**C.A.A.T. PSYCHOLOGICAL SERVICES, INC.**

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(657) 234-2206

**Therapy Packet**

Includes:

Notice of Policies and Practices to Protect the Privacy of Your Health

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**Notice of Policies and Practices to Protect the Privacy of Your Health Information and the Health Insurance Portability and Accountability Act (HIPAA)**

This notice describes how psychological and medical information about clients and/or their families may be used and disclosed and how clients and/or their families 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 protected health information* (*PHI*) related to the client and/or their families for *treatment, payment, and health care operations* with their *consent*. To help clarify these terms, here are some definitions:

* “*PHI”* refers to information in the client’s health record that could identify the client.
* *“Treatment, Payment and Health Care Operations”* 
  + *Treatment* is when I provide, coordinate or manage the client’s health care and other services related to their health care. An example of treatment would be when I consult with another health care provider, such as their physician or another mental health provider.
  + *Payment* is when I obtain reimbursement for the client’s health care. Examples of payment are when I disclose their PHI to their health insurer related to reimbursement for their 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 case management and care coordination, supervision, quality assessment and improvement activities, and business-related matters such as audits and administrative services.
* “*Use*” applies only to activities within my office such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies the client.
* “*Disclosure*” applies to activities outside of my office such as releasing, transferring, or providing access to information about the client and/or their families to other parties.

**II. Uses and Disclosures Requiring Authorization**

I may use or disclose PHI for purposes outside of treatment, payment, and health care operations when the client’s and/or their families’ 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 and health care operations, I need to obtain an authorization before releasing PHI, which includes psychotherapy notes. *“Psychotherapy Notes”* are notes I have made about conversations during an individual, group, joint, family counseling or psychological testing session.

Any use or disclosure of Psychotherapy Notes requires your Authorization unless the use or disclosure is:

a. For my use in treating you.

b. For my use in training or supervising mental health practitioners to help them improve their skills in group, joint, family, or individual counseling or therapy.

c. For my use in defending myself in legal proceedings instituted by you.

d. For use by the Secretary of Health and Human Services to investigate my compliance with HIPAA.

e. Required by law and the use or disclosure is limited to the requirements of such law.

f. Required by law for certain health oversight activities pertaining to the originator of the psychotherapy notes.

g. Required by a coroner who is performing duties authorized by law.

h. Required to help avert a serious threat to the health and safety of others.

Clients and/or their families may revoke authorizations at any time, provided each revocation is in writing. Clients and/or their families 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, and the law provides the insurer the right to contest the claim under the policy.

**III. Uses and Disclosures with Neither Consent nor Authorization**

I may use or disclose PHI without consent or authorization in the following circumstances:

* *Child Abuse*: If I have reasonable cause to believe that a child has suffered abuse or neglect, I am required by law to report it to the proper law enforcement agency or the California Department of Social Services. If a report is filed I may be required to provide additional information.
* *Adult and Domestic Abuse*: If I have reasonable cause to believe that abandonment, abuse, financial exploitation, or neglect of a vulnerable adult has occurred, I must immediately report the abuse to the California Department of Social Services. If I have reason to suspect that sexual or physical assault has occurred, I must immediately report to the appropriate law enforcement agency and to the Department of Social Services. If a report is filed I may be required to provide additional information.
* *Health Oversight*: If the California Board of Psychology subpoena me as part of investigations, hearings or proceedings relating to the discipline, issuance or denial of licensure, I must comply. This could include disclosing relevant mental health information.
* *Judicial or Administrative Proceedings*: If clients and/or their families are involved in a court proceeding and a request is made for information about the professional services that I have provided and the records thereof, such information is privileged under state law, and I will not release information without the written authorization by clients and/or their families or their legal representative, or a subpoena of which you have been properly notified and clients and/or their families have failed to inform me that they are opposing the subpoena, or a court order. The privilege does not apply when clients and/or their families are being evaluated for a third party or where the evaluation is court ordered. Please notify me immediately if there is a desire to challenge and attempt to withhold any legal request for records or PHI. I may assist in this process to the extent authorized by law and if circumstances justify further protecting PHI.
* *Serious Threat to Health or Safety*: I may disclose confidential mental health information to any person without authorization if I reasonably believe that disclosure will avoid or minimize imminent danger to the health or safety of the client, or the health or safety of any other individual.
* *Worker’s Compensation, Law Enforcement and other Government Requests*: If clients and/or their families file a worker's compensation claim, with certain exceptions, I must make available all mental health information in my possession relevant to that particular injury in the opinion of the California Department of Industrial Relations, to the relevant employer, representative, and the Division of Worker’s Compensation upon request. I can share or use PHI for special government activities such as law enforcement, military, national security and presidential protective services.
* *Other Situations*: I am permitted or required to disclose information without either consent or authorization in the following situations:
  + If a government agency is requesting the information for health oversight activities, I may be required to provide it for them.
  + If there is a complaint or lawsuit against me, I may disclose relevant information in order to defend myself.
  + I am allowed to share your information to respond to organ and tissue donation requests and to work with a medical examiner or funeral director when an individual dies.
  + There are some situations in which I am legally obligated to take actions, which I believe are necessary to attempt to protect others from harm and I may have to reveal some information about my services provided. These situations are unusual in my practice. These actions may include notifying the potential victim, contacting the police, seeking hospitalization for the client’s care, or contacting family members or others who can help provide protection. If such a situation arises, I strive, but may not be able, to discuss it with clients and/or their families before taking any action and I will limit my disclosure to what is necessary.
  + For appointment reminders and health related benefits or services. I may use and disclose your PHI to contact you to remind you that you have an appointment with me. I may also use and disclose your PHI to tell you about treatment alternatives, or other health care services or benefits that I offer.

