Patient/Client Therapy Policies Handout

Directions: Please read this whole packet and mark any points that are not clear. Then, bring this packet to our first meeting. Write down your questions, and we can discuss them at our first meeting. This packet will be yours to keep. **Please go ahead and sign the documents where necessary**. Look for the "**SIGN HERE**" marking to guide you. We can discuss how this information relates to you in person when we meet

Consent to Psychological Services

-I, the client (or his or her parent or guardian), understand I have the right not to sign this form. My signature below indicates that I have read and discussed this agreement; it does not indicate that I am waiving any of my rights. I understand I can choose to discuss my concerns with you, the therapist, before I start (or the client starts) formal therapy. I also understand that any of the points mentioned above can be discussed and may be open to change. If at any time during the treatment I have questions about anything in this contract, I know that I can talk with you about it.

-I certify that I am a permitted by law to sign this document since I am an adult or a parent with independent healthcare decision making power or a legal guardian of the patient.

-I understand that after therapy begins I have the right to withdraw my consent to therapy at any time, and for any reason. However, I will make every effort to discuss my concerns about my progress with you before ending therapy with you.

-I understand that no specific promises have been made to me by this therapist about the results of treatment, the effectiveness of the procedures used by this therapist, or the number of sessions necessary for therapy to be effective.

-I, after reading this entire packet, and after having been given a reasonable chance to ask any all questions and have also received satisfactory answers. I agree to act according to the points covered in this contract. I hereby agree to enter into therapy with this therapist (or to have the client enter therapy), and to cooperate fully and to the best of my ability, as shown by my signature here.

SIGN HERE (#1): I have read, understood, and agreed to the section entitled "Consent to Psychological Services"

Patient Printed Name: _____ Parent/Guardian Printed name (if minor):_____
Signature of Patient or Parent/Guardian:_____Date:_____

Policies regarding release of and storage of records

-If your records need to be sent to another professional, we will discuss it together. If you agree to share these records, you will need to sign a release form. This form states exactly what information is to be shared, with whom, and why, and it also sets time limits. You may read this form at any time. If you have questions, please ask me.

-Standard policy for psychologists is to destroy clients' records 6 years after the end of your therapy, or for juveniles, 6 years after termination of treatment (or 3 years after 18th birthday; whichever comes last). Until then, I will keep your case records in a safe place. If I must discontinue our relationship because of illness, disability, or other presently unforeseen circumstances, I ask you to agree to my transferring your records to another therapist who will assure their confidentiality, preservation, and appropriate access. If we do family or couple therapy (where there is more than one client), and you want to have my records of this therapy sent to anyone, all of the adults present will have to sign a release.

-As part of cost control efforts, an insurance company will sometimes ask for more information on symptoms, diagnoses, and my treatment methods. It will become part of your permanent medical record. Please understand that I have no control over how these records are handled at the insurance company. My policy is to provide only as much information as the insurance company will need to pay your benefits.

-If requested, I can provide a treatment summary unless I believe that to do so would be emotionally damaging to the requester. If that is the case, I will be happy to send the summary to another mental health professional that is working with you. There would, however, be an additional charge for this service. In some very rare situations, I may temporarily remove parts of your records before you see them. This would happen if I believe that the information will be harmful to you, but I would discuss this with you first.

-Pursuant to HIPAA, I keep Protected Health Information about patients in two sets of professional records. One set constitutes the Designated Medical Record. It includes information about reasons for seeking therapy, a description of the ways in which problems impact life, a diagnosis, the goals set for treatment, progress toward those goals, medical and social history, treatment history, past treatment records that have been received from other providers, reports of any professional consultations, billing records, and any reports that have been sent to anyone, including reports to an Insurance carrier. Except in unusual circumstances that involve danger to self or others or where information has been supplied to me others confidentially, a client may examine and/or receive a copy of the Designated Medical Record, if requested in writing.

-In addition, I also keep a set of Psychotherapy Notes. These Notes are for my own use and are designated to assist me in providing the best treatment. While the contents of Psychotherapy Notes vary from client to client, they can include the contents of conversations, analysis of those conversations, and how they impact on therapy. They also contain particular sensitive information that a client may reveal that is not required to be included in the Designated Medical Record.

