with your child to appropriately end the treatment relationship.

Therapy is most effective when a trusting relationship exists between the psychologist and the patient. Privacy is especially important in securing and maintaining that trust. One goal of treatment is to promote a stronger and better relationship between children and their parents. However, it is often necessary for children to develop a "zone of privacy" whereby they feel free to discuss personal matters with greater freedom. This is particularly true for adolescents who are naturally developing a greater sense of independence and autonomy. By signing this agreement, you will be waiving your right of access to your child's treatment records.

It is my policy to provide parents with general information about treatment progress, and I wholeheartedly welcome your feedback and insight regarding your child. Generally speaking, I will not share with you what your child has disclosed to me without your child's consent. If it is necessary to refer your child to another mental health professional with more specialized skills, I will share that information with you. I will tell you if your child does not attend sessions.

If your child is an adolescent, it is possible that he/she will reveal sensitive information regarding sexual contact, alcohol and drug use, or other potentially problematic behaviors. Sometimes these behaviors are within the range of normal adolescent experimentation, but at other times they may require parental intervention. We must carefully and directly discuss your feelings and opinions regarding acceptable behavior. If I ever believe that your child is at serious risk of harming him/herself or another, I will inform you.

Although my responsibility to your child may require my involvement in conflicts between the two of you, my involvement will be strictly limited to that which will benefit your child. This means, among other things, that you will treat anything that is said in session with me as confidential. Neither of you will attempt to gain advantage in any legal proceeding between the two of you from my involvement with your children. In particular, I need your agreement that in any such proceedings, neither of you will ask me to testify in court,

whether in person, or by affidavit. You also agree to instruct your attorneys not to subpoena me or to refer in any court filing to anything I have said or done. Involving me in such legal proceedings will interfere with the therapy relationship between me and your child, thereby jeopardizing your child's health and well-being.

Note that such agreement may not prevent a judge from requiring my testimony, even though I will work to prevent such an event. If I am required to testify, I am ethically bound not to give my opinion about either parent's custody or visitation suitability. 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.

As noted in the Psychological Services Agreement, if legal actions occur in which I am requested or subpoenaed to provide testimony (either by you or another party), you will be responsible to pay me directly for the following services: (a) the time spent preparing for court, (b) the time spent for transportation to/from court, and (c) the time spent in court. Because of the difficulty of legal involvement, I charge **$350.00 per hour** for preparation and attendance at any legal proceedings. Payment for the estimated number of hours is due 10 days prior to the court date and must be paid in the form of a cashier's check.

Statement of Agreement

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

Child's Name: ___________________________________ Date of Birth: ______________

Parent Signature: _________________________________ Date: _______________

Printed Name: ___________________________________

Parent Signature: _________________________________ Date: _______________

Printed Name: ___________________________________

Therapist Signature: ______________________________ Date: _______________

LUCY T. SMITH, PHD
CLINICAL PSYCHOLOGIST

12830 Hillcrest Rd, D-114 ▪ Dallas, TX 75230 ▪ 972-386-0511 ▪ lucy@drlucysmith.com

Credit Card Authorization Form

Dr. Lucy Smith requires that all clients keep an active credit card on file. This payment method will be used in the following situations:

Regardless of payment preferences outlined below, I authorize Lucy T Smith, PhD to charge the credit card on file in the following situations (*please initial by each item below*):

______ If I do not show up for a scheduled session (fee charged at the time of the session).

_____ If I forget payment in the form of cash or check (fee charged at the time of the session).

_____ If I cancel my appointment with less than 48-hours notice (fee charged at the time of late cancellation).

_____ To pay for other services you may need or request, such as report writing, telephone conversations lasting longer than 10 minutes, session time beyond the standard 45/50 minutes, and preparation of records or treatment summaries. Fees for these services are prorated based on your normal session fee.

I prefer to *(please check one)*:

☐ Pay at the time of each session with this credit card.

☐ Pay at the time of each session via cash or check.

CREDIT CARD INFORMATION:

Credit Card Type: ☐ Visa ☐ MasterCard ☐ Discover ☐ American Express

Account Number: _________________ - _________________ - _________________ - _________________

Cardholder's Name (as it appears on card): ____

Exp. Date: _____________ CVV2 (3 or 4 digit code on back): __________ Billing Zip Code: ______________

____ _________________________
Cardholder Signature Date Signed

____
Client Name

LUCY T. SMITH, PHD
CLINICAL PSYCHOLOGIST

12830 Hillcrest Rd, D-114 ▪ Dallas, TX 75230 ▪ 972-386-0511 ▪ lucy@drlucysmith.com

Communications, TeleMental Health, and Social Media Policies

This document outlines my office policies related to communications and the use of Social Media. Please read it to understand how I conduct my practice, how I conduct myself on the Internet as a mental health professional, and how you can expect me to respond to various interactions that may occur between us via electronic means.

