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Authority to Practice Interjurisdictional
Telepsychology under PSYPACT #10229
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Informed Participation Agreement

Welcome! I am glad you are here. Part of the psychotherapy process is making an informed decision about which provider you select to be your therapist. This document contains information about my professional services and business practices. It also contains summary information about the Health Insurance Portability and Accountability Act (HIPAA), a federal law that provides privacy protections and client 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. The Notice, which is included with this Agreement, explains HIPAA and its applications to your personal health information in greater detail.

The law requires that I obtain your signature acknowledging that I have provided you with this information by the end of our first visit. Although these documents are long and sometimes complex, it is very important that you read them carefully before our next session. You may revoke this Agreement in writing at any time. I am required to comply with your request yet am still able to follow through with obligations imposed on me by your health insurer to process or substantiate claims made under your policy and to collect payment for any outstanding invoices.

I hope these documents help you make an informed decision about if my services are the best fit for you. Please read them carefully. If you have any questions about these policies or any other aspect of my practice, please feel free to discuss them with me at any time. Once you sign this document, it will represent an agreement between us.

PSYCHOLOGICAL SERVICES

Psychotherapy incorporates multiple methods to address issues that pose challenges in a variety of life areas. Together we will explore your specific concerns and mutually set treatment goals so you have a sense of where we are headed in our work. We will regularly check in to evaluate our progress and make any necessary adjustments.

Psychotherapy is an active process, therefore much of your success depends on the effort that you put in, both during our scheduled visits and between visits. It will also mean that you take risks to try new, more effective behaviors. Having a provider who is able to support you, as well as challenge you toward progress is often the best approach. I invite you to talk with me at any time about how my approach is impacting our work together.

Psychotherapy can have risks and benefits. Since therapy often involves discussing issues that are of concern to you, you may experience uncomfortable emotions, such as sadness, guilt, helplessness, and anger. Psychotherapy has also demonstrated great benefits, such as

gaining a better understanding of yourself, improved relationships, reduction in symptoms or distress, and new ways of looking at problems. However, no guarantees can be made regarding the success of treatment.

CONFIDENTIALITY

I am obligated by law not to disclose any contact with you or any information that you disclose to me without your written permission. In all aspects of my practice, communication with or about my clients is protected by confidentiality regulations as stipulated by federal and state laws, and by the ethics of my profession.

There are, however, some situations written into law that deny me complete control over confidentiality. They are as follows:

1. I am legally required to report any situation of suspected child abuse or neglect to the proper authorities. I am also legally required to report suspected abuse, neglect, or exploitation of a vulnerable adult;

2. In some circumstances, my records may be subject to a subpoena issued by the court;

3. If I believe a that a client poses imminent danger to the health and safety of themselves or another individual, I am permitted by law to break confidentiality by contacting law enforcement officials and/or medical authorities who may then take protective action; and

4. If I am contacted by an insurance company or an auditor, I may be required to release client information as dictated by law.

This list is not exhaustive, but these are the most common circumstances that may occur regarding not maintaining complete confidentiality. The situations outlined above are out of the ordinary and have no impact on most people seeking psychological services. I share this information with you so that you may be fully informed and so that you may address any questions or concerns.

VISITS

Our scheduled time is set aside to focus on assisting you toward your goals. Making use of full visits is in your best interest, so I encourage you to be on time and to stay until the end.

DOCUMENTATION

You should be aware that, pursuant to HIPAA, I keep Protected Health Information about you in a clinical record. It includes information about the following: your reasons for seeking therapy; a description of the ways in which your concerns impact your life; your diagnosis (if applicable); the goals we set for treatment; your progress towards those goals; your medical and social history; your treatment history; any past treatment records that I 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. Except in unusual circumstances that involve danger to yourself and/or others, or where information has been provided to me confidentially by others, you may examine and/or receive a copy of your clinical record. You must request it in writing.