I hope that this written summary of exceptions to confidentiality is helpful. It is important that we discuss any questions or concerns that you may have. The laws governing confidentiality can be quite complex, there are times when I may need to seek formal legal advice.

I never share PHI for marketing purposes. I never sell PHI. I will never contact clients or their families for fundraising efforts. I do not include client’s names in a hospital or any other directory. I do not disclose PHI in the conduct of research.

**IV. Client’s Rights and Provider’s Duties**

*Client’s Rights*

* *Right to Request Restrictions*: Clients and/or their families have the right to ask me not to use or share certain health information for treatment, payment or health care operations. I am not required to agree to a restriction requested. If payment for a service is made out-of-pocket in full, clients and/or their families may ask me not to share that information with their health insurer. I will agree unless a law requires me to share the information.
* *Right to Receive Confidential Communications by Alternative Means and at Alternative Locations*: Clients and/or their families have the right to request and receive confidential communications of PHI by alternative means and at alternative locations. For example, clients may not want a family member to know that they are seeing me. Upon request, I may send bills to another address.
* *Professional Records – Right to Inspect and Copy*: The laws and standards of my profession require that I keep Protected Health Information about clients and/or their families in the client’s Clinical Record. Clients and/or their families may submit a written request to see or obtain a copy of the PHI in my mental health and billing records for as long as the PHI is maintained in the record. Except in the circumstance that I conclude that disclosure could reasonably be expected to be injurious to the health or to the life or safety of another, or that disclosure could reasonably be expected to lead to identification of a person who provided information to me in confidence under circumstances where confidentiality is appropriate, clients and/or their families may examine and/or receive a copy of the Clinical Record, usually within 30 days. In most situations, I am allowed to charge a reasonable copying fee. I may withhold the Record until the fees are paid, with some exceptions in emergency situations. If I refuse the request for access to the client’s records, clients and/or their families have a right of review, which I will discuss upon request.
* *Right to Amend*: Clients and/or their families have the right to request corrections to health information that they believe is incorrect or incomplete. I have the right deny the request and will tell you why in writing within 60 days.
* *Right to an Accounting*: Clients and/or their families have the right to receive an accounting of disclosures of PHI for 6 years prior to the date asked, including whom I shared information with and why. I will include all disclosures which clients and/or their families have neither provided consent nor authorization (as described in Section III of this Notice). I will not include disclosures for those about treatment, payment and health care operations and certain other disclosures clients and/or their families may have asked me to make. I will provide one accounting a year for free but may charge a reasonable, cost-based fee for additional requests made within 12 months.
* *Right to a Paper* Copy: Clients and/or their families have the right to request a paper copy of this notice from me at any time, even if they have agreed to receive the notice electronically. I will provide a paper copy promptly, once requested.
* *Right to Choose Someone to Act for You*: If clients and/or their families have given someone medical power of attorney or if someone is the client’s legal guardian, that person can exercise rights and make choices about the client’s health information. I will make sure that person has this authority and can act for the client before I take any action.

