Informed Consent for Psychotherapy or Psychotherapeutic Consultation

Welcome. I am a Doctor of Psychology, a Licensed Clinical Social Worker and a Diplomate of the American Psychotherapy Association. This information, like all information that you share with me, is private and confidential.

Clients Rights: Your decision to undergo psychotherapy is strictly voluntary and you are free to discontinue psychotherapy at any time.

Professional Fees: The full payment for each session is your responsibility to take care of at the time of service. I will have you complete a credit card authorization form when I meet with you to keep a credit card on file. If you prefer to pay by check I will still need to keep a credit card on file. The card will be used for charging any visit not paid by cash or check within 36 hours of receiving services, and if you choose to pay by credit card weekly. Email and general phone correspondence (non scheduled phone sessions) are charged at .5 per session fee (ten to twenty five minutes)and full fee (twenty-five to fifty minutes). Scheduled phone sessions are charged at full fee.

Conditions of Care and Cancellation Policy: My standard psychotherapy session is 50 minutes per week in the office. Responsible attendance weekly in the office with regularly reserved weekly scheduled appointments is an important factor in effective successful treatment. Ideally, you may **reserve a weekly session** time if available **or as another option** you may schedule a session **"as needed."** Once we set a **reserved weekly session** you are responsible for this weekly reservation. Your weekly session is held for you and not released to another patient until it is agreed upon that you will no longer be in a weekly psychotherapy or if you change to scheduling "**as needed."** Dr. Richman provides concierge style services, free from insurance demands, allowing her to focus solely on your care. Unlike psychotherapists that are burdened with insurance forms and procedures, Dr. Richman will provide prompt personal response to your concerns and collaborate with your psychopharmacologist or family members with your consent throughout your treatment process.

Occasionally, of course, it is necessary to miss or reschedule your reserved session. As a courtesy with weekly reserved clients, you may miss up to four sessions free of charge in a full treatment year or six sessions free of charge if you come twice per week. Thie policy starts over each January. I am happy to try to reschedule in the same week during office hours if session availability allows. Due to the nature of my practice, there is not a guarantee that I will be able to reschedule in that week if you cancel your reserved session. In the office sessions are the primary form of psychotherapy. At times, phone sessions (telemedicine/teletherapy) can be used during your scheduled session. Telemedicine/teletherapy will not replace or be as effective as in the office sessions. In general phone sessions are scheduled after hours at 7pm Monday through Thursday, and on Fridays from 9am to 4pm if not during your reserved session time. As a courtesy, please be reminded ALL sessions require a 24 hour notice of cancelation.

EMAIL IS NOT FOR MEDICAL EMERGENCIES OR URGENT QUESTIONS. Please do not use email for complicated issues that should be properly addressed via session. In an EMERGENCY call 911 or go to an Emergency Room. If I do need to be reached between sessions email may be used to request for me to call you or please call the office (310) 278-9702 as I check voicemail daily. Email and all

electronic correspondence from Dr. Richman does not constitute: 1) psychotherapy 2) an evaluation, or 3) a consultation. Nor will any such correspondence be considered as a replacement or substitute for a formal office session and/or consultation by Dr. Richman. Email is strictly a supportive tool with current clients.

Telemedicine/Teletherapy Informed Consent: I understand that "telemedicine/teletherapy" includes the practice of health care delivery, diagnosis, consultation, treatment, transfer of medical data, and education using interactive audio, video, or data communications. I understand that telemedicine also involves the communication of my medical/mental information, both orally and visually, to health care practitioners located in California or outside of California.

I understand that I have the following rights with respect to telemedicine:

(1) I have the right to withhold or withdraw consent at any time without affecting my right to future care or treatment nor risking the loss or withdrawal of any program benefits to which I would otherwise be entitled.

(2) The laws that protect the confidentiality of my medical information also apply to telemedicine/teletherapy. As such, I understand that the information disclosed by me during the course of my therapy is generally confidential. However, there are both mandatory and permissive exceptions to confidentiality, including, but not limited to reporting child, elder, and dependent adult abuse; expressed threats of violence towards an ascertainable victim; and where I make my mental or emotional state an issue in a legal proceeding.

I also understand that the dissemination of any personally identifiable images or information from the telemedicine/teletherapy interaction to researchers or other entities shall not occur without my written consent.