Because these are professional records, they can be misinterpreted and/or upsetting to untrained readers. For this reason, if you'd like to see them, I recommend that you initially review them with me or have them forwarded to another mental health professional so that you can discuss the contents. I would conduct this review meeting with our typical fee charge. In most situations, I am allowed to charge a copying fee of $1.00 per page and for certain other expenses. The exceptions to this policy are contained in the included HIPAA Notice Form. If I refuse your request for access to your clinical record, you have a right to review (except for information supplied to me confidentially by others), which I will discuss with you upon request.

ENDING THERAPY

Some clients benefit from brief involvement with therapy, while others find an extended length of time in therapy to be more valuable. I am committed to working with you as long as you are benefitting. At any time you think it is best to end therapy, it is important that we talk about this process together.

A natural point to end therapy is when you have met your goals. It could also be that you are not finding therapy to be helpful or you encounter other circumstances (e.g., switching insurance, change in income). Regardless of the reason, please discuss your thoughts with me so that we can make sure your next steps continue to support your well-being. It's important that we treat the end of therapy carefully as endings may bring up other losses. We will work together to make a positive transition and help you with getting healthy closure. If indicated, I will assist you with finding another therapist who better meets your needs.

If I do not have contact or communication from you for a period of 30 consecutive days, I will assume that you no longer intend to remain active in this therapy relationship, and your file will be closed. You have the option to contact me again at any time in the future to continue psychotherapy with me.

FEES

My basic fee is $175.00 per 53-minute outpatient psychotherapy session (CPT codes 90791 & 90837), unless otherwise arranged. Longer visits, shorter visits, and other interventions are prorated from this fee. Other services include telephone conversations with you that are of a therapeutic, problem-solving, or information-exchanging nature. Fees also pertain to attendance at meetings or phone calls with other professionals you have authorized. The fee for a phone session will be due at the next scheduled visit. Phone sessions will be indicated as such and are generally not reimbursed by insurance. You have the right to request and receive a receipt for services at any time.

CANCELLATIONS

If you need to cancel or reschedule an appointment, a minimum of 24-hour's notice is required. **The full fee will be charged for missed visits without such notification.** Please note that many insurance companies will not provide payment for missed visits.

PAYMENT FOR SERVICE

You are expected to pay for services at the time they are provided, unless other arrangements have been made. Please talk with me in advance if you are having difficulty making payments. Payments may be made by credit card or other discussed means. You are responsible for payment of all fees, even if you are planning to bill an insurance

company for reimbursement. If you prefer to use direct bank transfer (e.g., Zelle or Venmo), I recommend making your transaction private and using a vague description. Of course, this is your decision and your privacy to protect.

Failure to pay for services within a reasonable time period may result in me seeking outside assistance to collect charges due. This may involve hiring a collections agency. If such action is necessary, the costs to me will be included in this claim. The only information I will release is your name, nature of services provided, and the amount due. The law allows the sharing of this limited confidential information in these circumstances.

INSURANCE

In order for us to set realistic treatment goals and priorities, it is important to evaluate what resources you have available to pay for your treatment. If you have a health insurance policy, it will usually provide some coverage for mental health treatment. However, you (not your insurance company) are responsible for full payment of my fees.

Due to the rising costs of health care, insurance benefits have increasingly become more complex. It is sometimes difficult to determine exactly how much mental health coverage is available. "Managed Health Care" plans such as HMOs and PPOs often require authorization before they provide reimbursement for mental health services. These plans are often limited to short-term treatment approaches designed to work out specific problems that interfere with a person's usual level of functioning. It may be necessary to seek approval for more therapy after a certain number of sessions. While a lot can be accomplished in short-term therapy, some patients feel that they need more services after insurance benefits end.

