<u>Policies and Statement of Informed Consent</u>

This document contains important information about Trilogy Psychological Services, LLC professional services and business policies. Please read it carefully and ask questions if you have any. It also contains summary information about the <u>Health Insurance Portability and Accountability Act</u> (HIPAA), a federal law that provides privacy protection and patient rights with regard to the use and disclosure of your Protected Health Information (PHI) used for the purpose of treatment, payment, and health care operations. HIPAA requires that we provide you with a Notice of Privacy Practices (the Notice) for use and disclosure of PHI for treatment, payment, and health care operations. The Notice which is attached to this Agreement explains HIPAA and its application to your personal health information in greater detail. The law requires that we obtain your signature acknowledging that we provided you with this information at the end of these group sessions. Although these documents are long and sometimes complex, it is very important that you read them carefully before our next session. We can discuss any questions you have about procedures at that time. When you sign this document, it will represent an agreement between us. You may revoke this agreement in writing at any time. That revocation will be binding on us unless we have taken action in reliance on it; if there are obligations imposed on us by your health insurer in order to process or substantiate claims under your policy; or if you have not satisfied any financial obligations you have incurred.

PSYCHOLOGICAL SERVICES AND FEES _________ Client's Initials (Or GUARDIAN if client is a minor)

Trilogy Psychological Services (TPS) offers neuropsychological assessment, psycho-educational and gifted intellect assessment, forensic evaluations, psycho-diagnostic sessions, psychotherapy and neuro-feedback. Neuropsychological evaluations typically require between 6 and 10 hours from diagnostic interview through the feedback session. Psycho-educational and gifted intellect assessments typically take between 2 and 4 hours in total. The fee for neuropsychological, psycho-educational assessment, psychotherapy, and forensic evaluation is $150.00 per hour. Trilogy clinicians are available to attend school meetings for $100.00 per hour door to door. While report writing is included in the assessment fee, letter writing is an additional 150.00 per hour. Neuro-feedback sessions are $100.00/hr.

COUNSELING / THERAPY SERVICES AND FEES _________ Client's Initials (Or GUARDIAN if client is a minor)
Therapy appointments are usually scheduled for 50 minutes. Longer appointments can be scheduled according to the client(s)' needs. Clients are generally seen weekly or more/less frequently as acuity dictates and you and your therapist agree. You may discontinue treatment at any time. The fee for individual and family therapy is $100.00 per hour. Group fees vary based on length and group size.

A 'no-show' is defined as failure to cancel a scheduled appointment 24 hours prior to the appointment or completely failing to show for a scheduled appointment. Our no-show fee is $50.00 per incident ($120.00 for a family/group session). Additionally, we require a non-refundable $300.00 retainer before we will schedule another appointment if a client cancelled two previous appointments. By signing this Agreement, you agree to comply with this policy.

CONTACTING TPS _________ Client's Initials (Or GUARDIAN if client is a minor)
Our office hours are typically 9 AM to 5 PM, Monday through Friday. The schedule will vary throughout the year. Individual provider availability may vary. We may be reached via phone at 480-813-3990 or via email at trilogypsychological@gmail.com . If no one answers the phone, leave a message with detailed information and we will return your call by the end of the next business day. We will respond to emails by the end of the next business day. If you are difficult to reach, please include in your message times that you

are most likely to be available. The clinical staff also finds it efficient to set phone appointments to ensure timely contact. If you are unable to reach us and feel that you cannot wait, you can call the **Maricopa Crisis Line @ 1-800-631-1314** or contact your family physician, call 911, or the nearest emergency room and ask for the psychologist or psychiatrist on call.

INTERNET CORRESPONDENCE(S)_________ Client's Initials (Or GUARDIAN if client is a minor)
It is often helpful to correspond through email over the internet. Trilogy uses secure email, however confidentiality cannot be guaranteed when communicating over the internet. If you would prefer that personal information not be exchanged over email, Trilogy staff will work with you to ensure that all communications will be conducted through direct interactions (phone or in person). By initialing the above you are permitting the exchange of confidential information over the internet and understand the limitations in confidentiality when doing so.

LIMITS ON CONFIDENTIALITY _________ Client's Initials (Or GUARDIAN if client is a minor)
The law protects the privacy of all communications between a patient and a psychologist. In most situations, we can only release information about your treatment to others if you sign a written authorization form that meets certain legal requirements imposed by the Health Insurance Portability Accountability Act (HIPAA). There are other situations that require you provide written advance consent. Your signature on this agreement provides consent for those activities, as follows:

- We may find it helpful to consult other medical and mental health professionals about a case. During a consultation we do not reveal the identity of the patient. The other professionals are also legally bound to keep the patient information confidential. If you do not object, we will not tell you about these consultations unless we feel it is important to our work together. We will note all consultations in your Clinical Record (which is called "PHI" in our Notice of Psychologist's Policies and Practices to Protect the Privacy of Your Health Information).

- You should be aware that we practice with other mental health providers and that we employ administrative staff. In most cases, we need to share protected information with these individuals for both clinical and administrative purposes, such as scheduling, billing and quality assurance. All of the mental health professionals are bound by the same rules of confidentiality. All staff members have been given training about protecting your privacy and have agreed not to release any information outside of the practice without the permission of a professional staff member who has prior written authorization. Disclosures required by health insurers or to collect overdue fees are discussed elsewhere in this Agreement. If a patient threatens to harm himself\herself, we may be obligated to seek hospitalization for him/her, or to contact family members or others who can help provide protection.

