BAY AREA HEALTH PSYCHOLOGY

1690 Woodside Road, Suite 221, Redwood City, CA 94061
Telephone: (650) 999-0220
Fax: (855) 999-0220
Email: Info4BAHP@Gmail.com
www.BayAreaHealthPsychology.com

TREATMENT AUTHORIZATION AND AGREEMENT

Contract and Consent for Outpatient Psychotherapy

This document contains important information about the professional services and business policies of Bay Area Health Psychology (BAHP). It also contains summary information about HIPAA – the Health Insurance Portability and Accountability Act – a federal law that provides privacy protection and client rights regarding the use and disclosure of Protected Health Information (PHI). Please read this treatment agreement carefully and write down any questions you have so you can discuss them with your therapist at your next appointment. When you sign this document, it will represent an agreement between you, your therapist, and Bay Area Health Psychology.

PSYCHOLOGICAL SERVICES

The way therapy is conducted and the outcomes that occur depend on the particular issues you bring forward and how you and your therapist choose to approach them. Therapy is not like going to a medical doctor. It is a more collaborative process that requires trust and open communication. It requires active participation on your part, both during the sessions and at home between sessions. Psychotherapy can have benefits and risks. Because therapy often involves discussing difficult aspects of your life, you may experience uncomfortable feelings. On the other hand, therapy can lead to better management of your health and medical conditions, improved relationships, solutions to specific problems, and reductions in stress. There are no guarantees of what you will experience. If you have any questions or concerns about your work with your therapist, it is important to share those with your therapist. You have the right to ask questions about anything that happens in therapy. You are free to leave therapy at any time, but it is usually best to talk about your concerns first. If you decide that your therapist is not the right therapist for you, we can provide you with a referral to another therapist.

CANCELLATION POLICY

We reserve the right to charge the full session fee for any scheduled appointment that is missed or is cancelled with less than 24 hours notice. However, if we are able to reschedule the appointment with your therapist for a mutually agreeable time during the same week as the scheduled appointment, we will only bill for the new appointment. Of course, we cannot guarantee that your therapist will have alternate appointment times available.

PHONE CALLS

We always try to return phone messages promptly. Even on days that we are not in the office, we check my voicemail several times per day. In your message, please let us know if you want us to call you back and, if so, the best time and phone number for us to reach you. If you do not receive a return call from us within a reasonable amount of time please leave a second message (occasionally, voicemail systems fail) or send an email to Info4BAHP@Gmail.com as backup.

There may be occasion when our office needs to contact you by telephone to schedule a new appointment or change the day or time of your next appointment. If you do not answer, we may want to leave a message that identifies the call as coming from Bay Area Health Psychology. **If you do not agree and approve of our leaving a message on our home phone or cell phone, indicate this by putting**

your initials on the appropriate line below and bring this to my attention. In this case, I will indicate on your clinical record that we will not leave messages on your home phone or cell phone.

☐ I give my permission for any provider or staff member of Bay Area Health Psychology to leave a voice message on my home phone and/or cell phone regarding appointment scheduling.

☐ Do NOT leave any voice message on my home phone or cell phone for any reason, including appointment scheduling.

EMAIL AND TEXT MESSAGING

Your therapist might use email and text messaging ("texting") as alternate means of communication. This enables you to send email and text messages if you need to convey information to your therapist. *However, please note that email and text messaging are not secure modes of communication*. Emails and text messaging are best used for scheduling appointments or dealing with payments. We recommend that you do not send clinical information of a personal or confidential nature via email or text, or ask us to respond to you with personal or confidential information.

However, there may be occasions when you want or need to send clinical information to your therapist via email or text message, and there may be occasions when you want your therapist to provide you with clinical information via email or text message. There may also be occasions when your therapist believes it is necessary to send you clinical information via email or text messaging. Email and text message may be preferred and necessary when (a) it is important that information be received quickly, (b) either party wants a written record of the information or communication, or (c) when telephone communication is difficult or not possible; for example, when both parties cannot join a call at the same time, or when telephone coverage is weak or not available.

