Psychotherapist-Patient Service Agreement

This document contains important information about my professional services and business policies. It also contains summary information about the Health Insurance Portability Act (HIPAA,) a federal law that provides privacy protection and patient rights with regard to the use and disclosure of your Protected Health Information (PHI) used for the purpose of treatment, payment, and health care operations. HIPPA requires that I provide you with a Notice of Privacy Practices (the Notice) for use and disclosure of PHI for treatment, payment, and health care operations. The Notice, which you received with this packet, explains HIPPA in greater detail. We can discuss any questions you have about these documents now, or at any time in the future. **It is very important that you read all documents carefully. When you sign this document, it will represent an agreement between us.** You may revoke the Agreement in writing at any time. This revocation will be binding on me unless I have taken some action in reliance on it. For example, if you have not satisfied your financial obligations to me, or if there are obligations imposed on me by your health insurer to substantiate claims made on your policy, your revocation of this Agreement will not dissolve your duty to pay or my duty to cooperate with your insurer.

CONFIDENTIALITY IN THERAPY

I will treat what you tell me with great care. Under mot circumstances, my professional ethics (that is, my profession's rules about moral matters) and the law prevent me from telling anyone else about what you tell me unless you give me permission to do so. These rules and laws are the ways our society recognizes and supports the privacy of what we talk about—in other words, the "confidentiality" of therapy. But I cannot promise you that what you tell me will never be revealed to someone else. There are some limits on confidentiality. We need to review these rules, because I want you to understand clearly what I can and cannot keep confidential. You need to know about these rules so that you do not tell me something as a "secret" that I cannot keep secret. Please read these rules carefully. We can discuss them at any time you have questions about them**. Your signature on this Agreement provides your consent to these limits on confidentiality and affirms that you understand them.**

1. **When you or other persons are in physical danger, the law requires me to tell others about it.** Specifically:
   a. If I come to believe that you are threatening serious harm to another person, I am required to try to protect that other person. I may have to tell the person and the police or perhaps try to have you put in a hospital.
   b. If you seriously threaten or act in a way that is likely to harm yourself, I may have to seek a hospital for you or to call on your family members or others who can help to protect you. If such a situation does come up, I will try to discuss it with you first, or as soon after as possible.
   c. In an emergency where your life or health is in danger, and I cannot get your consent, I may give another professional some information to protect you. I will try to get your permission first, and I will discuss it with you as soon afterward as possible.
   d. If I suspect that you, or someone you tell me about is abusing a child, a disabled person, or a person over the age of 60 and living in a domestic situation, I must make a report to a state agency. To "abuse" means to hurt, neglect, or sexually molest another person. I do not have any legal power to investigate the situation to find out the facts. Once such a report is made, the state agency will investigate, and I might be required to provide additional information. If this might be your situation, you should discuss the legal aspects in detail with your lawyer before you tell me anything about these topics.

2. **If you are involved in a court case or proceeding** and a request is made for information concerning your diagnosis and treatment, such information is protected by the psychologist-patient privilege law. I cannot disclose any information without a court order. If you are involved in, or contemplating litigation, you should consult with your attorney to determine whether a court would be likely to order me to disclose information. Here are some situations where I may be required to testify:

   a. In child custody or adoption proceedings, where your fitness as a parent is questioned.
   b. In cases where your emotional or mental condition is important for a court's decision including, but not

limited to through the course of a personal injury lawsuit in which you are claiming emotional damages.

c. During a malpractice case or an investigation of any therapist by a professional group or when a government agency is seeking information for health oversight activities.
d. In a civil commitment hearing to decide if you will be admitted to a psychiatric hospital.
e. When you are seeing me for court-ordered evaluation or treatment. In this case, we will need to discuss confidentiality fully, because you don't have to tell me what you don't want a court to find out through my report.

3. Here are some things you need to know about confidentiality in regard to **insurance and money matters**:
   a. If you use your health insurance or any form of government-sponsored medical payment assistance (such as Medicare or Medicaid) to pay for a portion of your psychotherapy fees, insurance companies require some information about our therapy. Some will only want a diagnosis, procedure codes, dates of service, and fees. Some also want details about symptoms, treatment plans, psychotherapy interventions I used, your response to the treatment, and other detailed information. You should call your insurer to determine what they will require from me. (Please read the additional information in the "insurance reimbursement" section. Disclosures required to collect overdue fees are discussed there.) If your insurance company requests a copy of your Clinical Record and includes a release you have signed in their communications with me, I will have to release this information to them, although I will try to consult with you before I do so. If you object or refuse to allow me to forward records about you, the insurance company may request the money back that they have paid for your sessions. I will need to return these funds. At that time, all of the fees for your therapy sessions that were returned by me to the insurance company will have to be paid to me by you. Any time I need to return funds to an insurance company, you will be entirely responsible to pay those fees.
   b. If you are involved in a personal injury lawsuit for which Defendant's insurance has medical payments coverage, I may be asked to provide some information about our therapy to Defendant's insurance in order to allow that company to pay for your care under that provision of the policy. If you are involved in such a lawsuit for which your emotional damages are at issue, discuss the potential for this type of situation with your attorney.

