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INFORMED CONSENT FOR INDIVIDUAL PSYCHOTHERAPY

Prior to beginning treatment, it is important to understand my approach to therapy and agree to some rules about confidentiality during the course treatment. The information herein is in addition to the information contained in the Office Policies document. Under HIPAA and the APA Ethics Code, I am legally and ethically responsible to provide you with information so that you can give informed consent for treatment. As we go forward, I will try to remind you of important issues as they arise.

CONFIDENTIALITY

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

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. However, there are specific exceptions to this confidentiality including the following:

- When there is a risk of imminent danger to you or another person, I am required to take necessary steps to prevent such danger.

These situations have rarely occurred in my practice. If such situation occurs, I will make every effort to fully discuss it with you before taking any action.

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

Name_____ Date _____

Signature _____ Date_____

Therapist Signature _____ Date_____

ADDITIONAL INFORMATION – OFFICE POLICIES

PROFESSIONAL FEES

My fee is for the therapy hour. In addition to weekly appointments, I charge our agreed upon fee for other professional services you may need, though I will break down the hourly cost if I work for periods of less than one hour. Other services include report writing, telephone conversations lasting longer than 5 minutes, attendance at meetings with other professionals you have authorized, preparation of records or treatment summaries, and the time spent performing any other service you may request of me. I will not be involved in any legal proceedings that you become involved in. If in the rare or remote possibility that I am required to be involved in legal proceedings or testimony I will ask that you pay for my professional time at $400 per hour even if I am called to testify by another party.

I ask for 48 hours notice if you need to cancel our appointment. Cancellations with less than 24 hours notice will be charged full fee.

BILLING AND PAYMENTS

Please arrange for payment for each session at the time it is held, unless we agree otherwise. Payment schedules for other professional services will be agreed to when they are requested.

INSURANCE REIMBURSEMENT

I am currently not part of any HMO or PPO insurance plans. However, if your insurance covers "out of network" providers, you may be able to be reimbursed for a portion or all of the services depending on your insurance plan.

In order for us to set realistic treatment goals and priorities, it is important to evaluate what resources are 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.

CONTACTING ME

I am often not immediately available by telephone. While I am often working between 9 AM and 6 PM weekdays, I probably will not answer the phone when I am in meetings. When I am unavailable, my telephone is answered by 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. If you are unable to reach me and feel that you can't 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, if necessary.

CONSULTATION

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. If you don't object, I will not tell you about these consultations unless I feel that it is important to our work together.

While this written summary of exceptions to confidentiality should prove helpful in informing you about potential problems, it is important that we discuss any questions or concerns that you may have at our next meeting.

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

Signature _____ Date_____

COMMUNICATION BY EMAIL OR OTHER NON-SECURE MEANS

It may become useful during the course of treatment to communicate by email, or other electronic methods of communication. These methods, in their typical form, are not confidential means of communication. If you use these methods to communicate with me there is a possibility that a third party may be able to intercept and eavesdrop on those 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;
- Your employer, if you use your work email to communicate; or
- Third parties on the internet such as server administrators and others who monitor internet traffic,

If there are people in your life that you don't want accessing these communications, please speak with me about ways to keep your communications safe and confidential.

CONSENT FOR TRANSMISSION OF PROTECTED HEALTH INFORMATION BY NON-SECURE MEANS

I consent to allow Julie Rappaport to use unsecured email and mobile phone text messaging to transmit to me the following protected health information:

- Information related to the scheduling of meetings or other appointments
- Information related to billing and payment
- General acknowledgement that your message has been received if you are communicating clinical information

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 understand that I am not required to sign this agreement in order to receive treatment. I also understand that I may terminate this consent at any time.

Signature _____ Date_____