If it is necessary to use email or text messaging to transmit clinical information, you agree that (a) the information will be restricted to only that which is absolutely necessary, (b) the email or text message will be sent to only those recipients who must receive the information, (c) the email or text messages will not be forwarded to anyone, and (d) after viewing, the email or text messages will be deleted or stored in a secure manner. You also acknowledge that you understand the possibility that any email or text message, even after being deleted, may be accessed by unknown third parties (such as Google and Yahoo) and used for unknown purposes (e.g., marketing data analysis).

Your signature on this agreement indicates that you agree that it is acceptable for you and your therapist to use unsecure email and text messaging if/when necessary to transmit clinical information of a personal or confidential information, and you approve of such use. **If you do not agree and approve of the use of unsecure email or text messaging for transmission of clinical information of a personal or confidential nature, indicate this by putting your initials on the appropriate line below and bring this to the attention of your therapist.** In this case, your therapist will indicate on your clinical record not to use email or text messaging for clinical information.

☐ I approve of using email or text messaging with my clinical information.

☐ Do NOT use email or text messaging with my clinical information.

WEBSITES

We have a website that you are free to access (www.BayAreaHealthPsychology.com). We use it to provide information to others about Bay Area Health Psychology and our providers. You are welcome to

access and review the information that on the website and, if you have questions about it, please discuss it with your therapist.

WEB SEARCHES

We acknowledge that you might choose to gather information about us via the Internet. Much of the information about an individual that is available on the internet may be known to that person and some may be unknown or inaccurate. If you encounter any information about us through web searches, or in any other fashion, that presents a concern to you, please discuss this with your therapist so you and your therapist can deal with its potential impact on your treatment.

Recently it has become fashionable for clients to review information about their health care provider on various websites. Understand, though, that providers cannot respond to comments and related errors because of confidentiality restrictions. If you encounter such reviews of any of our providers or any professional with whom you are working, please share it with your therapist so you can discuss it and its potential impact on your therapy. Please do not rate the work of your therapist with you on any of these websites while you are in treatment. This is because it will violate your confidentiality and has a significant potential to damage your ability to work with your therapist.

EMERGENCIES

If you are experiencing a clinical emergency and cannot reach your therapist right away, please call 911 or go to your nearest hospital emergency room. If at any time during treatment you are concerned that you may be "in crisis" between sessions, please let your therapist know so that he or she can make appropriate plans for your safety.

CONFIDENTIALITY

We abide by the legal and ethical standards for confidentiality maintained by the American Psychological Association and by the State of California. In most situations, we can release information about your treatment to others only if you sign a written Authorization form that meets certain legal requirements from HIPAA and/or California law. However, in the following situations, no authorization is required and your therapist or another BAHP therapist may choose to disclose information you're your clinical record or discussed in a therapy appointment:

1. Your therapist may find it helpful to consult with another health and mental health professional about your case. During a consultation, your therapist will make every effort to avoid revealing your identity. The other professionals are also legally bound to keep the information confidential. Your therapist will note all consultations in your Clinical Record.

2. If you are involved in a court proceeding and a request is made for information concerning the professional services your therapist provided to you or information discussed during sessions, this information is protected by the psychologist-patient privilege. Your therapist cannot provide any information without your (or your legal representative's) written authorization unless there is a court order. However, if the court orders me to release this information to the court, your therapist is required by law to do so. If you are involved in or contemplating litigation, you should consult with your attorney to determine whether a court would be likely to order your therapist to disclose information.

3. If a government agency is requesting information for health oversight activities, your therapist may be required to provide information to them.

4. If you file a complaint or lawsuit against your therapist, BAHP, or any BAHP provider or staff member, we are allowed to disclose information about when sessions took place, what was discussed in sessions, and your therapist's notes to the court to defend ourselves.

