CONSENT FOR TREATMENT AND CONSENT FOR TELEMEDICINE

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OUTPATIENT SERVICES CONTRACT

Welcome to my practice. This document contains important information about my professional services and business policies. Please read it carefully and jot 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

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, I 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 me. At the end of the evaluation, I will notify you if I believe that I am not the right therapist for you and, if so, I will give you referrals to other practitioners whom I 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 my procedures, we should discuss them whenever they arise. If your doubts persist, I will be happy to help you set up a meeting with another mental health professional for a second opinion.

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MEETINGS

I normally conduct an evaluation that will last from 2 to 4 sessions. During this time, we can both decide if I am the best person to provide the services you need in order to meet your treatment goals. If we agree to begin psychotherapy, I will usually schedule one [45-minute] session (one appointment hour of [45] minutes duration) 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 48 hours advance notice of cancellation.

PROFESSIONAL FEES

My hourly fee is $250.00. If we meet more than the usual time, I will charge accordingly. In addition to weekly appointments, I charge this same hourly rate for other professional services you may need, though I will prorate the hourly cost if I work for periods of less than one hour. Other professional services include report writing, telephone conversations lasting longer than 10 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. If you become involved in legal proceedings that require my participation, you will be expected to pay for any professional time I spend on your legal matter, even if the request comes from another party.

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. 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.

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

Due to the rising costs of health care, insurance benefits have increasingly become more complex. It is sometimes difficult to determine exactly how much mental health coverage is available. "Managed Health Care" plans often require authorization before they provide reimbursement for mental health services. These plans are often limited to short-term treatment approaches designed to work out specific problems that interfere with a person's usual level of functioning. It may be necessary to seek approval for more therapy after a certain number of sessions. Though a lot can be accomplished in short-term therapy, some patients feel that they need more services after insurance benefits end.

You should also be aware that most insurance companies require that I provide them with your clinical diagnosis. Sometimes I have to provide additional clinical information, such as treatment plans, progress notes or summaries, or copies of the entire record. This information will become part of the insurance company files. Though all insurance companies claim to keep such information confidential, I have no control over what they do with it once it is in their hands. In some cases, they may share the information with a national medical information databank. I will provide you with a copy of any records I submit, if you request it. ***You understand that, by using your insurance, you authorize me to release such information to your insurance company. I will try to keep that information limited to the minimum necessary.***

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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 my services yourself to avoid the problems described above.

CONTACTING ME

I am often not immediately available by telephone. Though I am usually in my office between 9 AM and 5 PM, I probably will not answer the phone when I am with a patient. I do have call-in hours at 6 PM -7 PM. When I am unavailable, my telephone is answered by a voice mail. I will make every effort to return your call on the same day you make it, with the exception of weekends and holidays. If you are difficult to reach, please inform me of some times when you will be available. In emergencies, you may call me at (203) 776-2077. 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. If I will be away from my practice on vacation, I will provide you with the name of a colleague to contact who will cover the practice.

CONFIDENTIALITY [for adult patients]

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

In most legal proceedings, you have the right to prevent me from providing any information about your treatment. In some legal proceedings, a judge may order my testimony if he/she determines that the issues demand it, and I must comply with that court order.

There are some situations in which I am legally obligated to take action to protect others from harm, even if I have to reveal some information about a patient's treatment. For example, if I believe that a child [elderly person or disabled person] is being abused or has been abused, I am required to make a report to the appropriate state agency.

If I believe that a patient is threatening serious bodily harm to another, I am [may be] required to take protective actions. These actions may include notifying the potential victim, contacting the police, or seeking hospitalization for the patient. If the patient

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threatens to harm himself/herself, I may be obligated to seek hospitalization for him/her or to contact family members or others who can help provide protection. If a similar situation occurs in the course of our work together, I will attempt to fully discuss it with you before taking any action.

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 patient. The consultant is also legally bound to keep the information confidential. Ordinarily, I will not tell you about these consultations unless I believe that it is important to our work together.