-Insurance companies can request and receive a copy of the Designated Medical Record, they cannot receive a copy of Psychotherapy Notes without a separate written, signed authorization. Insurance companies cannot require such an authorization as a condition of coverage nor penalize a client in any way for refusal.

-HIPAA provides patients with several new or expanded rights with regard to their Designated Medical Record and disclosures of protected health information. These rights include requesting I amend the record; requesting restrictions on what information from the Designated Medical Record is disclosed to others; requesting an accounting of most disclosures of protected health information that the client has neither consented to nor authorized; determining the location to which protected information disclosures are sent; having any complaints made about policies and procedures recorded in the records; and the right to a paper copy of this Agreement, the attached notice form and my privacy policies and procedures. Dr. Brunner is happy to discuss any of these rights with you. Patients under 18 years of age who are not emancipated their parents should be aware that the law may allow both parents to examine their child's treatment records.

HIPPA Policies and Procedures

Notice of Psychologist's Policies and Practices to Protect the Privacy of Your Health Information

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 operation purpos 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 physicia or another psychologist.

- Payment is when I obtain reimbursement for your healthcare. Examples of payment are when I disclose your P 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, an 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* 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, such as payment of 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 or health care operations, I will obtain an authorization from you before releasing this information. will also need to obtain an authorization before releasing your Psychotherapy Notes. "Psychotherapy Notes" are notes I have made about our conversation during a private, group, joint, or family counseling sessions, which I have kept separ 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) I have relied on that authorization: or (2) if the authorization was obtained as a condition of obtaining insurance coverage. Law provides the insurer the right to contes 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 – I am required to report PHI to the appropriate authorities when I have reasonable grounds to believe th a minor is or has been the victim of neglect or physical and/or sexual abuse.
- Adult and Domestic Abuse – If I have the responsibility for the care of an incapacitated or vulnerable adult, I am required to disclose PHI when I have a reasonable basis to believe that abuse or neglect of the adult has occurred or that exploitation of the adult's property has occurred.
- Health Oversight Activities – If the Arizona Board of Psychological Examiners is conducting an investigation, then I ar required to disclose PHI upon receipt of a subpoena from the Board.
- Judicial and Administrative Proceedings – If you are involved in a court proceeding and a request is made for information about the professional services I provided to you and/or the records thereof, such information is privileged

under state law, and I will not release information without the written authorization by you, your legally appointed representative or a court order. The privilege does not apply when you are being evaluated for a third party 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 me an explicit threat of imminent serious physical harm or death to a clearly identified or identifiable victim(s) and I believe you have the intent and ability to carry out such a threa I have a duty to take reasonable precautions to prevent the harm from occurring, including disclosing information to the potential victim and the police and in order to initiate hospitalization procedures. If I believe there is an imminent risk that you will inflict serious harm on yourself, I may disclose information in order to protect you.

• Worker's Compensation – I may disclose PHI as authorized by and to the extent necessary to comply with laws relatin to worker's compensation or other similar programs, established by law, that provide benefits for work-related injuries o illness without regard to fault.

IV. Patient's Right and Psychologist's Duties

Patient's Rights:

• Right to Request Restrictions – You have the right to request restriction on certain uses and disclosures of PHI. 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 righ 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. On 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 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 am allowed to den your access to PHI under certain circumstances, but in some cases you may have this decision reviewed. On your reque I will discuss with you the details of the request and the 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 recor I am allowed to 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. On your request 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 hav agreed to receive the notice electronically.

Psychologist's Duties:

• 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 the 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.

• If I revise my policies and procedures, you are entitled to receive a revised copy of the Notice by calling and requesting copy of my "notice" or by visiting my office and picking up a copy.

V. Complaints

-If you are concerned that I have violated your privacy rights, or you disagree with a decision I made about access to you records, you may contact me for further information.

-You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Service.