(3) I understand that there are risks and consequences from telemedicine/teletherapy, including, but not limited to, the possibility, despite reasonable efforts on the part of my psychotherapist, that: the transmission of my medical information could be disrupted or distorted by technical failures; the transmission of my medical information could be interrupted by unauthorized persons; and/or the electronic storage of my medical information could be accessed by unauthorized persons. In addition, I understand that telemedicine/teletherapy based services and care may not be as complete as face-to-face services. I also understand that if my psychotherapist believes I would be better served by another form of psychotherapeutic services (e.g. face-to-face services) I will be referred to a psychotherapist who can provide such services in my area. Finally, I understand that there are potential risks and benefits associated with any form of psychotherapy, and that despite my efforts and the efforts of my psychotherapist, my condition may not be improve, and in some cases may even get worse.

(4) I understand that I may benefit from telemedicine/teletherapy, but that results cannot be guaranteed or assured.

(5) I understand that I have a right to access my medical information and copies of medical records in accordance with California law.

I have read and understand the information provided above and consent. I have discussed it with my psychotherapist, and all of my questions have been answered to my satisfaction. **___INITIAL**

Most insurance companies do not reimburse for missed sessions. Should your account become delinquent by a three month period, and you do not comply with a mutually agreed upon schedule of payment, your account may be turned over to a collection agency. The prevailing party in any collection efforts, including arbitration or litigation, shall be entitled to recover a reasonable sum for attorneys' fees. If you would like to submit a bill to your insurance company for reimbursement, please let me know and I will provide you with an invoice at the end of each month. I do not work directly with insurance companies, but if your policy provides for some reimbursement for work with out-of-network providers, I will be happy to provide you with the required documentation. As was indicated in the section, Health Insurance & Confidentiality of Records, you must be aware that submitting a mental health invoice for reimbursement carries a certain amount of risk. Not all issues, conditions, and problems which are the focus of psychotherapy, are reimbursed by insurance companies. It is your responsibility to verify the specifics of your coverage.

Termination of Treatment: By law, I have no obligation to continue to provide treatment. I can terminate treatment if payment is not timely, or if some problem emerges that is not within my scope of competence, or for any other reason. If at any time I am unable to provide you with appropriate care within my scope of services, I will offer you three referrals for follow-up. I am governed by various regulations and by the code of ethics of my profession. I am required to inform you of certain aspects of your psychotherapy.

Contact: I make every attempt to answer voicemail and return the call on the same day. If you are unable to reach me and feel that you cannot await my return call, please contact your psychiatrist, or call 911 if you feel that it is an emergency.

Confliction Resolution: By signing below, you and I agree to address any grievances we may have with each other (e.g., billing or claims of malpractice) directly. Due to the nature of the therapeutic process and the fact that it often involves making a full disclosure with regard to many matters which may be of a confidential nature, it is agreed that should there be legal proceedings (such as, but not limited to divorce and custody disputes, injuries, lawsuits, etc.), neither you nor your attorney, nor anyone else acting on your behalf will call on me, Dr. Richman, to testify in court or at any other proceeding, nor will a disclosure of the psychotherapy records be requested. If we cannot settle the matter between us, then we agree to seek the assistance of a neutral third party (upon whom or which we jointly agree) to assist us by way of non-binding mediation. If an agreement still is not reached, we agree that any dispute, claim or controversy arising out of or relating to this agreement, or the breach, termination, enforcement, interpretation or validity of this agreement, including the determination of the scope or applicability of this section will be determined by arbitration in Los Angeles, California, before one arbitrator. You are agreeing to have any issue of medical or psychological malpractice decided by neutral arbitration and you agree to give up the use of a jury/court trial. A judgment based on the arbitrator's award may be entered in any court having jurisdiction.