4. **Children and families** create some special confidentiality considerations:
   a. When I treat children under the age of 12, I must tell their parents or guardians whatever they ask me. As children grow more able to understand and choose, they assume legal rights. For those between the ages of 12 and 18, things they tell me may be treated as confidential. However, parents and guardians do have the right to *general* information, including how therapy is going. They need to be able to make well-informed decisions about therapy. I may also have to tell parents or guardians some information that I am told about other family members. This is especially true if these other's actions put anyone in any danger. Patients under 12 years of age and their parents should be aware that the law allows parents to examine their child's records. Parents of children between 12 and 18 cannot examine their child's records unless the child consents and unless I find that there are no compelling reasons for denying the access. Parents are entitled to information regarding their child's current physical and mental condition, diagnosis, treatment needs, services provided, and services needed.
   b. Since parental involvement is often crucial to successful treatment, in most cases, I ask that patients between 12 and 18 years of age enter into a verbal agreement with me that allows parents access to certain additional treatment information. If everyone agrees, during treatment, I will provide parents with additional information. Generally, I ask that both parents and adolescents agree to accept my judgment regarding what additional material will be shared. I will always disclose information to parents (or others if necessary) if I believe a teenager is engaging in life-threatening or very dangerous behavior. Otherwise, I believe teenagers typically need a private relationship in which to discuss their thoughts and feelings, and I will only share information I believe will be enhancing to improved understanding and communication between parents and child and/or improve functioning of the child.

Occasionally, if parents or children do not agree to allow communication between parties, I will refer them to another therapist.

c. In the case of joint custody of a child who is a patient here, and either parent brings that child for therapy, either parent will be informed of the child's treatment **if the parent asks me for that information.** Both parents have a legal right to be informed of their child's treatment and progress if they request such information.

In cases where I treat several members of the same family, (parents, children, or other relatives) the confidentiality situation can become very complicated. At the start of our treatment or when a new family member enters the treatment, we must all have a clear understanding of our purposes and my role. Then we can be clear about any limits on confidentiality that may exist. You should assume that confidentiality will necessarily decrease if you choose to include others in your therapy or should you agree to my seeing others known to you. If you begin individual therapy with me and decide to include another party at a later date, the confidentiality of previously discussed material cannot be guaranteed.

When I treat couples, I encourage partners to communicate directly and honestly, and I assume that all information shared by either partner is open for discussion in the context of couple's therapy 0r individual or family therapy for the members of the couple.

a. If you tell me something that your spouse doesn't know, and not knowing this could physically harm him or her, I cannot promise to keep it confidential. I will try to work with you to decide on the best long-term way to handle situations like this.
b. If you and your spouse have a custody dispute or a court hearing is coming up, I will need to know about it. My professional ethics prevent me from doing both therapy and custody evaluation.
c. If more than one married or family member sees me for therapy, you must agree at the start of treatment that if you eventually decide to divorce, you will not request my testimony for either side. The court, however, may order me to testify. *When you sign this document, you are agreeing not to request my testimony in the event of a divorce.*
d. All members of a family must sign a release form for me to release information about therapy to an outside party if I create a common record of therapy.

Other confidentiality matters:

a. If you want me to send or discuss information about our therapy to or with someone else, including a family member, you must ask me to do so directly and usually will sign a "release of records" form. I have copies that you can see. If you sign this form, I retain the right to release such information in any form (verbal, written, etc) I choose. (Note exceptions above on pg. 1)
b. I will occasionally consult with other professionals outside of my practice about your treatment in order to provide you with the best quality of care. During a consultation with another professional, I make every effort to avoid revealing the identity of my patient. The other professionals I may consult are all bound to the same rules of confidentiality as I am. If you don't object, I will not tell you about these consultations unless I feel it is important for our work together. (If you have requested the consultation, you must sign a release form.)
c. I may share protected information without notation or consent with others within my practice for both clinical and administrative purposes, such as billing, scheduling, clinical consultation, and quality assurance. All of my staff members have been given training about protecting your privacy.
d. A court will not consider information that you also share outside of therapy, willingly and publicly, protected or confidential because the Doctor-Patient privilege will be deemed to have been broken.
e. If you file a medical malpractice complaint or lawsuit against me, I am permitted to disclose relevant information regarding your care in order to formally defend myself.
f. If you file a worker's compensation claim, and I am rendering my treatment to you within the provisions of the Illinois Worker's Compensation Act, I must, upon appropriate request, provide a copy of your record to your employer or the appropriate Human Resources officer of your employer.