5. If you file a worker's compensation claim, your therapist may be required, upon written request of your employer, to provide all information relevant to or bearing upon the injury for which the claim was filed.

There are some situations in which your therapist or another BAHP provider is legally required to take actions that are necessary to protect others from harm. In these situations your therapist or another BAHP provider may have to reveal information about your treatment.

1. If your therapist or another BAHP provider has reason to believe that a child under the age of 18 has been abused, abandoned or neglected, or if your therapist or another BAHP provider believes you have accessed, streamed, or downloaded material where a child is engaged in an obscene sexual act, we are required by law to file a report with an appropriate government agency. Once the report is filed, we may be required to provide additional information.

2. If your therapist or another BAHP provider has reason to believe that an elder person, 65 years or older, or a dependent adult has been abused, abandoned or neglected, we are required by law to file a report with an appropriate government agency. Once the report is filed, we may be required to provide additional information.

3. If you communicate an explicit threat of imminent serious physical harm or death to a clearly identifiable victim or victims, and your therapist or another BAHP provider believes you have the apparent intent and ability to carry out such a threat, we are required to take protective actions including notifying the potential victim(s), contacting the police, and/or seeking to hospitalize you.

4. If your therapist or another BAHP provider believes that there is imminent risk that you will inflict serious physical harm or death on yourself, your therapist or another BAHP provider may be required to take protective actions. These actions may include attempting to have you hospitalized, calling the police, or contacting your family members or others who can assist in protecting you.

There are two additional situations in which we are not legally required to take action, but we reserve the right to do so at our discretion to protect others from harm, and your signature on this form indicates your consent to do so.

___ Please write your initials here to indicate that you have read and agree to these provisions.

1. If your therapist or another BAHP provider believes that you and/or someone else is or may be preparing to engage in or assist in the preparation or execution of violence against identified, unidentified, or as-yet-to-be-identified victims currently or at any time in the future, we reserve the right to notify law enforcement and share relevant information disclosed to your therapist or another BAHP provider in sessions or out of sessions by you or anyone else.

2. If your therapist or another BAHP provider believes that you are in possession of one or more firearms or weapons that was/were obtained legally or illegally, and that you should not be in

possession of such firearms or weapons by virtue of your mental state or condition, we reserve the right to notify law enforcement and share relevant information disclosed to your therapist or another BAHP provider in sessions or out of sessions by you or anyone else.

If any of these situations arise, your therapist or the other BAHP provider will make every effort to fully discuss it with you before taking any action and will limit disclosures to only that which is necessary. Although this summary of exceptions to confidentiality should prove helpful in informing you about potential problems, it is important that you and your therapist discuss any questions or concerns that you may have about it now or in the future.

PROFESSIONAL RECORDS

The laws and standards of the profession of psychologist require that we keep Protected Health Information (PHI) about you in your Clinical Record. Except in unusual circumstances (e.g., that involve danger to yourself and/or others, where access is likely to cause substantial harm, or where information has been supplied to your therapist confidentially by 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. For this reason, we recommend that you initially review them in the presence of your therapist or have them forwarded to another mental health professional so you can discuss the contents. If your therapist refuses your request for access to your records, you have a right to have this reviewed. Additional information about your rights regarding your Clinical Record is contained in the HIPAA Notice that have been provided to you.

MINORS AND PARENTS

Clients who are under the age of 18 and are not legally emancipated should be aware that law generally allows parents to examine their child's Clinical Record (with some exceptions). However, because privacy in psychotherapy is often crucial to successful progress, particularly with adolescents, a therapist may request that parents' respect the confidentiality of their child's treatment by not requesting the child's treatment records. If parents agree, during treatment the therapist will provide you with general information about the progress of the child's treatment and his/her attendance at scheduled sessions. The therapist will also provide parents with a summary of their child's treatment when it is complete. However, even with parental agreement to the confidentiality of their child's treatment, if the therapist feels the child is in danger or is a danger to someone else, he or she will notify the parents of his or her concern.