If you are planning to file a claim with an insurance company, I encourage you to investigate if the out-of-network services I provide are eligible for reimbursement. If you have any questions, I encourage you to contact your insurance administrator and ask the following questions: 1) How much will insurance pay for an out-of-network provider for individual and/or couples psychotherapy?; and 2) Does the insurance plan have a deductible (i.e., an amount that you will have to pay out of pocket before any insurance coverage begins) for mental health services and, if so, how much is it? If my services are eligible for reimbursement, you will pay me directly for the full cost of my services and then you will submit documentation to the insurance company to request any eligible reimbursement from them. With advance notice, I can provide you with a receipt for services and accompanying information to support your request.

You should also be aware that your contract with your health insurance company requires that I provide it with information relevant to the services that I provide to you, including a clinical diagnosis. Sometimes I am required to furnish insurance companies with additional clinical information such as treatment plans and summaries or copies of your entire clinical record. In such situations, I will make every effort to release only the minimum information about you that is necessary for the purpose requested. This information will become a part of the insurance company files and will probably be stored on a computer. Though insurance companies claim to keep such information confidential, I have no control over what they do with it once it is in their hands. In some cases, they may share the information with a national medical information databank. I will provide you with a copy of any report I submit to your insurance, per your request. **By signing this Agreement, you agree that I can provide requested information to your carrier.**

Once we have all of the information about your insurance coverage, we will discuss what we can expect to accomplish with the benefits that are available and what will happen if they run out before you feel ready to end our sessions. It is important to remember that you have the right to pay for my services yourself to avoid the problems described above, unless your insurance company's contract with me prohibits that arrangement.

CLIENT RIGHTS

HIPAA provides you with several rights with regard to your clinical record and disclosures of protected health information. These rights include requesting that I 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; and having any complaints you make about my policies and procedures recorded in your records; and the right to a paper copy of this Agreement, the included Notice form, and my privacy policies and procedures.

CONTACTING ME

I am often not immediately available by telephone since I do not answer the phone when I am with a client or in a meeting. I will make every effort to return your call on the same day you leave a message, with the exception of weekends and holidays. When you leave a message, please state your name, your number, and times when you will be available for a call back.

LIMITED ELECTRONIC COMMUNICATION

Please do not use email or text to communicate **confidential information** as your privacy cannot be guaranteed. Email or text should **not** be used in the case of an emergency. Text and email is best used to communicate information about logistics, such as appointment times and forms.

EMERGENCIES

If you are experiencing a psychological emergency and I am unable to be reached:

- Call 911;
- Call 988 to talk with a crisis counselor; or
- Go to the closest Emergency Department.

MINORS & PARENTS

If you are under 18 years of age and are not emancipated, please be aware that the law may provide your parents the right to examine your treatment records. Because privacy in psychotherapy is often crucial to successful progress, particularly with teenagers, it is my policy to request an agreement from parents that they consent to give up their access to your records. If they agree, during treatment, I will provide them only with general information about our work together, including progress in treatment and attendance at scheduled sessions. Any other communication will require your Authorization, unless I feel that you are in danger or a danger to someone else, in which case I will notify your parents of my concern. Before giving them any information, I will discuss the matter with you, if possible, and do my best to handle any objections you may have with what I am prepared to discuss.

SIGNATURES FOR CONSENT TO PARTICIPATE IN THERAPY

I have read and understand the contents of the Informed Participation Agreement. I agree to the arrangements outlined within it.

Client Signature _____ Date _____

Printed Name _____

Parent or Legal Guardian if under age 18 _____ Date _____

SIGNATURE FOR HIPAA NOTICE OF PRIVACY PRACTICES

My signature below indicates that I have read, understood, and received a copy of the HIPAA Notice of Privacy Practices for the Office of Danielle Oakley, PhD.

Client Signature _____ Date _____

Printed Name _____

Parent or Legal Guardian if under age 18 _____ Date _____

SIGNATURE FOR LIMITED ELECTRONIC COMMUNICATION

My signature below indicates that I have read, understand, and agree to limited communication by email and text that does not pertain to treatment information. I understand that email and text are not for communicating confidential information or to be used in the case of emergencies.

Client Signature _____ Date _____

Printed Name _____

Parent or Legal Guardian if under age 18 _____ Date _____