While this written summary of exceptions to confidentiality should prove helpful in informing you about potential problems, it is important that we discuss any questions or concerns that you may have now or in the future. The laws governing confidentiality can be quite complex, and I am not an attorney. In situations where specific advice is required, formal legal advice may be needed.

PROFESSIONAL RECORD

You should be aware that, pursuant to HIPAA, I keep Protected Health Information (PHI) about you in two sets of professional records. One set constitutes your Clinical Record. This includes a description of your primary symptoms, your diagnosis, your progress in therapy, any treatment plan I generate, and sometimes medical information like medicines you take or medical history, your previous psychiatric or therapeutic records (if I have copies of them), some correspondence between you and me, authorization to release or receive information, and all matters pertaining to insurance and money.

In addition, I may also make some Psychotherapy Notes. These notes are for my own use and are designed to assist me in providing you with the best treatment. While the contents of Psychotherapy Notes vary from client to client, they can include the contents of our conversations, my analysis of those conversations, and how they impact your therapy. They may also contain sensitive information that you may reveal to me that is not required to be included in your Clinical Record. These Psychotherapy Notes are separate from your Clinical Record. While insurance companies can request and receive a copy of your Clinical Record (you may have already signed authorization for this as a condition of insurance coverage), they cannot receive a copy of your Psychotherapy Notes without separate Authorization. Please note that on the rare occasions that Psychotherapy Notes are requested, I try to negotiate a summary of pertinent information instead of the actual notes. As part of compliance with government rules, an agency may review your records. You may examine and receive a copy of both sets of records, if you request it in writing. Because these are professional records, they can be misinterpreted or confusing to untrained readers. For this reason, I recommend that you initially review them in my presence or have them forwarded to another mental health professional so you can discuss the contents. There will be a service charge to forward records.

I maintain my Psychotherapy Notes (when I make them) and most of the Clinical Record, and my administrative assistant maintains the business (or money and insurance) elements of the Clinical Record. In order for my assistant to assist you or your insurance company, she does have access to your name, dates of service, demographic information, your diagnosis and very limited other clinical information. She does not read the Psychotherapy Notes, if I make any, about our sessions. My assistant is chosen with great care and is subject to all the legal and ethical principles regarding your privacy and confidentiality that I am. She will thus guard any information about you very carefully.

PATIENT RIGHTS:

HIPAA provides you with rights with regard to your Clinical Records 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; having any complaints you make about my policies and procedures in your records; and the right to a paper copy of the Agreement, the attached Notice form, and my privacy policies and procedures. I am happy to discuss any of the rights with you.

UNDERSTANING RISKS:

While the goal of psychotherapy is to help people function better, sometimes, people seeking therapy feel worse instead of better. Sometimes material that arises in therapy can be very upsetting. Sometimes couple's therapy can lead to conflict or divorce. These and other outcomes are risks of entering psychotherapy. Please ask me about any concerns you have regarding negative outcomes or risks of psychotherapy.

LEGAL DUTIES OF PATIENTS:

Providing Accurate and Complete Information to me. As my patient, you have a duty to provide accurate and complete information to me that is relevant to your diagnosis and treatment. You are not under a duty to volunteer all information about yourself, but if you are aware that I have not ascertained some aspect of your mental health or medical history or current circumstances or behaviors that **could pose a risk of harm to yourself or others, you must volunteer the additional information to me.** If you give me false or misleading information that poses harm to yourself or others, you could be found liable under Illinois law for contributory negligence. This can include details about past diagnoses, list of medications, suicidal or homicidal thoughts, intentions, or behaviors, or accurate contact information, as examples.

Duty to Cooperate with Treatment. I expect all my patients to cooperate and participate in treatment to the extent that they are able. I will always explain the necessity of a preferred treatment or clinical recommendation when asked. If you intentionally disregard my healthcare advice after my explanation of its necessity, and you are fully cognizant of the potential consequences of refusing treatment, I cannot be held legally responsible for any resulting injury or damages to you under Illinois law. Your duty to cooperate with treatment will always be within the bounds of the consent you give through this Agreement.