I will not use or share PHI other than as described in this notice unless clients and/or their families request in writing. Clients and/or their families may revoke permission to share information at any time by submitting a written request.

*Provider’s Duties*

* I am required by law to maintain the privacy of PHI, to follow the duties and practices described in this notice and to provide clients and/or their families with a copy of this notice.
* I will inform clients and/or their families promptly if a breach occurs that may have compromised the privacy or security of PHI.

**V. Questions and Complaints**

If clients and/or their families have questions about this notice, disagree with a decision I make about access to the client’s records, or have other concerns about privacy rights, they may contact me at (657) 234-2206.

If clients and/or their families believe that privacy rights have been violated and wish to file a complaint with me, they may send their written complaint to me at 1820 West Orangewood Ave, Ste 105, Orange, CA 92868. They may also send a written complaint to the Board of Psychology 1625 North Market Blvd., Ste N-215, Sacramento, CA 95834. I will not retaliate against anyone for exercising their right to file a complaint.

**Acknowledgement of Receipt of Privacy Notice**

Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), you have certain rights regarding the use and disclosure of your protected health information. By checking the box below, you are acknowledging that you have received a copy of HIPAA Notice of Privacy Practices.

BY SIGNING BELOW I AM AGREEING THAT I HAVE READ, UNDERSTOOD AND AGREE TO THE ITEMS CONTAINED IN THIS DOCUMENT.

**AGREEMENT FOR SERVICE / INFORMED CONSENT**

**INTRODUCTION**

This Agreement is intended to provide the “Client” (i.e. you or your child) with important information regarding the practices, policies, and procedures of CAAT Psychological Services, Inc. and its provider Dr. Tiffany Shader (herein “Therapist”), and to clarify the terms of the professional therapeutic relationship between Therapist and Client. Any questions or concerns regarding the contents of this Agreement should be discussed with Therapist prior to signing it.

**BENEFITS AND RISKS OF TREATMENT**

Psychotherapy is a process in which Therapist and Client discuss numerous issues, events, experiences, and memories for the purpose of creating positive change so Client can experience his/her/their life more fully. It provides an opportunity to better and more deeply understand oneself, as well as any problems or difficulties Client may be experiencing. Psychotherapy is a joint effort between Client and Therapist. Progress and success may vary depending upon the particular problems or issues being addressed, as well as many other contextual factors.

Participating in therapy may result in a number of benefits to Client, including, but not limited to reduced stress and anxiety, a decrease in negative thoughts, changes in behavior, improved interpersonal relationships, better comfort in social, work, school, or family settings, and improved self-confidence. Such benefits may also require substantial effort on the part of Client, including active participation in the therapeutic process, honesty, and a willingness to change feelings, thoughts, and behaviors. A minor client may benefit most from psychotherapy when his/her/their parents, guardians, or other caregivers are supportive of the therapeutic process. There is no guarantee that therapy will yield any or all of the benefits listed above.

Participating in therapy may also involve some discomfort including remembering and discussing unpleasant events and experiences. The process may evoke strong feelings of sadness, anger, fear, etc. There may be times in which Therapist will challenge Client’s perceptions and assumptions and offer different perspectives. The issues presented by Client may result in unintended outcomes, including changes in personal relationships. Client should be aware that any decision on the status of his/her personal relationships is the responsibility of Client.

During the therapeutic process, many Clients find that they feel worse before they feel better. This is generally a normal course of events. Personal growth and change may be easy and swift at times but may also be slow and frustrating. Client should address any concerns he/she/they has regarding his/her/their progress in therapy with Therapist. I will help you to secure an appropriate consultation with another mental health professional if you desire one.

**PROFESSIONAL CONSULTATION**

Professional consultation is an important component of a healthy psychotherapy practice. As such, Therapist regularly participates in clinical, ethical, and legal consultation with appropriate professionals. During such consultations, Therapist will not reveal any personally identifying information regarding Client.