Although this written summary of exceptions to confidentiality is intended to inform you about potential issues that could arise, it is important that we discuss any questions or concerns that you may have at our next meeting. I will be happy to discuss these issues with you and provide clarification when possible. However, if you need specific clarification or advice I am unable to provide, formal legal advice may be needed, as the laws governing confidentiality are quite complex and I am not an attorney.

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

PRINT NAME (Print name) _____

SIGNATURE _____ DATE _____

WITNESS SIGNATURE _____ DATE _____

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Informed Consent for Telemedicine Services

COVID-19 Public Health Emergency Waiver

As enacted under the 1135 waiver provided by the Secretary of the Department of Health and Human Services and the Health and Human Services Office of Civil Rights (OCR) during the COVID-19 nationwide public health emergency, your health care providers may provide telemedicine services in good faith through everyday communication technologies even though these technologies may not fully comply with the requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Rules and as such may not provide protection of confidential identification or protected medical information. Your health care provider may use audio or video communication technology to provide telemedicine services during the COVID-19 nationwide public health emergency through any non-public facing remote communication product that is available to communicate with patients. Video conferencing must occur on a secure site such as a Zoom, DOXY.ME with HIPPA protection.

Expected Benefits:

- Improved access to psychological services enabling me to remain in my home (or at a remote site).
- More efficient psychological evaluation and management without coming into the office.

Possible Risks:

There are potential risks associated with the use of telemedicine. These risks include, but may not be limited to:

- In rare cases, information transmitted may not be sufficient (e.g., poor audio or visual resolution of images) to allow for appropriate delivery of services.
- Delays in medical evaluation and treatment could occur due to deficiencies or failures of the equipment.
- In very rare instances, security protocols could fail, causing a breach of privacy of personal medical information.

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By signing this form, I understand and agree to the following:

1. I understand that the laws that protect privacy and the confidentiality of telepsychology sessions and medical information also apply to telemedicine, and that no information obtained in the use of telemedicine be used without my consent.
2. I understand that I have the right to withhold or withdraw my consent to the use of telepsychology in the course of my care at any time, without affecting my right to future care or treatment.
3. I understand that I have the right to inspect all information obtained and recorded in the course of a telemedicine interaction and may receive copies of this information for a reasonable fee.
4. I understand that a variety of alternative methods of care may be available to me, and that I may choose one or more of these at any time.
5. I understand that telemedicine may involve electronic communication of my personal medical information to other medical practitioners or therapists.
6. I understand that it is my duty to inform my therapist of electronic interactions regarding my care that I may have with other healthcare providers.
7. I understand that I may expect the anticipated benefits from the use of telemedicine in my care, but that no results can be guaranteed or assured.
8. I understand that my insurance deductibles and/or co-pays apply to telemedicine services.
9. I understand that during the COVID-19 Nationwide Public Health Emergency my health care provider may use communication technologies that may not provide protection of confidential identification or protected medical information.
10. I agree to telepsychology services and to maintain confidentiality for the telepsychology services and no one will record the session without permission of all parties.
11. I agree to use the video-conferencing platform selected for our virtual sessions (DOXY.ME) and the psychologist will explain how to use it. The

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backup plan will be the use of the telephone and specific telephone number(s) in the event of technical problems.

12. I will have a secure internet connection and not use a public or free internet connection. I will conduct my telepsychology sessions in a quiet, private space, free of distractions (i.e. cell phone) and not in the presence of others who can hear but are not participating in the session.

Patient Consent To The Use of Telemedicine Services

I have read and understand the information provided above regarding telemedicine, have discussed it with my therapist and all of my questions have been answered to my satisfaction. I hereby give my informed consent for the use of telemedicine for telepsychology services.

I hereby authorize ***Diane E. Sholomskas, Ph.D.*** use DOXY.ME telemedicine services in the course of my evaluation, diagnosis and treatment.

Print Name
of Patient _____

Signature
of Patient _____

Authorized Signer _____
(Relationship to patient)

Date: _____