POYNER
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INFORMED CONSENT FOR TREATMENT AND/OR OTHER 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. By signing this document, you certify that you have read it in its entirety (six pages), understand it, agree with and will abide by each provision.

IMPORTANT

- For their safety, children under the age of 13 cannot be left alone in the waiting room. Parents/Guardians are ultimately responsible for the safety of their children, including those 13 or older when left in the waiting room unsupervised.
- For everyone's safety, firearms, knives or other weapons are not allowed on the premises.
- To keep our office clean: no food or drink (other than water or food for babies) are allowed inside the building.
- Regarding substances: smoking and vaping are not allowed within 30 feet of our office, and no illicit drugs or alcohol are allowed on the premises.

THERAPY SERVICES

Psychotherapy is not easily described in general statements. It varies depending on the personalities of the clinician and patient and the particular problems you hope to address. There are many different methods I may use in therapy. Psychotherapy calls for an active effort on your part. In order for therapy to be most successful, you will have to work on things we talk about 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. On the other hand, although there are no guarantees as to what you will experience, psychotherapy has also been shown to have benefits for people who go through it. If you have concerns about working with me, it is important that we discuss them. However, to best meet your needs, I am always willing to facilitate a referral to another mental health professional. The same is true if I believe I am not the best therapist to meet your needs.

TESTING, ASSESSMENTS AND EVALUATIONS

If you request testing or an evaluation for yourself or a child, the assessment generally begins with an informational interview followed by the administration of psychological and/or educational tests. You have the right to inquire about the nature and purpose of all tests and procedures, and you have the right to receive feedback about test results/interpretations/recommendations, unless there is an entity that can legally state otherwise. In these cases, no confidentiality exists and I have no control over who has access to the information. In certain cases (legal, child protective cases, military, Social Security disability and others), the results of an evaluation could have the potential to positively or negatively impact a person, but you *always* have the right to refuse to participate in an evaluation. Although it is sometimes possible to complete testing in one sitting, an evaluation typically requires several hours or more. The types of feedback you receive could include verbal explanations, a comprehensive written report or a general summary. Feedback typically occurs in person, but in some cases we can do this via telephone. Important: Your insurance statements may show services on a date when you or your child were not in the office. This is because we are allowed to charge for test scoring, interpretation and report writing. You will be responsible for co-pays as directed by your insurance.

MEETINGS, PROFESSIONAL FEES, BILLING AND PAYMENTS

Therapy typically consists of a once-weekly 50-minute session, but could occur more often depending on circumstances. Note: I cannot guarantee that you will be given appointments on a same day or same time basis. My hourly fee for therapy, testing and consultation is $80. You will be expected to pay for each service at the time it is given unless we agree otherwise, or unless you have insurance covering the services I provide. Payments include but are not limited to self-pay, **co-pays**, **deductibles**, no shows and/or late cancellation fees. In some, but not all, cases we will allow a one-time allowance for missing payments, but the amount due must be paid prior to the next appointment, or you will have to be rescheduled. We reserve the right to charge a $50 no-show fee or late cancellation fee, unless certain circumstance apply, as well as a $50 fee for returned checks. 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 and/or collections. If these actions are necessary, their costs will be included in the claims. In most 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.

If you have a health insurance policy, it will usually provide coverage for mental health treatment. However, you (not your insurance company) are responsible for the full payment of fees. ***You understand and agree that it is your responsibility to obtain any preauthorization of services required by your insurance—even if we have contacted your insurance and receive authorization or have attempted to receive authorization. If you do not obtain preauthorization and it is required by your insurance, you acknowledge that you are responsible for payment.*** Although we will do our best to determine if your insurance covers our services, we cannot guarantee coverage or continued coverage. Please read your insurance coverage information and call your plan administrator if you have any concerns about payment. You should also be aware that most insurance companies require that I provide them with your clinical diagnosis, but sometimes I'm required to provide additional clinical information, such as treatment plans, progress notes, summaries or copies of the entire record (in rare cases). I cannot guarantee that your insurance company will keep your records confidential. Please call your plan administrator if you have any concerns. ***By using your insurance, you authorize me to release such information to your insurance company.***