Limits of Confidentiality: In general, law protects the privacy of all communications between a client and a mental health professional. With some limited exceptions, I can only release information about our work together with your written /verbal permission. The exceptions include child custody, a judge orders my testimony, child, or elder abuse, if I believe that a person is threatening serious bodily harm to another or to themselves, if you are required to

sign a release of confidential information by your medical insurance, and if you are required to sign a release for psychotherapy records if you are involved in litigation or other matters with private or public agencies. Also, couples being seen in couple, family and group work are obligated legally to respect the confidentiality of others. The therapist will exercise discretion (but cannot promise absolute confidentiality) when disclosing private information to other participants in your treatment process. The therapist cannot keep secrets from others involved in your treatment. I may at times speak with my professional colleagues about our work without asking permission, but your identity will be disguised. Clients under 18 do not have full confidentiality from their parents. It is also important to be aware of other potential limits to confidentiality that include the following: all records as well as notes on sessions and phone calls can be subject to court subpoena under certain extreme circumstances. Most records are stored in locked files, but some are stored in secured electronic devices. Cell phones, fax and email are used on some occasions. All electronic communications can compromise your confidentiality.

Health Insurance & Confidentiality of Records: Disclosure of confidential information may be required by your health PPO in order to process the claims. If you instruct me, I will communicate the minimum necessary information to the carrier. I have no control or knowledge over what insurance companies do with the information I submit or who has access to this information. You must be aware that submitting a mental health invoice for reimbursement carries a certain amount of risk to confidentiality, privacy, or to future eligible to obtain health or life insurance. The risk stems from the fact that mental health information is entered into insurance companies' computers and soon will also be reported to the, congress-approved, National Medical Data Bank. Accessibility to companies' computers or to the National Medical Data Bank database is always in question, as computers are inherently vulnerable to break-ins and unauthorized access. You signature also verifies that you understand that services provided may not be covered by your policy and that you are financially responsible for these services even if deemed unnecessary or not payable by your carrier when you request out of network reimbursement.

When Disclosure Is Required By Law: Some of the circumstances where disclosure is required by the law are: where there is a reasonable suspicion of child, dependent or elder, abuse or neglect; and where a client presents a danger to self, to others, to property, or is gravely disabled (for more details see also Notice of Privacy Practices form).

Privileged Communication: The above refers to a client's right not to have confidential information revealed in court or other legal proceedings. Privilege is waived when: 1) A client has consented specifically and in writing to disclose information; 2) When the client has disclosed a significant part of the information to a third party; 3) Or any of the following (Sections 910 through 1027 of the California Evidence Code) a) When the client is a minor under 18 years of age, the parent or guardian is holder of the privilege; b) When the client is in a criminal proceeding based on an insanity plea, or when a client introduces own mental health as issue in legal proceedings; c) When client alleges a breach of duty against the therapist; d) When client seeks help from the therapist to commit or plan a crime; e) When the client is dangerous to self or others; or f) When client is under 18 years of age, is the victim of a crime and disclosing the information is in the best interest of the client. I may occasionally find it helpful to consult other professionals about a case. During the consultation I will not give any identifying

information about you to keep your identity anonymous. In addition, the consultant is legally bound to keep the information confidential.

E-mails, Cell Phones, Computers, and Faxes: It is very important to be aware that computers and email and cell phone communication can be relatively easy to access by unauthorized people and hence can compromise the privacy and confidentiality of such communication. Emails, in particular, are vulnerable to such unauthorized access due to the fact that servers have unlimited and direct access to all emails that go through them. Additionally, my emails are encrypted, but can be upon request and faxes can be sent erroneously to the wrong address. My computer is equipped with a password and I back up all confidential information from my computer to a hard drive on a regular basis and my server is HIPAA protected. Please notify me if you decide to avoid or limit, in any way, the use of any or all communication devices, such as email, cell phone or faxes. If you communicate confidential or highly private information via email, I will assume that you have made an informed decision, will view it as your agreement to take the risk that such communication may be intercepted, and I will honor your desire to communicate on such matters via email. Please, be aware that emails are part of the medical records, and do not use email for emergencies. Due to computer or network problems emails may not be deliverable. By signing below, you authorize the use of email for communication with informed consent, and accept that HIPAA related privacy issues cannot be guaranteed.

I hereby acknowledge that I received a copy of this mental health/psychotherapy practice's Informed Consent. There is a copy that is present in the waiting room of the office. A copy is always present with Dr. Richman and any amended copy will be available to me. **___INITIAL**

HIPAA NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. IT IS MY LEGAL DUTY TO SAFEGUARD YOUR PROTECTED HEALTH INFORMATION (PHI).