VI. Effective Date of this notice is April 14, 2003.

SIGN HERE (#2) : I have read, understood, and agreed to the sections entitled "Policies regarding release of and storage of records" and "HIPAA Policies and Procedures"

Patient Printed Name: _____ Parent/Guardian Printed name (if minor):_____

Signature of Patient or Parent/Guardian:_____Date:_____

Policies related to Insurance

- I understand I am fully responsible for all charges billed and due at the time of service by Dr. Brunner. Even if I have insurance, I understand that the processing of claims is my responsibility only. I understand Dr. Brunner will defer questions from the insurance company to me as appropriate, and that if there are extensive issues that a nominal administrative fee may be charged. I understand Dr. Brunner makes no promises regarding how much the insurance company may reimburse me.

SIGN HERE (#3): I have read, understood, and agreed to the section entitled "Policies related to Insurance"

Patient Printed Name: _____ Parent/Guardian Printed name (if minor):_____
Signature of Patient or Parent/Guardian:_____Date:_____

SIGNATURE REQUIRED TO AUTHORIZE RELEASE OF INFORMATION

I hereby authorize the written and/or telephone release of any and all information including, but not limited to, billing records, medical records of psychotherapy sessions, treatment summaries and diagnostic information necessary to process insurance claims on my behalf. I understand that Dr. Brunner will release only what is necessary to meet insurance requirements. I further understand that when any financial statements, reports or case records are transmitted by electronic mail, or by surface mail to my insurance company or managed care company, Dr. Brunner cannot make any assurances to me as to who will view these records once they are received. I hereby authorize that the payment of any insurance benefits to which I am entitled for the services rendered by Dr. Brunner be paid directly to Dr. Brunner. This assignment of benefits and release of information will remain in effect until revoked in writing by me. A photocopy or faxed copy of this assignment and release is to be considered as valid as the original.

SIGN HERE (#4): I have read, understood and agreed to section entitled: "Signature Required to Authorize Release of Information":

Patient Printed Name: _____ Parent/Guardian Printed name (if minor):_____
Signature of Patient or Parent/Guardian:_____Date:_____

Notice of Privacy Practices

I am committed to keeping everything you share completely confidential. Whatever you speak about will not be shared with anyone else without your written permission. However, there are certain limits to this confidentiality that I would like you to know about.

1) If you have been referred by the court or any agency of the court, I may be required to furnish information to them.
2) If you are involved in certain kinds of litigation, such as worker's compensation, and inform the court of the services you have received from us, you may be waiving your right to have your records remain confidential. This would need to be clarified with your attorney.
3) If you threaten to harm yourself or someone else, I am obligated to inform potential helpers or victims. Information would be divulged only if I perceive that there is imminent danger to a readily identifiable victim, yourself, or the public. I am obligated to warn and protect if I believe you intend to carry out serious violence, even if you have not made a specific verbal threat.
4) If I have reason to suspect there is child abuse or neglect, I am obligated by law to report this to the appropriate state agency.
5) If I reasonably believe that a vulnerable adult is being abused, neglected, or exploited, I may report this information to the county adult protective services provider.
6) If you are a minor, your parents or guardians will be informed of your progress, if they ask. However, I will not reveal specific details of our conversations without your permission unless I determine that your safety or basic psychological stability are at risk.
7) Your health care insurance may require information to process claims or to authorize benefits.
8) If anyone issues a subpoena, I may be compelled to testify before the Board and produce your relevant records and papers.

If you are concerned about some of your information, you have the right to ask me not to use or share it for treatment, payment, or administrative purposes. You will have to tell me what you want in writing. Although I will try to respect your wishes, I may not be able to agree to these limitations. However, if I do agree, I promise to comply with your wishes. You will be told if your information is shared per the privacy limitations listed above.

You have the right to request to receive confidential communication by alternative means and at alternative locations. For example, you could request that bills/statements be sent to a different address if you didn't want a family member to know about them.

You can request to inspect, obtain a copy of, or amend information about yourself in our mental health or billing records. Under certain circumstances, your request may be denied, but you may be able to have this decision reviewed.