If you have any questions about anything within this document, I encourage you to bring them up when we meet.

COMMUNICATIONS

Communication in the Therapy Relationship

The main form of communication in our work together is face-to-face communication during our therapy sessions. However, it may become useful during the course of treatment to communicate by phone, email, text message (e.g., "SMS"), facsimile, or other electronic methods of communication. Be informed that these methods, in their typical form, are not confidential means of communication. If you use these methods to communicate with me, there is a reasonable chance that a third party may be able to intercept and eavesdrop on these messages. The kinds of parties that may intercept these messages include, but are not limited to:

- People in your home or other environments who can access your phone, computer, or other devices that you use to read and write messages. (In addition, such devices might also store records of your phone calls and voicemail messages.)
- Your employer, if you use your work email to communicate with me.
- Third parties on the Internet such as server administrators and others who monitor Internet traffic.

Communications Policies

- I respond to emails, text messages, and phone calls as soon as possible. My response time is typically faster for emails and text messages. I typically respond to all communication within 24-hours of receipt during normal business hours.
- All electronic communication will become a part of your medical record.
- Electronic communication is best used for administrative purposes (i.e., appointment scheduling, billing). It is typically more helpful to communicate about clinical issues during our scheduled session times. If something arises between sessions, please feel free to contact me to set up a time to discuss in person or over the phone.
- Sometimes when working with adolescents, parents will send me periodic emails with clinically relevant information that they want to share with me. This can be helpful as a time effective and convenient way to relay information to me. However, please be aware that if you choose to send such clinical information via unsecure electronic means, there is always the risk of your privacy being breached. In addition, I tend to respond to such messages solely with an acknowledgement that I received the information. If you instead desire to have a more in-depth conversation about such clinical issues, please contact me to schedule an appointment.
- **If you have a crisis or emergency,** you may call me or send me an email or text message. However, **you should also call 911 or go to the nearest emergency room.**
- All faxes sent to my office are received as e-faxes, which make them vulnerable to the same potential breaches in security as email and text messages.
- Your email/text communication will not be forwarded to a third party without your expressed permission, unless you have already signed a release for me to communicate with a professional or unless required by law.

TELEMENTAL HEALTH

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 psychotherapy via a remote platform, 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. 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. It can also be helpful to wear headphones.

- 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 obtain 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 more acute 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.

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 them. 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 Psychological Services Agreement still apply in telepsychology. Please let me know if you have any questions about this.

In Case of Technology Failure

During a telepsychology session, we could encounter a technological failure. The most reliable backup plan is to contact one another via telephone. Please make sure that you have a phone with you and that I have that phone number. If we are on a phone session and we get disconnected, please call or text me to resume our conversation.

Appropriateness of Telepsychology

There are instances where telepsychology is not appropriate or helpful (e.g., if you are having suicidal or homicidal thoughts, experiencing psychotic symptoms, in a crisis that cannot be solved remotely, or experiencing symptoms that need to be addressed in person or through a higher level of care). I will let you know if I decide that telepsychology is no longer the most appropriate form of treatment for you, and we will discuss options of either meeting in person or making a referral to another professional or to a higher level of care.

Emergency Procedures Specific to Telepsychology

Assessing and evaluating threats and other emergencies can be more difficult when conducting telepsychology than with 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 (ECP) who is near your location and who I will contact in the event of a life-threatening crisis or emergency to assist in addressing the situation. Please write this person's name and contact information on the specified lines at the end of this document. Your signature at the end of this document indicates that you understand I will only contact this individual in the extreme circumstances stated above.

In addition to delineating an Emergency Contact Person, I ask that you also inform me your typical location for telepsychology sessions as well as of the nearest mental health hospital to your primary location that you prefer to go to in the event of a mental health 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 or go to your nearest emergency room. Call me back after you have called or obtained emergency services.

Financial Matters

The same fee and cancellation/no show 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. Please contact your insurance company in order to determine whether these sessions will be covered (if you plan to obtain reimbursement).

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.

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.

SOCIAL MEDIA POLICY

Friending

I do not accept friend or contact requests from current or former clients on any social networking site (Facebook, LinkedIn, etc.). I believe that adding clients as friends or contacts on these sites can compromise your confidentiality and our respective privacy. It may also blur the boundaries of our therapeutic relationship. If you have questions about this, please bring them up when we meet and we can talk more about it.