Psychotherapists have always managed patient records with great concern for privacy and confidentiality. Although the security of these records have continuously been addressed by my profession's Code of Ethics, as well as State and Federal laws, the rules have been considerably strengthened by the provisions of the Health Insurance Portability and Accountability Act (HIPAA). The following information provides details about the provisions of the HIPAA and your rights concerning privacy and your records.

PHI constitutes information created or noted by me that can be used to identify you. It contains data about your past, present, or future health or condition, the provision of health care services to you, or the payment for such health care. Use of PHI means when I share, apply, utilize, examine, or analyze information within my practice; PHI is disclosed when I release, transfer, give, or otherwise reveal it to a third party outside my practice. With some exceptions, I may not use or disclose more of your PHI than is necessary to accomplish the purpose for which the use or disclosure is made; however, I am always legally required to follow the privacy practices described in this Notice.

Please note that I reserve the right to change the terms of this Notice and my privacy policies at any time. Any changes will apply to PHI already on file with me. Before I make any important changes to my policies, I will immediately change this Notice and post a new copy of it in my office. You may also request a copy of this Notice from me, or you can view a copy of it in my office.

HOW I WILL USE AND DISCLOSE YOUR PHI.

I will use and disclose your PHI for many different reasons. Some of the uses or disclosures will require your prior written authorization; others, however, will not. Below you will find the different categories of my uses and disclosures, with some examples.

A. Uses and Disclosures Related to Treatment, Payment, or Health Care Operations Do Not Require Your Prior Written Consent.

1. **For treatment**. I may disclose your PHI to physicians, psychiatrists, psychologists, and other licensed health care providers who provide you with health care services or are otherwise involved in your care. Example: If a psychiatrist is treating you, I may disclose your PHI to her/him in order to coordinate your care.

2. **For health care operations**. I may disclose your PHI to facilitate the efficient and correct operation of my practice. Examples: Quality control - I might use your PHI in the evaluation of the quality of health care services that you have received or to evaluate the performance of the health care professionals who provided you with these services. I may also provide your PHI to my attorneys, accountants, consultants, and others to make sure that I am in compliance with applicable laws.

3. **To obtain payment for treatment**. I may use and disclose your PHI to bill and collect payment for the treatment and services I provided you. Example: I might send your PHI to your insurance company or health plan in order to get payment for the health care services that I have provided to you. I could also provide your PHI to business associates, such as billing companies, claims processing companies, and others that process health care claims for my office.

4. **Other disclosures**. Examples: Your consent isn't required if you need emergency treatment provided that I attempt to get your consent after treatment is rendered. In the event that I try to get your consent but you are unable to communicate with me (for example, if you are unconscious or in severe pain) but I think that you would consent to such treatment if you could, I may disclose your PHI.

B. Certain Other Uses and Disclosures Do Not Require Your Consent.

1. When disclosure is required by federal, state, or local law; judicial, board, or administrative proceedings; or, law enforcement. Example: I may make a disclosure to the appropriate officials when a law requires me to report information to government agencies, law enforcement personnel and/or in an administrative proceeding.

2. If disclosure is compelled by a party to a proceeding before a court of an administrative agency pursuant to its lawful authority.

3. If disclosure is required by a search warrant lawfully issued to a governmental law enforcement agency.

4. If disclosure is compelled by the patient or the patient's representative pursuant to California Health and Safety Codes or to corresponding federal statutes of regulations, such as the Privacy Rule that requires this Notice.

5. To avoid harm. I may provide PHI to law enforcement personnel or persons able to prevent or mitigate a serious threat to the health or safety of a person or the public.

6. If disclosure is compelled or permitted by the fact that you are in such mental or emotional condition as to be dangerous to yourself or the person or property of others, and if I determine that disclosure is necessary to prevent the threatened danger.

7. If disclosure is mandated by the California Child Abuse and Neglect Reporting law. For example, if I have a reasonable suspicion of child abuse or neglect.

8. If disclosure is mandated by the California Elder/Dependent Adult Abuse Reporting law. For example, if I have a reasonable suspicion of elder abuse or dependent adult abuse.

9. If disclosure is compelled or permitted by the fact that you tell me of a serious / imminent threat of physical violence by you against a reasonably identifiable victim or victims.