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. In the case of parenting and/or child issues, if I am required to testify, I will **NOT** give an opinion about either parent's custody, visitation, suitability, or fitness. If the court appoints a custody evaluator or guardian *ad litem*, I will only provide information if appropriate releases are signed or a court order is provided. If I am required to appear as a witness or perform work related to any legal matter, the party responsible for my participation agrees to reimburse me at the rate of $150 per hour for time spent traveling, speaking with attorneys, reviewing and preparing documents, testifying, being in attendance and/or any other case-related costs. **Important**: Your insurance will *not* cover legal services or fees.

COMMUNICATION

I am often not immediately available by telephone. When I am unavailable, my telephone is answered by office staff or 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. However, due to my schedule, I am unable to engage in lengthy, non-emergency services that can be reasonably addressed in therapy. If you are unable to reach me and there is an emergency (i.e. thoughts of suicide/homicide/self-harm) you must call 911 or go to the nearest emergency room. Our office is open M-Th from 8:00 a.m. – 5:00 p.m. We are closed on Friday unless you have a special arrangement. I do not email, text or communicate via social media with the people who see me. Nor do I respond to this type of communication from anyone in treatment with me. Regarding other forms of communication, if you provide this office with a telephone number, you are giving me or my staff permission to contact you and/or leave a voicemail, unless you state otherwise in writing. In addition, you give me permission to fax or electronically transmit billing and/or collections information. Finally, you give me and my staff permission to fax information you have approved with a signed release of confidentiality (such as records) or is mandated by an outside entity (i.e. legal or protective services). I reserve the right to charge ten cents per page of copied material.

ACCESS AND STORAGE OF RECORDS AND ELECTRONIC HEALTH INFORMATION

Your records are stored in the following manners: Paper file that is stored in a locked office in a locked file cabinet and/or in an electronic file that is protected by encryption.

DRIVING IMPAIRMENT

I respectfully request that you be free of alcohol or other intoxicants prior to coming in for therapy so that we can have the best chance of being successful in our work together. If, during the session, I come to suspect that your senses are impaired in any way, I will address that concern to determine if we can continue the treatment session. If, in fact, you are "intoxicated" for whatever reason, the session will end and I or my office staff will attempt to make arrangements for safe transportation from my office. This may involve calling a relative, friend, emergency contact, or calling a taxi cab. If, for some reason, you refuse to cooperate, then I have the option to contact the police in order to ensure your safety and the safety of others. In the event that a session is ended due to suspected intoxication, the full fee for the session will be due, regardless of the actual duration of the session. If I have realistic concerns related to your ability to drive safely because of, but not limited to, mental illness, dementia or a medical problems, I reserve the right to contact the Department of Public Safety in that regard. However, I will always advise you of this step prior to any contact.

CONFIDENTIALITY

In general, the privacy of all communications between a patient and a clinician is protected by law. Releasing information requires your written permission except in certain circumstances. If a judge orders my testimony or records, I must comply. I am legally required to take protective actions if I believe that a child, vulnerable adult or elderly person is being abused or has been abused, or if I believe a person has the intention or plan to hurt themselves or another person. These actions may include notifying a state agency and/or a potential victim and/or contacting the police and/or seeking inpatient care. However, I will attempt to fully discuss it with you before taking any action.

You should be aware that I practice with other health professionals and that I may employ administrative staff. In most cases, I need to share protected information with these individuals for both clinical (consultation with clinicians only) and administrative staff for such services as scheduling, billing and quality assurance. During a consultation, I make every effort to avoid revealing the identity of my patient, and any clinician with whom I consult 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. All clinicians and staff members will be given training about protecting your privacy and will agree not to release any information outside of the practice without the permission of a professional staff member.

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 you. I will be happy to discuss these issues with you and provide clarification upon your request. 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.