Following

I do not follow current or former clients on blogs or Twitter. My reasoning is that I believe casual viewing of clients' online content outside of the therapy hour can create confusion in regard to whether it's being done as a part of your treatment or to satisfy my personal curiosity. In addition, viewing your online activities without your consent and without our explicit arrangement towards a specific purpose could potentially have a negative influence on our working relationship. If there are things from your online life that you wish to share with me, please bring them into our sessions where we can view and explore them together, during the therapy hour.

Use of Search Engines

It is NOT a regular part of my practice to search for clients on Google or Facebook or other search engines. Extremely rare exceptions *may* be made during times of crisis. If I have a reason to suspect that you are in danger and you have not been in touch with me via our usual means (coming to appointments, phone, or email) there *might* be an instance in which using a search engine (to find you, find someone close to you, or to check on your recent status updates) becomes necessary as part of ensuring your welfare. These are unusual situations and if I ever resort to such means, I will fully document it and discuss it with you when we next meet.

Location-Based Services

If you use location-based services on your mobile phone, you may wish to be aware of the privacy issues related to using these services. I do not place my practice as a check-in location on various sites such as Foursquare, Gowalla, Loopt, etc. However, if you have GPS tracking enabled on your device, it is possible that others may surmise that you are a therapy client due to regular check-ins at my office on a weekly basis. Please be aware of this risk if you are intentionally "checking-in" from my office or if you have a passive LBS app enabled on your phone.

Business Review Sites
You may find my psychology practice on sites such as Yelp, Healthgrades, Yahoo Local, Bing, or other places which list businesses. Some of these sites include forums in which users rate their providers and add reviews. Many of these sites comb search engines for business listings and automatically add listings regardless of whether the business has added itself to the site. If you should find my listing on any of these sites, please know that my listing is NOT a request for a testimonial, rating, or endorsement from you as my client. The American Psychological Association's Ethics Code states under Principle 5.05 that it is unethical for psychologists to solicit testimonials: "Psychologists do not solicit testimonials from current therapy clients/patients or other persons who because of their particular circumstances are vulnerable to undue influence." Of course, you have a right to express yourself on any site you wish. But due to confidentiality, I cannot respond to any review on any of these sites whether it is positive or negative. I urge you to take your own privacy as seriously as I take my commitment of confidentiality to you.

You should also be aware that if you are using these sites to communicate indirectly with me about your feelings about our work, there is a good possibility that I may never see it. If we are working together, I hope that you will bring your feelings and reactions to our work directly into the therapy process. This can be an important part of therapy, even if you decide we are not a good fit. None of this is meant to keep you from sharing that you are in therapy with me whenever and with whomever you like. Confidentiality means that I cannot tell people that you are my client and my Ethics Code prohibits me from requesting testimonials. But you are more than welcome to tell anyone you wish that I am your therapist or how you feel about the treatment I provide to you, in any forum of your choosing. If you do choose to write something on a business review site, I hope you will keep in mind that you may be sharing personally revealing information in a public forum. I urge you to create a pseudonym that is not linked to your regular email address or friend networks for your own privacy and protection.

Consent for Transmission of Protected Health Information by Non-Secure Means

I consent to allow Dr. Lucy Smith to use unsecured email and mobile phone text messaging to transmit to me the following protected health information:

(Please initial each that you are consenting to.)

_________ Information related to the scheduling of sessions or other appointments.
_________ Information related to billing and payment.
_________ Referral information when relevant.
_________ Responses to email or text messages that I sent to Dr. Smith of my own accord.
_________ Brief clinical information or updates that Dr. Smith feels is better communicated in writing (for reasons of either clarity or convenience).

In addition, I offer automated appointment reminders that can be sent via email or text message 48-hours prior to your scheduled appointment time. These messages are sent via unsecure methods so have the same potential risks as outlined above. If you would like to receive these reminder notifications, please initial below (you can select either email or text messaging or both options):

_________ I would like to receive appointment reminders via email. Please use the following email address:

____

_________ I would like to receive appointment reminders via text messaging to the following cell phone number:

____

_________ None of the above. I will remember my appointments on my own.

I use an electronic medical record that includes a client portal. Here are some of the great options that will be available to clients who create an account on this system:

- Ability to schedule appointments directly online
- Access to view and print your invoices
- Secure online messaging

If you would like to take advantage of this online system, please provide an email address you would like to use to set up an account, and I will send you a welcome letter through the system:

Email address: ____

Please initial by each item below.

_____ I voluntarily agree to receive TeleMental Health services for psychotherapy and, I give my informed consent for psychological treatment by Lucy Smith, PhD.

_____ I agree to take full responsibility for the security of any communications or treatment on my own computer or electronic device and in my own physical location. I understand I am solely responsible for maintaining the strict confidentiality of my user ID, password, and/or connectivity link. I will not allow another person to access my user ID or connectivity link to access the services. I also understand that I am responsible for using this technology in a secure and private location so that others cannot hear my conversation.