**MY TREATMENT MODALITIES**

I utilize evidence-based treatment, most commonly *Cognitive Behavioral Therapy*. What this means is that I help kids, teens, and/or parents with the following:

1. **Emotions**: Identifying, expressing, and understanding your emotions, including “stuck” emotions like anxiety or depression
2. **Thoughts**: Getting clear on negative, harsh thoughts about yourself or others, and examining them closely to see if there are healthier ways of thinking about yourself or others
3. **Behaviors**: Behaviors are anything that we do. Some behaviors help us, others harm us – my job is to help you get clear on what your behaviors are, if they’re helping or harming, and how to help you do more behaviors that make you feel better
4. **Relationships**: Relationships is anything to do with other people. If friendships, family relationships, or romantic relationships are giving you trouble, then we’ll seek to figure out what the issues are, and work towards creating a better relationship that works for who you are and what you need

**HOURS, AVAILABILITY & FEES**

Therapy sessions are typically 50-minutes, one time per week or every other week. The fee is $250 per 50-minute session. During our first few sessions, we can both decide if I am the best person to provide the services that you need in order to meet your treatment goals. During this period, you should evaluate whether you and your child feel comfortable working with me. Therapy involves a commitment of time, money, and energy, so you should be intentional about the therapist you select.

If psychotherapy is begun, I will schedule one 50-minute session per week or every other week at a time we agree on. Occasionally, due to scheduling limitations or the needs of a particular child/teen/parent, sessions will be less than 50 minutes. **Once an appointment hour is scheduled, you will be expected to pay for it unless you provide a 48 hour advance notice of the cancellation.** Clients are expected to pay for services at the time services are rendered. Clients’ credit card will be charges after services are rendered. Therapist reserves the right to use the services of a collection agency when other reasonable efforts to obtain payment or arrangements for payment of services have been exhausted.

**SESSION LOCATION**

VIRTUAL: Due to the current Covid-19 pandemic, sessions are generally held virtually through *Simple Practice*. At the beginning of therapy, you will gain access to a client portal in *Simple Practice*. Through this portal you and/or your child will be able to join virtual sessions.

INDOORS: Once the pandemic improves, and I am ready to begin meeting with clients indoors, I will let you know and offer you the chance to meet at my office. The decision to continue sessions virtually versus changing to indoors meetings, is entirely up to you and your child/teen. I am happy to consult with you on the pros and cons of virtual vs. indoor meetings. A hybrid option is always available as well.

**INSURANCE**

I am not on any insurance panels, but I would be happy to create an insurance-ready bill for you to submit to your carrier for reimbursement.

**THERAPIST AVAILABILITY**

The best way to reach me is through the client portal on *Simple Practice* or to call me. Although you can email me, my email is not HIPPA compliant so confidentiality cannot be guaranteed through this method. During the week I will respond within 24 hours. If I will be unavailable for an extended period of time, the name of a colleague to contact in my absence will be made available to you. Therapist is unable to provide 24-hour crisis service. In the event that Client is feeling unsafe or requires immediate medical or psychiatric assistance, he/she should call 911 or go to the nearest emergency room and ask for the mental health professional on call.

Client should also be aware of the following resources that are available in the local community to assist individuals in crisis:

Crisis Hotline: 877-727-4747 Youth Shelter: 949-494-4311

Domestic Violence Help: 800-799-7233 Rape Crisis Hotline: 714-957-2737

CHOC Hospital: 714-771-8113

**THERAPIST COMMUNICATIONS**

Therapist may need to communicate with Client by telephone, mail, or other means. Please indicate acceptable means of Therapist communications by checking the appropriate choices below.

\_\_\_\_\_ Therapist may call me at this number\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_ Therapist may send mail to this address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_ Therapist may send email to this email address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**ELECTRONIC COMMUNICATION**

Client should be aware that email and other electronic communications such as text messages may be unknowingly accessed by unauthorized persons and consequently compromise the privacy and confidentiality of such communications. Please do not include any private information via email or text message. Additionally, email are best left for logistics – any other emotionally-charged communications should happen via phone call or in person. I do not text message clients. Please notify Therapist if you decide to avoid or limit in any way the use of any or all electronic communication devices, such as email or cell phone. If you communicate confidential or private information via these methods, Therapist will assume that you have made an informed decision, will view it as your agreement to take the risk that such electronic communications may be intercepted, and will honor your desire to communicate in such a manner. While I may try to return messages in a timely manner, I cannot guarantee immediate response and request that you do not use these methods of communication to discuss therapeutic content and/or request assistance for emergencies.

Services by electronic means, including but not limited to telephone communication, the Internet, facsimile machines, and e-mail is considered telemedicine by the State of California. Under the California Telemedicine Act of 1996, telemedicine is broadly defined as the use of information technology to deliver medical services and information from one location to another. If you and your therapist chose to use information technology for some or all of your treatment, you need to understand that:

(1) You retain the option to withhold or withdraw consent at any time without affecting the right to future care or treatment or risking the loss or withdrawal of any program benefits to which you would otherwise be entitled.