PARENT AUTHORIZATION FOR MINOR'S MENTAL HEALTH TREATMENT

In order to authorize mental health treatment for your child, you must have either sole or joint legal custody of your child. If you are separated or divorced from the other parent of your child, please notify me immediately. I will ask you to provide me with a copy of the most recent custody decree that establishes custody rights of you and the other parent or otherwise demonstrates that you have the right to authorize treatment for your child. If you are separated or divorced from the child's other parent, please be aware that I may find it necessary to contact the other parent and advise them I am meeting with your child. I believe it is important that all parents have the right to know, unless there are truly exceptional circumstances, that their child is receiving mental health evaluation or treatment.

One risk of child therapy involves disagreement among parents and/or disagreement between parents and the therapist regarding the child's treatment. If such disagreements occur, I will listen carefully so that I can understand your perspectives and fully explain my perspective. Ultimately, parents decide whether therapy will continue. If either parent decides that therapy should end, I will honor that decision unless there are extraordinary circumstances. However, in most cases, I will ask that you allow me the option of having a few closing sessions with your child to appropriately end the treatment relationship.

In the course of my treatment of your child, I may meet with the child's parents/guardians separately or together. Note: my patient is your child – not the parents/guardians/siblings/other family members of the child. If I meet with you or other family members in the course of your child's treatment, I may document the meeting in your child's treatment records. Please be aware that progress notes will be available to any person or entity that has legal access to your child's treatment record. In some situations, I am required by law or by the guidelines of my profession to disclose information, whether or not I have you or your child's permission. I have listed some of these situations below.

Confidentiality ***cannot be maintained*** when:

- A child tells me they plan to cause serious harm or death to themselves, and I believe they have the intent and ability to carry out this threat in the very near future. I must take steps to inform a parent or guardian or others of what the child has told me and how serious I believe this threat to be and to try to prevent the occurrence of such harm.
- A child tells me they plan to cause serious harm or death to someone else, and I believe they have the intent and ability to carry out this threat in the very near future. In this situation, I must inform a parent or guardian or others, and I may be required to inform the police and/or the person who is the target of the threatened harm.
- A child is doing things that could cause serious harm to them or someone else, even if they do not intend to harm themselves or another person. In these situations, I will need to use my professional judgment to decide whether a parent or guardian should be informed.
- A child tells me, or I otherwise learn that, it appears that a child is being neglected or abused--physically, sexually or emotionally--or that it appears that they have been neglected or abused in the past. In this situation, I am required by law to report the alleged abuse to the appropriate state child-protective agency.
- I am ordered by a court to disclose information.

DISCLOSURE OF MINOR'S TREATMENT INFORMATION TO PARENTS

Therapy is most effective when a trusting relationship exists between the clinician and the patient. Privacy is especially important in earning and keeping that trust. As a result, it is important for children to feel free to discuss personal matters without fear that their thoughts and feelings will be immediately communicated to their parents. It is my policy to provide you with general information about your child's treatment, but not to share specific information your child has disclosed to me without your child's agreement, unless what is shared puts the child in danger. You can always ask me questions about the types of information I would disclose. Even

when we have agreed to keep your child's treatment information confidential from you, I may believe that it is important for you to know about a particular situation that is going on in your child's life. As such, when meeting with you, I may sometimes describe your child's problems in general terms, without using specifics, in order to help you know how to be more helpful to your child.

PARENT/GUARDIAN AGREEMENT NOT TO USE MINOR'S THERAPY INFORMATION/RECORDS IN CUSTODY LITIGATION

When a family is in conflict, particularly conflict due to parental separation or divorce, it is very difficult for everyone, particularly for children. Although my responsibility to your child may require my helping to address conflicts between the child's parents, my role will be strictly limited to providing treatment to your child. You agree that in any child custody/visitation proceedings, neither of you will seek to subpoena my records or ask me to testify in court, whether in person or by affidavit, or to provide letters or documentation expressing my opinion about any matter related to you or your child. However, your agreement may not prevent a judge from ordering my testimony. If I am required to testify, I am ethically bound not to give my opinion about either parent's custody, visitation suitability, or fitness. If the court appoints a guardian ad litem or Child Protective Services is involved, I may be compelled to release information.