10. For public health activities. Example: In the event of your death, if a disclosure is permitted or compelled, I may need to give the county coroner information about you.

11. For health oversight activities. Example: I may be required to provide information to assist the government in the course of an investigation or inspection of a health care organization or provider.

12. For specific government functions. Examples: I may disclose PHI of military personnel and veterans under certain circumstances. Also, I may disclose PHI in the interests of national security, such as protecting the President of the United States or assisting with intelligence operations.

13. For research purposes. In certain circumstances, I may provide PHI in order to conduct medical research.

14. For Workers' Compensation purposes. I may provide PHI in order to comply with Workers' Compensation laws.

15. Appointment reminders and health related benefits or services. Examples: I may use PHI to provide appointment reminders. I may use PHI to give you information about alternative treatment options, or other health care services or benefits I offer.

16. If an arbitrator or arbitration panel compels disclosure, when arbitration is lawfully requested by either party, pursuant to subpoena duces tectum (e.g., a subpoena for mental health records) or any other provision authorizing disclosure in a proceeding before an arbitrator or arbitration panel.

17. I am permitted to contact you, without your prior authorization, to provide appointment reminders or information about alternative or other health-related benefits and services that may be of interest to you.

18. If disclosure is required or permitted to a health oversight agency for oversight activities authorized by law. Example: When compelled by U.S. Secretary of Health and Human Services to investigate or assess my compliance with HIPAA regulations.

19. If disclosure is otherwise specifically required by law.

C. Certain Uses and Disclosures Require You to Have the Opportunity to Object.

1. Disclosures to family, friends, or others. I may provide your PHI to a family member, friend, or other individual who you indicate is involved in your care or responsible for the payment for your health care, unless you object in whole or in part. Retroactive consent may be obtained in emergency situations.

D. Other Uses and Disclosures Require Your Prior Written Authorization.

In any other situation not described in Sections IIIA, IIIB, and IIIC above, I will request your written authorization before using or disclosing any of your PHI. Even if you have signed an authorization to disclose your PHI, you may later revoke that authorization, in writing, to stop any future uses and disclosures (assuming that I haven't taken any action subsequent to the original authorization) of your PHI by me.

WHAT RIGHTS YOU HAVE REGARDING YOUR PHI

These are your rights with respect to your PHI:

A. The Right to See and Get Copies of Your PHI. In general, you have the right to see your PHI that is in my possession, or to get copies of it; however, you must request it in writing. If I do not have your PHI, but I know who does, I will advise you how you can get it. You will receive a response from me within 30 days of my receiving your written request. Under certain circumstances, I may feel I must deny your request, but if I do, I will give you, in writing, the reasons for the denial. I will also explain your right to have my denial reviewed. If you ask for copies of your PHI, I will charge you not more than $0.25 per page. I may see fit to provide you with a summary or explanation of the PHI, but only if you agree to it, as well as to the cost, in advance.

B. The Right to Request Limits on Uses and Disclosures of Your PHI. You have the right to ask that I limit how I use and disclose your PHI. While I will consider your request, I am not legally bound to agree. If I do agree to your request, I will put those limits in writing and abide by them except in emergency situations. You do not have the right to limit the uses and disclosures that I am legally required or permitted to make.

C. The Right to Choose How I Send Your PHI to You. It is your right to ask that your PHI be sent to you at an alternate address (for example, sending information to your work address rather than your home address) or by an alternate method (for example, via email instead of by regular mail). I am obliged to agree to your request providing that I can give you the PHI, in the format you requested, without undue inconvenience.

D. The Right to Get a List of the Disclosures I Have Made. You are entitled to a list of disclosures of your PHI that I have made. The list will not include uses or disclosures to which you have already consented, i.e., those for treatment, payment, or health care operations, sent directly to you, or to your family; neither will the list include disclosures made for national security purposes, to corrections or law enforcement personnel, or disclosures made before April 15, 2003. After April 15, 2003, disclosure records will be held for six years. I will respond to your request for an accounting of disclosures within 60 days of receiving your request. The list I give you will include disclosures made in the previous six years (the first six year period being 2003-2009) unless you indicate a shorter period. The list will include the date of the disclosure, to whom PHI was disclosed (including their address, if known), a description of the information disclosed, and the reason for the disclosure. I will provide the list to you at no cost, unless you make more than one request in the same year, in which case I will charge you a reasonable sum based on a set fee for each additional request.