If you have questions about this notice, disagree with a decision I make about access to your records, or have other concerns about your privacy rights, please discuss them with me. You can also send a written complaint to the Secretary of the US Department of Health and Human Services.

After you have signed this consent, you have the right to revoke it (by writing a letter telling me you no longer consent), and I will comply with your wishes about using or sharing your information from that time on. However, if I have already used or shared some of your information, I cannot change that. Please sign and date this sheet to acknowledge that you have read and understood this notice of privacy policies. This form complies with federal regulations (HIPAA).

<u>SIGN HERE</u> (#5): I have read, understood, and agreed to the section entitled "Privacy Practices"

Patient Printed Name: _____ Parent/Guardian Printed name (if minor):_____

Signature of Patient or Parent/Guardian:_____Date:_____

Administrative Policies

General information

-I have a regular non-forensic (not involving legal issues) and then a forensic rate which is a higher fee. Services will be billed and due at the time of service. Except in the case of emergency or illness, if you do not give 48 hours notice, then you will be charged my full fee.

-Our meetings are 45-50 minutes. Please be on time. If I am ever unable to start on time, I ask for your understanding. Commonly I have crisis situations I must handle on the spot.

-You may want me to use my professional knowledge to help you with things that do not fit into the 45-50 minute clinical hour. I will then pro-rate the fee.

Activity	Time	Charge
Telephone consultation	Variable	Prorated fee
Extended therapy session	10 minutes	
Review of records	60 minutes	
Corresponding with teacher	30 minutes	
Base charge - Assessment	12 hours	
School Meeting, Hospital visit	Variable	
Scoring/interpreting a measure	15 minutes	

-I may have assistants work with me who understand the need for appropriate confidentiality.

Communication

-I cannot promise I will be available at all times. I do not take calls when I am in session or conducting an assessment. Usually, I can return calls during the work week.

-If you have a life-threatening emergency, you should call 911 immediately. If you have a behavioral or emotional crisis and cannot reach me soon enough to have your needs met, via my after hours service (520-296-8572), you or your family members should call the crisis counseling services at SAMHC (622-6000), or go to the nearest hospital's emergency room.

-There may be periods of time (e.g. vacations, illness, family emergencies) when I am out of town or not available to return phone calls. In these instances, other qualified professionals will provide coverage for him and will return your call or I will provide a forwarding number. .

-I use email only to receive information, never to give clinical advice or offer my thoughts on issues. Please be aware I may not respond to an email you sent, because I see so many every day. Please do not ask me questions via email unless I invite this form of internet interaction. We can discuss emails during sessions.

SIGN HERE (#6): I have read, understood, and agreed to the section entitled "Administrative Practices"

Patient Printed Name: _____ Parent/Guardian Printed name (if minor):_____
Signature of Patient or Parent/Guardian:_____Date:_____

The risks of therapy

As with any treatment, there are some risks as well as many benefits with therapy.

There is a risk that you or your child will have to deal with uncomfortable feelings or memories, and may at different points along the process regress or feel worse than when they came in to how healing may involve the externalization of internalized issues. There may longer periods of time when the patient and those around them feel worse or seem to not be benefiting. This is a common occurrence. There is a risk that therapy may not work out well for you. If it seems I am not helping you, or we are not a good match, I will gladly refer you to someone who will better serve your needs.

SIGN HERE (#7): I have read, understood, and agreed to the section entitled "The risks of therapy"

Patient Printed Name: _____ Parent/Guardian Printed name (if minor):_____
Signature of Patient or Parent/Guardian:_____Date:_____

Authorization to securely store credit card information

Because I am able to efficiently work without an assistant, the way I do business is I store - in a password protected fashion – a credit card on file. By signing below, you stating that you understand and agree to this policy. You also are consenting to have your credit card used to pay for an appointment not cancelled with at least 48 business hours notice.

SIGN HERE (#8): I have read, understood, and agreed to the section entitled "Authorization to securely store credit card information"

Patient Printed Name: _____ Parent/Guardian Printed name (if minor):_____
Signature of Patient or Parent/Guardian:_____Date:_____