NOTICE OF POLICY AND PRACTICES TO PROTECT THE PRIVACY OF YOUR HEALTH INFORMATION (PHI)
Health Insurance Portability and Accountability Act (HIPAA)

This notice describes how psychological and medical information about you may be used and disclosed and how you can obtain access to this information. **Please review this policy 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 healthcare operations and purposes with your consent. To help clarify these terms, here are some definitions:

a. "PHI" refers to information in your health record that could identify you.
b. Treatment, Payment and Health Care Operations:
    - "Treatment" is when I provide, coordinate or manage your health care and other services related to your health. An example of treatment would be when I consult with another health care provider, such as your family physician, primary care physician or another clinician.
    - "Payment" is when I obtain reimbursement for your healthcare. Examples of payment are when I disclose your PHI to your health insurer to obtain reimbursement for your healthcare 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, case management and care coordination.
c. "Use" applies on to activities within my office/practice such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.
d. "Disclosure" applies to activities outside my office/practice 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 without your consent or authorization in the following circumstances:

- Child Abuse or Neglect: If I have reason to believe that a child under the age of 18 years is the victim of abuse or neglect, the law requires that I make a report to the appropriate government agency, usually to the Department of Human Services. Once such a report is filed, I may be required to provide additional information.
- Adult or Domestic Abuse: If I have reason to believe that a vulnerable adult is suffering from abuse, neglect or exploitation, I am required by law to make a report to either the Oklahoma Department of Human Services, the District Attorney's office or the Municipal Police Department as soon as I become aware of the situation. A vulnerable adult means an individual who is an incapacitated person who, because of physical or mental disability, incapability or other disability, is substantially impaired in the ability to provide adequately for the care or custody of him/herself, or is unable to manage his/her property and financial affairs effectively, or to meet essential requirements for mental or physical health or safety, or to protect him/herself from abuse, neglect or exploitation without assistance from others.
- Health Oversight: If you file a disciplinary complaint against me with the Oklahoma State Board of Examiners of Psychologists or Oklahoma State Board of Mental Health, they would have the right to view your relevant confidential information as part of the proceedings.

- Judicial or Administrative Proceedings: If you are involved in a court proceeding and a request is made for information about your diagnoses and treatment and records thereof, such information is privileged under State law and I will not release the information without written authorization from you or your personal or legally appointed representative, or a court order. The privilege does not apply when you are being evaluated for a third party or where the evaluation is court ordered. You will be informed in advance if this is the case.
- Serious Threat to Health and Safety: If you communicate to me an explicit threat to kill or inflict serious bodily injury upon a reasonably identifiable person, and you have the apparent intent and ability to carry out that threat, I have the legal duty to take reasonable precautions. These precautions may include disclosing relevant information from your mental health records, which is essential to protect the rights and safety of others. I also have such a duty if you have a history of physical violence of which I am aware, and I have reason to believe there is a clear and imminent danger that you will attempt to kill or inflict serious bodily injury upon a reasonably identifiable person.
- Worker's Compensation: If you file a Worker's Compensation claim, you will be giving permission for the Administrator of the Worker's Compensation Court, the Oklahoma Insurance Commissioner, Attorney General or District Attorney (or a designee for any of these) to examine your records relating to the claim.
- Appointment Reminders: I may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards or letters).
- Agency Review: As an agency contracted with the State of Oklahoma, PHI can be released to the Oklahoma Health Care Authority or Oklahoma Department of Mental Health and Substance Abuse Services for oversight activities as authorized by law, including conducting or arranging for a medical review, auditing functions, including fraud, abuse detection and compliance programs. In addition, our compliance officer conducts periodic quality control audits or institutional reviews which will require access to your records.

