Informed Consent for Therapy Services

Introduction
Welcome and thank you for choosing Whittaker Psychological Services (WPS) for your mental health needs. As we look to develop a therapeutic relationship, it is important for you to understand your rights and responsibilities as a client, as well as WPS practice policies.

Confidentiality
Generally, by law, communications between a client and therapist cannot be disclosed. In addition, in most cases, the release of your information require that you sign a written authorization form granting permission. However, there are some exceptions to confidentiality. These include:

- If there is reasonable suspicion that the client is a danger to oneself or someone else.
- If there is suspicion of abuse, neglect, or recurrent domestic harm.
- Subpoena- therapist is ordered by court to release information .
- Otherwise required by law to release information.
- Client is below the age of 18.
- Insurance claims/third party payer requests – Therapist at times will need to share information about a diagnosis and treatment with health insurance companies for reimbursement or to determine what care is covered.

Record Keeping
A record describing therapy goals, treatment plans, interventions, our discussions, description of therapy sessions, dates and fees are maintained. These records are kept in a secure location and can only be accessed by me. Clients are entitled to receive a copy of these records. WPS reserves the right to charge a fee associated with record requests.

Fees and Payment
Payment is expected at the time of service. The fee for an initial appointment for individual therapy is $200. Follow-up appointments are $175 per session. These sessions are 45 minutes in length but can vary depending on the needs of the client. The initial and follow-up appointments for couples therapy is $250 per hour.

For home/school-based services, the fee is $300 per 60 minutes sessions. Home services that are outside of a 10-mile radius from office site will incur and additional $50 charge.

A no show or late cancellation fee of $90 will be charged for missed appointments. However, depending on the services provided, WPS reserves the right to charge fees up to the full billable rate of the missed appointment.

I accept all major credit cards, Zelle, Venmo, cash or check. A returned check fee of $30 will be assessed for a check returned for insufficient funds, and your account will need to be paid to date by the next appointment.

If you need to submit a claim form to your insurance company, an invoice can be provided for this purpose. **Please note that WPS does not accept insurance for home-based or testing services.**

Additional Services

Testing
The fee for testing services is $300 per hour. To schedule testing, you will need to sign a testing agreement and pay in full prior to the administration.

Telephone Calls, Letters, Attendance to meetings, Reviewing Records
As a courtesy, there is no charge for telephone calls with you or other professionals that is under 5 minutes long. Thus, if telephone consults exceed this time limit, there is a $30 fee assessed for each 10-minute increment.

A $90 fee is charged for letters, or 504 plans written on your behalf.

If you require my attendance to meetings on your behalf, these services are charged and prorated at $250 per hour if the meeting is virtual and $300 per hour in person. In litigation cases, $350 per hour is charged for preparation and attendance to any legal proceeding.

Appointment & Scheduling
If you are unable to keep your appointment, you must provide at least **24 hours' notice**. Failure to do so will result in a late cancellation charge billed to you for up to the full session fee. I reserve the right to terminate therapy with a client who does not show up for two or more appointments.

First time clients - If you schedule and do not show up for your 1st appointment, you will not be allowed to schedule future appointments.

Emergencies
In the event of a mental health emergency please call 911 or go to the nearest emergency room.

WHITTAKER PSYCHOLOGICAL SERVICES
LICENSED PSYCHOLOGIST

Patient Information and Consent for Teletherapy

Teletherapy is the delivery of psychological services using audio and visual electronic systems. It allows the clinician to provide mental health services remotely.

HIPPA confidentiality requirements apply the same for teletherapy as for face-to-face therapy. Please note the following carefully:

- Recording of sessions is NOT permitted.
- Ensure you have a secure internet connection. Avoid the use of public/free Wi-Fi.
- Ensure you have a private space that is safe and free of distractions.

As your psychologist, I may determine that teletherapy is no longer appropriate for you and will propose alternate options.

It is recommended that you contact your insurance company prior to our engaging in teletherapy sessions to determine whether these sessions will be covered. If your insurance carrier does not cover teletherapy, you will be responsible for the session fees.

Since teletherapy services rely on technology, there are risks involved in the transmission of information. These include but are not limited to disruption or distortion due to equipment failure and other people gaining access to our private conversation.

I accept that teletherapy does not provide emergency services. If I am experiencing an emergency, I understand that I can call 911 or go to the nearest emergency room.

Consent for Therapy

By signing below, I agree that I have read and understood the treatment agreement provided to me and have had all my questions answered satisfactorily. I agree to abide by the policies set forth by this document and understand that I have a right to withdraw from treatment at any time.