(2) All existing confidentiality protections are equally applicable.

(3) Your access to all medical information transmitted during a telemedicine consultation is guaranteed, and copies of this information are available for a reasonable fee.

(4) Dissemination of any of your identifiable images or information from the telemedicine interaction to researchers or other entities shall not occur without your consent.

(5) There are potential risks, consequences, and benefits of telemedicine.

- Potential benefits include, but are not limited to improved communication capabilities, providing convenient access to up-to-date information, consultations, support, reduced costs, improved quality, change in the conditions of practice, improved access to therapy, better continuity of care, and reduction of lost work time and travel costs. Effective therapy is often facilitated when the therapist gathers within a session or a series of sessions, a multitude of observations, information, and experiences about the client. Therapists may make clinical assessments, diagnosis, and interventions based not only on direct verbal or auditory communications, written reports, and third person consultations, but also from direct visual and olfactory observations, information, and experiences.

- When using information technology in therapy services, potential risks include, but are not limited to the therapist's inability to make visual and olfactory observations of clinically or therapeutically potentially relevant issues such as: your physical condition including deformities, apparent height and weight, body type, gait and motor coordination, posture, work speed, any noteworthy mannerism or gestures, physical or medical conditions including bruises or injuries, basic grooming and hygiene including appropriateness of dress, eye contact (including any changes in the previously listed issues), sex, chronological and apparent age, ethnicity, facial and body language, and congruence of language and facial or bodily expression. Potential consequences thus include the therapist not being aware of what he or she would consider important information, that you may not recognize as significant to present verbally the therapist.

Therapist does not accept requests to add current or former clients on social networking sites. Adding clients on these sites and/or communicating via such sites is likely to compromise client privacy and confidentiality. For this same reason, Therapist requests that Client not communicate with Therapist via any interactive social networking websites or applications.

**CONFIDENTIALITY AND ITS LIMITS**

The law protects the privacy of all communications between a patient and a therapist. In most situations, I can only release information about your treatment to others if you sign a written authorization form that meets certain legal requirements. However, there are a number of exceptions to this basic rule, where I am permitted or required to disclose information without either your consent or authorization. Some of the circumstances are as follows:

* *Self-harm:* If you threaten to harm yourself, I will take action to protect you. This may include seeking hospitalization, or contacting family members or others who can help provide protection.
* *Others harm:* If you threaten harm to an identifiable victim, I must take protective actions, and notify the potential victim and contacting the police.
* *Abuse/neglect*: If I have knowledge, or reasonably suspect, that a child under the age of 18 has been the victim of child abuse or neglect, or if an elderly person 65 years or older is suffering from physical abuse or neglect, the law requires that I file a report with the appropriate government agency. Once such a report is filed, I may be required to provide additional information.
* *Child pornography*: If I have knowledge of an adult who knowingly downloads, streams, or accesses through any electronic or digital media, a film, photograph, videotape, video recording, negative, or slide in which a child is engaged in an act of obscene sexual conduct.

If any such situation arises, I will make every effort to fully discuss it with you before taking any action and I will limit my disclosure to what is necessary.

**MINORS AND CONFIDENTIALITY**

Communications between Therapist and a minor (under the age of 18) Client are confidential. However, legal guardians who provide authorization for treatment are often involved in minor clients’ treatment. Legal guardians should be aware that Therapist is not a conduit of information from Client. Psychotherapy can only be effective if there is a trusting and confidential relationship between Therapist and Client. Although a legal guardian can expect to be kept up to date about Client’s progress in therapy, he/she will typically not be privy to detailed discussions between Therapist and Client. However, legal guardian can expect to be informed in the event of any serious concerns Therapist might have regarding the safety and well-being of Client, including suicidality. Additionally, Therapist, based on Therapist’s professional judgment, may discuss the treatment progress of minor clients with legal guardian(s).

**CLIENT LITIGATION**

Therapist will not voluntarily participate in any litigation or custody dispute in which Client and another individual, or entity are parties. Therapist has a policy of not communicating with Client’s attorney and will generally not write or sign letters, reports, declarations, or affidavits to be used in Client’s legal matter. Therapist will generally not provide records or testimony unless compelled to do so. Should Therapist be subpoenaed, or ordered by a court of law, to appear as a witness in an action involving Client, Client agrees to reimburse Therapist for any time spent for preparation, travel, or other time in which Therapist has made themself available for such an appearance at Therapist’s usual and customary rate of $250 per 50 minutes.