FINANCIAL AGREEMENT

GENERAL PROCEDURES

The following are general procedures for sessions. Individual psychotherapy sessions begin on the hour or 10 minutes after the hour as determined by your therapist, and generally last 45 to 55 minutes. Sometimes, sessions begin late. This occurs when a therapist must respond to an emergency or take extra time to help someone finish a particularly difficult session. Your understanding and patience is appreciated.

It is our policy and practice to render professional services on a fee-for-service basis with consideration for insurance payment. Bay Area Health Psychology accepts payment by check, cash, PayPal, VenMo, and Affinipay online credit card payment.

If your therapist or another BAHP provider is a contracted in-network provider for your insurance company, and you agree to have payments sent directly to our office, we will bill your insurance for you at no cost as a courtesy. Payments received will be applied to your account. However, *if your insurance fails to provide reimbursement for any reason, you are ultimately responsible for payment*. If we cannot secure payment from your insurance within 60 days after our making reasonable attempts, we will bill you directly, and we will provide you with a "super bill" that you can submit to your carrier to have them send the reimbursement to you.

NOTICE TO MEDICARE PATIENTS: If you have assigned your Medicare benefits to a "managed Medicare program" such as United Healthcare or Humana, and this program requires you to use one of their in-network providers which excludes our providers as "out of network", *you are responsible to pay our full fee for all services provided whether you are aware or unaware that you are enrolled in the managed Medicare program or believe that you have that program as secondary coverage*. This provision applies even if a BAHP staff member or provider represented to you at any time that services provided to you will be covered by Medicare as a result of your presenting a Medicare card or ID number.

___ If you have Medicare coverage, please write your initials here to indicate that you have read, understand, and agree to this provision.

MISSED APPOINTMENTS AND LATE CANCELATIONS: Appointments that are missed or cancelled less than 24 hours in advance may be billed to you up to our allowable contract rate if your therapist is an in-network provider with your insurance payer, or at the full agreed-upon fee if your therapist is an out-of-network provider or if you have no insurance. *You, and not your insurance company, will be responsible to pay for missed or canceled sessions.*

AUTHORIZATION TO PAY BENEFITS TO PSYCHOLOGIST
I hereby authorize payment of benefits directly to my BAHP provider or another BAHP provider contracted with my insurance payer, for services provided, not to exceed the reasonable and customary charge for these services. I understand that I am financially responsible for all charges not covered by this authorization.

___ Write your initials here to indicate that you have read, understand, and agree to this provision.

RELEASE OF INFORMATION
I authorize the release of any information necessary to process claims and request payment of benefits either to myself or to the party who accepts assignment above. A photocopy of this Assignment shall be considered as effective and valid as the original.

___ Write your initials here to indicate that you have read, understand, and agree to this provision.

In the event your account becomes delinquent and is referred for collection, the undersigned agrees to pay for legal and/or collection fees.

AUTHORIZATION

I HAVE ADDED MY INITIALS WHERE REQUESTED ON PAGE 2 REGARDING PHONE MESSAGES, PAGE 2 REGARDING UNSECURED TEXT MESSAGES AND EMAILS, PAGE 4 REGARDING ALLERTING LAW ENFORCEMENT TO PROTECT THE PUBLIC, AND PAGE 6 REGARDING AUTHORIZATION TO PAY AND RELEASE OF INFORMATION.

I HAVE READ AND UNDERSTOOD THE POLICIES OUTLINED ABOVE. I AM THE RESPONSIBLE PARTY FOR THE CLIENT NAMED BELOW. MY SIGNATURE BELOW INDICATES THAT I AGREE TO TREATMENT UNDER THESE CONDITIONS.

Print Client Name: _____

Signature of Client: _____ Date: _____

Signature of Responsible Party: _____ Date: _____

Print Name of Responsible Party: _____

Relationship to Client: _____

Signature of Therapist: _____ Date: _____