Client Name: _____Client Signature:_____

Date: _____

If signed by other than client, indicate relationship: _____

WHITTAKER PSYCHOLOGICAL SERVICES
LICENSED PSYCHOLOGIST

NOTICE OF PRIVACY PRACTICES

This Notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review this notice carefully. Your health record contains personal information about you and your health. This information about you that may identify you and that relates to your past, present, or future physical or mental health or condition and related health care services is referred to as Protected Health Information ("PHI"). This Notice of Privacy Practices describes how your provider may use and disclose your PHI in accordance with applicable law. It also describes your rights regarding how you may gain access to and control your PHI. Under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), your provider is required to maintain the privacy of PHI and to provide you with notice of his or her legal duties and privacy practices with respect to PHI. Your provider is required to abide by the terms of this Notice of Privacy Practices. Your provider reserves the right to change the terms of this Notice of Privacy Practices at any time. Any new Notice of Privacy Practices will be effective for all PHI that your provider maintains at that time. Your provider will provide you with a copy of the revised Notice of Privacy Practices by sending a copy to you in the mail upon request or by providing one to you at your next appointment.

HOW YOUR PROVIDER MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU:

For Treatment: Your PHI may be used and disclosed by those who are involved in your care for the purpose of providing, coordinating, or managing your healthcare treatment and related services. This includes consultation with clinical supervisors or other treatment team members. Your provider may disclose PHI to any other consultant only with your authorization.

For Payment: Your provider may use and disclose PHI so that he or she can receive payment for the treatment services provided to you. Examples of payment-related activities are: making a determination of eligibility or coverage for insurance benefits, processing claims with your insurance company, reviewing services provided to you to determine medical necessity, or undertaking utilization review activities. If it becomes necessary to use collection processes due to lack of payment for services, only disclose the minimum amount of PHI necessary for purposes of collection will be disclosed.

For Health Care Operations: Your provider may use or disclose, as needed, your PHI in order to support his or business activities including, but not limited to, quality assessment activities, licensing and conducting or arranging other business activities. For example, your PHI may be shared with third parties that perform various business activities provided we have a written contract with the business that requires it to safeguard the privacy of your PHI. Your PHI may be used to contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services.

Required by Law: Under the law, your provider must make disclosures of your PHI to you upon your request. In addition, disclosures must be made to the Secretary of the Department of Health and Human Services for the purpose of investigating or determining compliance with the requirements of the Privacy Rule.

Without Authorization: Applicable law and ethical standards permit your provider to disclose information about you without your authorization only in a limited number of other situations. The types of uses and disclosures that may be made without your authorization are those that are:

- Required by Law, such as the mandatory reporting of child abuse or neglect or elder abuse, or mandatory government agency audits or investigations.
- Required by Court Order
- Necessary to prevent or lessen a serious an imminent threat to the health or safety of a person or the public. If information is disclosed to prevent or lessen a serious threat it will be disclosed to a person or persons reasonably able to prevent or lessen the threat, including the target of the threat.

Verbal Permission: Your provider may use or disclose your information to family members that are directly involved in your treatment with your verbal permission.

With Authorization: Uses and disclosures not specifically permitted by applicable law will be made only with your written authorization, which may be revoked.

YOUR RIGHTS REGARDING YOUR PHI

You have the following rights regarding PHI maintained about you. To exercise any of these rights, please submit your request in writing to your provider:

Right of Access to Inspect and Copy. In most cases, you have the right to inspect and copy PHI that may be used to make decisions about your care. Your right to inspect and copy PHI will be restricted only in those situations where there is compelling evidence that access would cause serious harm to you. Your provider may charge a reasonable, cost-based fee for copies.

Right to Amend. If you feel that the PHI your provider has about you is incorrect or incomplete, you may ask for it to be amended, although your provider is not required to agree to the amendment.

Right to an Accounting of Disclosures. You have the right to request an accounting of certain disclosures that your provider makes of your PHI. Your provider may charge you a reasonable fee if you request more than one accounting in any 12-month period.

Right to Request Restrictions. You have the right to request a restriction or limitation on the use or disclosure of your PHI for treatment, payment, or healthcare operations. Your provider is not required to agree to your request.

Right to Request Confidential Communication. You have the right to request that your provider communicate with you about medical matters in a certain way or at a certain location.

Right to a Copy of This Notice. You may ask your provider for a paper copy of this notice at any time.

COMPLAINTS

If you believe your privacy rights have been violated, you may submit a complaint with the Federal Government. Filing a complaint will not affect your right to further treatment or future treatment. To file a complaint with the Federal Government, contact:

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge receipt of the Notice of Privacy Practices, which explains my rights and the limits on ways my provider may use or disclose personal health information to provide service.

Client Name: _____ Client Signature:_____

Date: _____

If signed by other than client, indicate relationship:

_____