**PSYCHOTHERAPIST-PATIENT PRIVILEGE**

The information disclosed by Client, as well as any records created, is subject to the psychotherapist-patient privilege. The psychotherapist-patient privilege results from the special relationship between Therapist and Client in the eyes of the law, akin to the attorney-client privilege or the doctor-patient privilege. Typically, the client is the holder of the psychotherapist-patient privilege. If Therapist receives a subpoena for records, deposition testimony, or testimony in a court of law, Therapist will assert the psychotherapist-patient privilege on Client’s behalf until instructed, in writing, to do otherwise by Client or Client’s representative. Client should be aware that he/she might be waiving the psychotherapist-patient privilege if he/she/they makes his/her/their mental or emotional state an issue in a legal proceeding. Client should address any concerns he/she/they might have regarding the psychotherapist-patient privilege with his/her/their attorney.

For a minor Client, the holder of the psychotherapist-patient privilege is either the minor, a court appointed guardian, or minor’s counsel. Parents typically do not have the authority to waive the psychotherapist-patient privilege for their minor children, unless given such authority by a court of law.

**RECORDS AND RECORD KEEPING**

Therapist may take notes during session and will also produce other notes and records regarding Client’s treatment. These notes constitute Therapist’s clinical and business records, which by law, Therapist is required to maintain. Such records are the sole property of CAAT Psychological Services, Inc. Therapist will not alter the normal record keeping process at the request of any client. Should Client request a copy of Therapist’s records, such a request must be made in writing. Therapist reserves the right, under California law, to provide Client with a treatment summary in lieu of actual records. Therapist also reserves the right to refuse to produce a copy of the record under certain circumstances, but may, as requested, provide a copy of the record to another treating health care provider. For a minor Client, a legal guardian will generally have the right to access the records regarding Client. However, this right is subject to certain exceptions set forth in California law. Should a legal guardian request access to Therapist’s records, such a request will be responded to in accordance with California law. Therapist will maintain Client’s records for ten years following termination of therapy. For a minor Client, Therapist will maintain Client’s records for ten years following termination of therapy or when Client is 25 years of age, whichever is longer. After the aforementioned time period, Client’s records will be destroyed in a manner that preserves Client’s confidentiality.

**TERMINATION OF THERAPY**

The length of treatment and the timing of the eventual termination of treatment depend on the specifics of Client’s treatment plan and progress. It is a good idea to plan for the termination of treatment in collaboration with Therapist.

Therapist reserves the right to terminate therapy at her discretion. Reasons for termination include, but are not limited to, untimely payment of fees, failure to comply with treatment recommendations, conflicts of interest, failure to participate in therapy, Client needs are outside of Therapist’s scope of competence or practice, or Client is not making adequate progress in therapy. Failure to participate in therapy includes Client missing or rescheduling multiple therapy appointments (more than twice a month), failing to make a follow up appointment for more than six weeks, and non-responsiveness to Therapist communications (phone calls, emails, messages, etc.) for more than one month.

Client has the right to terminate therapy at his/her/their discretion. Upon either party’s decision to terminate therapy, Therapist will generally recommend that Client participate in at least one, or possibly more, termination sessions. These sessions are intended to facilitate a positive termination experience and give both parties an opportunity to reflect on the work that has been done. Therapist will also attempt to ensure a smooth transition to another therapist by offering referrals to Client, if needed or applicable.

**ACKNOWLEDGEMENT**

By signing below, Client acknowledges that he/she/they has reviewed and fully understands the terms and conditions of this Agreement. Client has discussed such terms and conditions with Therapist, and has had any questions with regard to its terms and conditions answered to Client’s satisfaction. Client agrees to abide by the terms and conditions of this Agreement and consents to participate in psychotherapy with Therapist. Moreover, Client agrees to hold Therapist and CAAT Psychological Services, Inc. free and harmless from any claims, demands, or suits for damages from any injury or complications whatsoever, save negligence, that may result from such treatment. I understand that I am financially responsible to Therapist for all charges.