- Situations occur where we are permitted or required to disclose information without either your consent or Authorization:

    - If you are involved in a court proceeding and request is made for information concerning the professional services we provided you, such information is protected by the psychologist/therapist-patient privilege law. We cannot provide any information without you or your legal representative's written authorization, or a court order. If you are involved in or contemplating litigation, you should consult with your attorney to determine whether a court would be likely to order us to disclose information.

- If a government agency is requesting the information for health oversight activities, we may be required to provide it for them.

- If a patient files a complaint or lawsuit against us, we may disclose relevant information regarding that patient in order to defend ourselves.

There are some situations in which we are legally obligated to take actions, which we believe are necessary to attempt to protect others from harm and we may have to reveal some information about a patient's treatment. These situations may include:

- If we have reason to believe that a minor who we have examined is or has been the victim of injury, sexual abuse, neglect or deprivation of necessary medical treatment, the law requires us to file a report with the appropriate government agency, usually the Office of Child Protective Services. Once such a report is filed, we may be required to provide additional information.

- If we have reason to believe that any adult patient who is either vulnerable and/or incapacitated and who has been the victim of abuse, neglect or financial exploitation, the law requires us to file a report with the appropriate state official, usually a protective services worker. Once such a report is filed, we may be required to provide additional information.

- If a patient communicates an explicit threat of imminent serious physical harm to a clearly identified or identifiable victim including themselves, and we believe that the patient has the intent and ability to carry out such threat, we must take protective actions that may include notifying the potential victim, contacting the police, or seeking hospitalization for the patient.

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 now or in the future. The laws governing confidentiality can be quite complex, and we are not attorneys. In situations where specific advice is required, formal legal advice may be needed.

PROFESSIONAL RECORDS __________ Client's Initials (Or GUARDIAN if client is a minor)
The laws and standards of our profession require that we keep Protected Health Information about you in your Clinical Record. It includes information about your reasons for seeking services, a description of the ways in which your problem impacts your life, your diagnosis, the goals that we set for treatment, your progress towards those goals, your medical and social history, your treatment history, any past treatment records that we receive from other providers, reports of any professional consultations, your billing records, and any reports that have been sent to anyone, including reports to your insurance carrier.

PATIENT RIGHTS __________ Client's Initials (Or GUARDIAN if client is a minor)
HIPAA provides you with several new or expanded rights with regard to your Clinical Record and disclosures of protected health information. These rights include requesting that we amend your record; requesting restrictions on what information from your Clinical Record is disclosed to others; requesting an accounting of most disclosures of protected health information that you have neither consented to nor authorized; determining the location to which protected information disclosures are sent; having any complaints you make about our policies and procedures recorded in your records; and the right to a paper copy of this Agreement, the attached Notice form, and our privacy policies and procedures. We are happy to discuss any of these rights with you.

MINORS & PARENTS _________ Client's Initials (Or GUARDIAN if client is a minor)
Trilogy provides testing, assessments and counseling to minors, defined to be individuals under the age of 18.
If a parent/legal guardian is bringing the child in for services, the **written consent of both parents** or legal guardians is required except as otherwise determined by law. Additional documentation of guardianship might need to be provided in certain circumstances, such as divorce, before treatment can begin.

BILLING AND PAYMENTS _________ Client's Initials (Or GUARDIAN if client is a minor)
Payment is due at the time of service. Please see our fee schedule, attached. Payment and/or copayment is due upfront. If you do not use insurance you will be responsible for pursuing any reimbursement from your insurance provider. Trilogy will provide you with a receipt for services for your records and to submit to the insurance company if necessary.

Upon scheduling your first appointment, you will be required to give your credit card information and agree to authorize Trilogy to charge that card for your sessions in the event that other payment has not been made at the time of service, or in the event of late cancellation or missed session that was not cancelled prior to 24 hr notice.

If your account has not been paid for more than 60 days and arrangements for payment have not been agreed upon, we have the option of using legal means to secure the payment. This may involve hiring a collection agency or going through small claims court which will require us to disclose otherwise confidential information. In most collection situations, the only information we release regarding a patient's treatment is his/her name, the nature of services provided, and the amount due. If such legal action is necessary, all costs will be included in the claim and be the responsibility of the patient.

INSURANCE REIMBURSEMENT _________ Client's Initials (Or GUARDIAN if client is a minor)
Though all insurance companies claim to keep client information confidential, we have no control over what is done with it once it is in their hands. By signing this Agreement, you agree that we can provide any and all requested information to your carrier.

APPROVAL GIVEN
By signing this agreement you give us the permission to treat you or your child in accordance with the information stated in this document. This treatment includes but is not limited to neuropsychological assessment, psycho-educational/intellectual assessment, psychotherapy, group therapy and other treatments previously discussed and agreed upon with the patient.

Consent for Treatment
By signing below, you are stating that:

1) You have read and understood this 4-page (including this page) policy statement.

2) You have had your questions answered to your satisfaction.

I accept, understand, and agree to abide by the contents and terms of this agreement. Further, I consent to participate in evaluation and/or treatment. I understand that I may withdraw from treatment at any time

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Patient's Name

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Guardian's Name if patient is a minor

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Guardian's Name if patient is a minor

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Patient or Guardian's Signature

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Date

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Patient or Guardian's Signature

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Date