E. The Right to Amend Your PHI. If you believe that there is some error in your PHI or that important information has been omitted, it is your right to request that I correct the existing information or add the missing information. Your request and the reason for the request must be made in writing. You will receive a response within 60 days of my receipt of your request. I may deny your request, in writing, if I find that: the PHI is (a) correct and complete, (b) forbidden to be disclosed, (c) not part of my records, or (d) written by someone other than me. My denial must be in writing and must state the reasons for the denial. It must also explain your right to file a written statement objecting to the denial. If you do not file a written objection, you still have the right to ask that your request and my denial be attached to any future disclosures of your PHI. If I approve your request, I will make the change(s) to your PHI. Additionally, I will tell you that the changes have been made, and I will advise all others who need to know about the change(s) to your PHI.

F. The Right to Get This Notice by Email You have the right to get this notice by email. You have the right to request a paper copy of it, as well.

HOW TO COMPLAIN ABOUT MY PRIVACY PRACTICES

If, in your opinion, I may have violated your privacy rights, or if you object to a decision I made about access to your PHI, you are entitled to file a complaint with the person listed in Section VI below. You may also send a written complaint to the Secretary of the Department of Health and Human Services at 200 Independence Avenue S.W. Washington, D.C. 20201. If you file a complaint about my privacy practices, I will take no retaliatory action against you.

PERSON TO CONTACT FOR INFORMATION ABOUT THIS NOTICE OR TO COMPLAIN ABOUT MY PRIVACY PRACTICES

If you have any questions about this notice or any complaints about my privacy practices, or would like to know how to file a complaint with the Secretary of the Department of Health and Human Services, please contact me at: Melissa Richman, Psy.D, LCSW 310.278.9702

EFFECTIVE DATE OF THIS NOTICE: This notice went into effect on February 16, 2017

PLEASE COMPLETE AND SIGN

Print Name: _____Signature:_____

Date:_____ Home:_____ Work:_____ Mobile:_____

Address: _____

City/Zip: _____

Email: _____

Date of Birth:_____ Social Security #: _____

Emergency Contact and Phone #: _____

Relationship to patient: _____

I hereby acknowledge that I received a copy of this mental health/psychotherapy practice's Informed Consent. There is a copy that is present in the waiting room of the office. A copy is always present with Dr. Richman and any amended copy will be available to me. _____Initial

It is very important that you are aware that computer, email, texts, efax communication can be relatively easily accessed by unauthorized people and hence can compromise the privacy and confidentiality of such communication. Thus are vulnerable to unauthorized access due to the fact that servers and communication companies may have unlimited and direct access to emails texts efaxes and can go through them. My email is encrypted although. You should not communicate any information to your healthcare provider that you would not want included in a postcard sent through the Post Office. Email on your phone, tablets and laptop have inherent privacy risks especially through your employer or school. Emails, texts faxes are part of your clinical record. Please notify Dr. Richman if you decide to avoid or limit in anyway the use of such communication. If you communicate confidential and private information via unencrypted phone calls, messages, emails, texts, efax, you hereby attest that you have evaluated the risks and made an informed decision to do so. You also attest to such instances that you have chosen to take the risks that such communication can be intercepted. You also consent to receive communications from. Dr. Richman via unencrypted phone calls, phone messages, emails, texts and efax. Please do not use such communication for emergency. This consent will be retroactive from the beginning of treatment. _____Initial

CREDIT CARD AUTHORIZATION

Please **COMPLETE AND SIGN** all information on this form to authorize us to accept your credit card.

I, _____hereby authorize Melissa Richman, Psy.D, LCSW A Psychotherapy Corporation and Licensed Clinical Social Worker ("Dr. Richman"), to charge my credit card for her professional services. This amount may be charged to my card for each appointment I make with Dr. Richman. The amount charged may change from time to time, in keeping with Dr. Richman's then current hourly rate.

Please circle card type: MasterCard / Visa / American Express

Card Number:_____

Expiration Date: Month _____ Year _____ Security Code _____

Billing Zip Code _____

Signature: _____