Client name/signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Guardian name/signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Client phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Guardian phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Client/Guardian address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Agreement and Informed Consent for Telepsychology**

This Agreement and Informed Consent for Telepsychology contains important information focusing on psychological services using the phone or the Internet. Please read this carefully and let me know if questions or concerns arise. When this document is signed, it will represent an agreement between us.

**Benefits and Risks of Telepsychology**

Telepsychology refers to providing psychological services remotely using telecommunications technologies, such as video conferencing or telephone. One of the benefits of telepsychology is that clients and/or their families can engage in services with me without being in the same physical location. This can be helpful in ensuring continuity of care if the client or psychologist moves to a different location, takes an extended vacation, or is otherwise unable to continue to meet in person, provided the different locations satisfy requirements of the psychologist’s licensure. Telepsychology is also more convenient and takes less time for travel to the meeting, etc. Telepsychology, however, requires technical competence on both our parts to be helpful. Although there are benefits of telepsychology, there are some differences between in-person psychotherapy and telepsychology, as well as some risks. For example:

* *Risks to Confidentiality*: Because telepsychology sessions take place outside of the psychologist’s private office, there is potential for other people to overhear sessions if sessions are not conducted in a private place for the duration of the session. On my end, I will take reasonable steps to ensure privacy. It is important for clients and/or their families to secure a private place for our session where they will not be interrupted. It is also important for clients and/or their families to protect the privacy of our session on their cell phone or other device. Clients and/or their families should participate in psychological services only while in a room or area where other people are not present and cannot overhear the conversation. I will use headphones to increase privacy and I encourage clients and/or their families to do the same.
* *Issues Related to Technology*: There are many ways that technology issues might impact telepsychology. For example, technology may stop working during a session, other people might be able to get access to our private conversation, or stored data could be accessed by unauthorized people or companies.
* *Crisis Management and Intervention*: I may not engage in telepsychology with clients who are currently in a crisis situation requiring high levels of support and intervention. Before engaging in telepsychology, we will develop an emergency response plan to address potential crisis situations that may arise during the course of our telepsychology work.
* *Efficacy*: Most research shows that telepsychology is as effective as in-person psychotherapy. However, some therapists believe that something is lost by not being in the same room. For example, there is debate about a therapist’s ability to fully understand non-verbal information when working remotely.

**Electronic Communications**

Clients and/or their families and I will decide together which kind of telepsychology service to use. Clients and/or their families may have to have certain computer or cell phone systems to use telepsychology services. They are solely responsible for any cost them to obtain any necessary equipment, accessories, or software to take part in telepsychology.

**Confidentiality**

I have a legal and ethical responsibility to make my best efforts to protect all communications that are a part of my telepsychology practice. However, the nature of electronic communications technologies is such that I cannot guarantee that all communications will be kept confidential or that other people may not gain access to such communications. I will try to use updated encryption methods, firewalls, and back-up systems to help keep protected health information private, but there is a risk that electronic communications may be compromised, unsecured, or accessed by others. Clients and/or their families should also take reasonable steps to ensure the security of our communications (e.g., only using secure networks for telepsychology sessions and having passwords to protect the device used for telepsychology).

The extent of confidentiality and the exceptions to confidentiality outlined in the Notice of Privacy Practices and the Agreement and Informed Consent for Treatment, Agreement and Informed Consent for Group Treatment, or Agreement and Informed Consent for Assessment still apply in telepsychology. Please let me know if any questions or concerns arise about exceptions to confidentiality.

**Appropriateness of Telepsychology**

On a case-by-case basis, I may schedule in-person sessions to conducted psychological testing or to “check in” in-person. I will inform clients and/or their families if I decide that telepsychology is no longer the most appropriate form of treatment or services. I will discuss options of engaging in in-person services or referrals to another professional in the location of the client and/or their families who can provide appropriate services.

**Emergencies and Technology**

Assessing and evaluating threats and other emergencies can be more difficult when conducting telepsychology than in traditional in-person psychological services. To plan for some of these difficulties, clients and/or their families and I will create an emergency plan before engaging in telepsychology services. I generally ask clients and/or their families to identify the location during the session and an emergency contact person who is near the location who I can contact in the event of a crisis or emergency to assist in addressing the situation. I may ask that clients and/or their families sign a separate authorization form allowing me to contact the emergency contact person as needed during such a crisis or emergency.