_____ I understand that there will be no recording of the online session and that all information disclosed within sessions and the written records pertaining to those sessions are confidential and may not be revealed to anyone without my written permission, except where disclosure is required by law.

Typical location during telepsychology sessions (please provide a specific address):

____

Current phone number (of cell phone you will have available during telepsychology sessions):

____

Please list your Emergency Contact Person (ECP) here:

Name: ____ Phone: ____________-___________

Please list your preferred hospital here:

Name: ____ Phone: ________________________

I have been informed of the risks, including but not limited to my confidentiality in treatment, of transmitting my protected health information by unsecured means. I also express understanding of Dr. Smith's policies regarding TeleMental Health and Social Media.

____ _________________________

Signature of Client or Authorized Representative Date Signed

____

Printed Name of Client or Authorized Representative

LUCY T. SMITH, PHD
CLINICAL PSYCHOLOGIST

12830 Hillcrest Rd, D-114 ▪ Dallas, TX 75230 ▪ 972-386-0511 ▪ lucy@drlucysmith.com

THIS NOTICE DESCRIBES HOW PSYCHOLOGICAL AND MEDICAL 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

I 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:

- *"PHI"* refers to information in your health record that could identify you.
- *"Treatment, Payment and Health Care Operations"*
  - *Treatment* is when I provide, coordinate or manage your health care and other services related to your health care. An example of treatment would be when I consult with another health care provider, such as your family physician or another psychologist.
  - *Payment* is when I obtain reimbursement for your healthcare. Examples of payment are when I 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 my 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 my office, such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.
- *"Disclosure"* applies to activities outside of my office, such as releasing, transferring, or providing access to information about you to other parties.

II. Uses and Disclosures Requiring Authorization

I 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 I am asked for information for purposes outside of treatment, payment and health care operations, I 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) I have relied on that authorization; or (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 nor Authorization

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

- **Child Abuse:** If I have cause to believe that a child has been, or may be, abused, neglected, or sexually abused, I must make a report of such within 48 hours to the Texas Department of Protective and Regulatory Services, the Texas Youth Commission, or to any local or state law enforcement agency.

- **Adult and Domestic Abuse:** If I have cause to believe that an elderly or disabled person is in a state of abuse, neglect, or exploitation, I must immediately report such to the Department of Protective and Regulatory Services.

- **Health Oversight:** If a complaint is filed against me with the State Board of Examiners of Psychologists, they have the authority to subpoena confidential mental health information from me relevant to that complaint.

- **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 state law, and I will not release information, without written authorization from you 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 I 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, I may disclose relevant confidential mental health information to medical or law enforcement personnel.

- **Worker's Compensation:** If you file a worker's compensation claim, I may disclose records relating to your diagnosis and treatment to your employer's insurance carrier.

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 about you. However, I am 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 seeing me. Upon your request, I 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 and psychotherapy notes in my mental health and billing records used to make decisions about you for as long as the PHI is maintained in the record. I may deny your access to PHI under certain circumstances,

but in some cases you may have this decision reviewed. On your request, I 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. I may deny your request. On your request, I 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 for which you have neither provided consent nor authorization (as described in Section III of this Notice). On your request, I 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 me upon request, even if you have agreed to receive the notice electronically.

<u>Psychologist's Duties:</u>

I am required by law to maintain the privacy of PHI and to provide you with a notice of my legal duties and privacy practices with respect to PHI.

I reserve the right to change the privacy policies and practices described in this notice. Unless I notify you of such changes, however, I am required to abide by the terms currently in effect.

<u>V. Complaints</u>

If you are concerned that I have violated your privacy rights, or you disagree with a decision I made about access to your records, you may contact The Texas State Board of Examiners of Psychologists at 512-305-7700.

You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services. This address can be provided upon request.

I reserve the right to change the terms of this notice and to make the new notice provisions effective for all PHI that I maintain. I will provide you with a revised notice by verbal or written communication.

LUCY T. SMITH, PHD
CLINICAL PSYCHOLOGIST

12830 Hillcrest Rd, D-114 ▪ Dallas, TX 75230 ▪ 972-386-0511 ▪ lucy@drlucysmith.com

Patient Name: ______________________________

Parent Name: ______________________________
(if applicable)

Address: ______________________________
____

Notice of Privacy Practices Acknowledgment of Receipt Form

Your signature below indicates that you have received a copy of the Notice of Privacy Practices. If you have any questions about the Notice of Privacy Practices, please ask Lucy T. Smith, PhD.

______________________________ ______________________________
Client Signature Date

OR

______________________________ ______________________________
Parent Signature Date

OR

______________________________ ______________________________
Legal Guardian Signature Date

____
Legal Guardian Relationship to Patient