III. Patient's Rights and Clinician's Duties

You have the following rights regarding PHI we maintain about you. To exercise any of these rights, please submit your request in writing to our Privacy Officer (Kim Woodhouse, LPC) at 14453 SE 29th St. Suite D, Choctaw, OK 73020:

- Right to Request Restrictions: You have the right to request restrictions on certain uses and disclosures of Protected Health Information about you. 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 right 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. Upon 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 may deny your access to PHI under certain circumstances, but in some cases you may have this decision reviewed. On your request, I will discuss with you the details of the request and 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 record. I may deny your request, but on your request, I will discuss with you the amendment process.
- Right to an Accounting: You generally have the right to receive an accounting of disclosures of PHI regarding you. On your request, I 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 have agreed to receive the notice electronically.
- Clinician'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. 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, I will notify you in writing by mail, or at your next appointment.

IV. Questions and Complaints

If you desire further information about our privacy practices, or if you have questions, please contact this office. If you are concerned that your privacy rights have been violated or you disagree with a decision I made about access to your records, you may contact the Privacy Officer (Kim Woodhouse, LPC) of Poyner Psychological Services at 14453 SE 29th St. Ste. D Choctaw, OK 73020. You may also send a written question or complaint to the Secretary of the U.S. Department of Health and Human Services. The person listed above can provide you with the appropriate address upon request. We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or the U.S. Department of Health and Human Services.

V. Effective Date, Restrictions, and Changes to Privacy Policy

This notice will go into effect on January 1, 2019. I reserve the right to change the terms of this notice and to make the new notice provisions effective for all PHI that I maintain. I will provide you with a revised notice in writing by mail or at your next appointment.

You have the right to services:

- That respect your privacy and dignity; that they are provided in a prompt, courteous and respectful manner;
- That respect your cultural and ethnic identity, religion, disability, gender, age, marital status and sexual orientation;
- That are provided in a physical environment that is safe, sanitary, allows for effective treatment and which safeguards the privacy and confidentiality of interactions with your provider;
- From providers who are qualified, competent, focused on your care, and reasonably accessible to you;
- That emphasize your participation in developing a treatment plan specific to your needs and include your agreement to work toward defined goals;
- That in relation to admission, discharge or treatment, are free of discrimination on the basis of age, sex, race, creed, color, national origin, ethnicity, religion, pregnancy, marital status, disability or sexual orientation.

Rights to Current Information Concerning:

- Your diagnosis, recommended appropriate or medically necessary treatment options that relate to your care, potential alternatives and accompanying risks, benefits and costs (in writing for Medicare patients). This information, regardless of cost or benefit coverage, will be explained in terms and in a language that you can reasonably understand;
- Written financial agreements in which you entered for treatment services rendered;
- Possible consequences or conditions under which you may be transferred to another treatment program or therapist and the accompanying risks, benefits and costs of such a transfer;
- Names and credentials of providers involved in your care;
- Your responsibilities to ensure better treatment outcomes;
- Your records and having information explained or interpreted as necessary, except when protected or restricted by law;
- How to access emergency services needed outside of normal business hours or when you are away from you usual place of residence or work;
- How your healthcare insurance plan evaluates new technology for inclusion as a covered benefit;
- How to select a new behavior healthcare delivery office or provider if your current provider is affected by termination or closure;
- Resources and procedures available through your healthcare insurance plan for communicating concerns or questions, for expressing dissatisfaction with services or care, and for requesting an appeal if not satisfied with any decisions regarding dissatisfaction with services or care;
- Services available to you and charges for those services including services not covered under health plan's benefits.

INFORMED CONSENT FOR TREATMENT AND/OR OTHER SERVICES CONTRACT

Patient Name: _____ Guardian: (if patient is a child): _____

The client or responsible party must sign this form before services can begin.

By signing below, I certify that I have read, had any questions answered, fully understand, agree with and will abide by the provisions contained in the entire INFORMED CONSENT FOR TREATMENT AND/OR OTHER SERVICES CONTRACT. If you would like a copy of this document, please let us know.

_____ _____

Patient or Guardian or Authorized Patient Representative Date