If the session is interrupted for any reason, such as the technological connection fails, and the client and/or their families are experiencing an emergency situation, do not call me back; instead, contact King County Crisis Connections at (206) 461-3222, or 911, or proceed immediately to the nearest emergency room. Call me back after emergency services have been called or obtained.

If the session is interrupted and there is not an emergency situation, disconnect from the session and try to reconnect. If after 2 minutes there has not been a reconnection, on SimplePractice, I will call the phone number on file. If I do not call back within 5 minutes, then call me at (206) 236-1294, Ext. 4.

If there is a technological failure and we are unable to resume the connection, I will only charge the prorated amount of actual session time. I will try to send a message through SimplePractice or email or call to reschedule.

**Fees**

The same fee rates will apply for telepsychology as apply for in-person psychological services. Clients and/or their families will still be expected to pay for each session at the time it is held, unless we agree otherwise in writing. Clients and/or their families are recommended to contact their insurance provider directly and inquire if potential reimbursement differs between telepsychology and in-person services.

**Records**

The telepsychology sessions shall not be recorded in any way unless agreed to in writing by mutual consent. I will maintain a record of telepsychology services in the same way I maintain records of in-person sessions in accordance with my policies.

**Consent to Use the Telehealth by SimplePractice Service**

Telehealth by SimplePractice is the technology service clients and/or their families and I will use to conduct telehealth videoconferencing appointments. It is simple to use and there are no passwords required to log in. By signing this document, you acknowledge:

* Telehealth by SimplePractice is NOT an Emergency Service and in the event of an emergency, you will use a phone to call 911.
* Though you and I may be in direct, virtual contact through the Telehealth Service, neither SimplePractice nor the Telehealth Service provides any medical or healthcare services or advice including, but not limited to, emergency or urgent medical services.
* The Telehealth by SimplePractice Service facilitates videoconferencing and is not responsible for the delivery of any healthcare, medical advice or care.
* You do not assume that I have access to any or all of the technical information in the Telehealth by SimplePractice Service – or that such information is current, accurate or up-to-date. You will not rely on me to have any of this information in the Telehealth by SimplePractice Service.
* To maintain confidentiality, you will not share your telehealth appointment link with anyone unauthorized to attend the session.

**Informed Consent**

This Agreement is intended as a supplement to the Agreement and Informed Consent that we agreed to at the outset of psychological services and does not amend any of the terms of that Agreement.

Your signature below indicates agreement with the above terms and conditions.

**Client Signature or Parent/Guardian Signature Date**

**Tiffany Shader, PhD Date**

**Licensed Clinical Psychologist**

**CA license # 32997**

**Financial Agreement**

***Fee Agreement***

We have agreed on a session fee of $250 per session

***Fee Schedule***

My session fee is $250 for 50 minutes. If we meet for less than 50 minutes, I charge $105 for 25 minutes, $125 for 30 minutes, $165 for 40 minutes, and $190 for 45 minutes or longer. If you have questions about how I calculate these rates, please ask me so we can discuss it.

***Fee Payment***

Payment for each session is expected at the time it is held, unless I agree to otherwise in writing. In most cases, the credit card information clients and/or their families submit to the client’s record will be charged in the evening of the day services are provided.

***Parent Consultation Fees***

There is no fee for 1 weekly phone consultation of 10 minutes or less. After 10 minutes, or at the beginning of the second phone call in a given week, I will begin pro-rating based on my hourly session fee. If we have not agreed beforehand on a paid session, I will always let you know during our call the point at which I will begin pro-rating our consultation.

***Appointments & Cancellations***

Please remember to cancel or reschedule 48 hours in advance. You will be responsible for the entire fee if cancellation is less than 24 hours.

The standard meeting time for psychotherapy is 50 minutes. It is up to you, however, to determine the length of time of your sessions. Requests to change the 50-minute session needs to be discussed with the therapist in order for time to be scheduled in advance.

A $10.00 service charge will be charged for any checks returned for any reason for special handling.

Cancellations and re-scheduled session will be subject to a full charge if NOT RECEIVED AT LEAST 24 HOURS IN ADVANCE. This is necessary because a time commitment is made to you and is held exclusively for you. If you are late for a session, you may lose some of that session time.

BY SIGNING BELOW I AM AGREEING THAT I HAVE READ, UNDERSTOOD AND AGREE TO THE ITEMS CONTAINED IN THIS DOCUMENT.

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Name of Guardian Name of Child

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Signature of Guardian Date