Abiding by Legal Agreements I expect you to abide by any provisions of your joint parenting agreement, for example, notifying or requesting permission of another parent regarding your child's involvement in therapy. I may not, as a matter of course, notify the other parent. You are responsible for doing so if you have agreed to do this in a legal document.

Reviews, Discussion of Treatment, Complaints, and Online Postings
A patient may, through the course of treatment, desire to speak about his or her experience under my treatment. There is nothing preventing you from voluntarily discussing the fact that you are under my care with a friend or relative. Please note that discussing the specifics of our work together may affect the confidentiality of our communication in a legal setting. If you are dissatisfied with my treatment, I urge you to discuss your grievances with me. If you choose to make an online posting about my treatment (such as on "Yelp"), please note that under Illinois law, posting false statements online constitutes defamation and can expose you to civil or criminal liability. There is nothing preventing me from exercising my rights under the law to combat false statements about my practice.

TERMINATION OF THERAPY:

When we have concluded our work together at the end of your therapy, I will discharge you from treatment and close your case. At that time, you will no longer be considered an active patient and I will not be responsible for your care. You are free to return to active therapy at any time, assuming I am able to take you, at which time your case will re-open. **If you have not made an appointment, contacted me to schedule an appointment, or attended an appointment within a 7 day period, or immediately if you fail to attend a scheduled appointment and do not contact me about it, your case will be closed, and you will be considered discharged from therapy and no longer under my care.** At the time when you attend a new appointment, your case will re-open.

PROFESSIONAL FEES, BILLING, AND INSURANCE MATTERS:

My fee for a 52-60 minute therapy session is $170.00. Sessions scheduled for a shorter length of time are billed at a lower amount based on the same rate: $3.27 per minute. The fee for an initial consult is $210.00. The charge for phone consultation or therapy or other services is $35.00 for each ten-minute segment. (Note that insurance companies will not typically pay for phone consultations.) Other services include report writing, consulting with other professionals, preparation of records or treatment summaries, and the time spent performing any other service you may request of me. If you become involved in legal proceedings that require my participation, you will be expected to pay for all of my professional time, including preparation and transportation costs, even if I am called to testify or consult **by another party.** My fee for preparation for, travel to, and attendance at any legal proceeding is $350.00 per hour.

If you need to cancel an appointment made in person, by phone, or through email or texting, you must do so 24 hours in advance or you will be charged the full psychotherapy session rate. Please note that insurance companies will not reimburse for missed appointments.

BILL PAYMENT, INSURANCE REIMBURSEMENT, AND COLLECTIONS:

"Self-pay" means you are paying your psychotherapy fees yourself. Payment is due at the time of service. **I AM IN NETWORK ONLY WITH THE ORIGINAL, EMPLOYER-SPONSORED BLUE CROSS/BLUE SHIELD OF ILLINOIS PPO. I am not in network with Blue Cross Choice (or any other policy that has been instituted since January, 2016), any HMOs or other PPOs**. If you have a health insurance policy, it will often provide some coverage for mental health treatment. I will sometimes file claims with your insurance carrier, as a courtesy to you, as long as you provide me with all necessary information. **You (not your insurance company) are responsible for full payment of my fees. It is very important that you find out exactly what mental health services your insurance policy covers, what reimbursement they will pay, and if there are any conditions or exclusions to your mental health coverage. It is especially important that you find out whether your plan requires pre-authorization for mental health services. You are responsible for finding out if I am a covered provider for your plan. If you have any questions, you should call your plan administrator. I accept assignment from BCBS of IL PPO through an employer only. You must pay for services directly if you have another plan. The balance on your account is always your responsibility.** If your insurance company has not paid your claims in 45 days, the balance will become your responsibility to pay immediately. If you believe insurance should be paying more than they are, you will need to contact them to secure payment. It is not our responsibility to obtain payment from your insurance company. In addition, any time your **insurance company requests a refund of payment** they have sent to me, I must return the funds and they will need to be paid to me by you immediately.

We expect full payment of any balances within 30 days of our sending out a statement to you. If you have not made payment or contacted us after 60 days, we will turn over your account to a collection agency. You will then be responsible for any attorney's or court costs or any cost of collection. Our office or a collection office will contact you at any number or location we have knowledge of or through any modality we/they identify in order to collect on a bill. We may also attempt to collect payment on your account through a small claims complaint or other civil action in the event that our collection methods are unsuccessful. This action, if taken, may require me to disclose otherwise confidential information.

When assessment or treatment is sought for a minor or adult child**, payment is the responsibility of the parent who arranges or authorizes the appointment for the patient.** After a parent authorizes his or her child to enter into therapy by bringing, arranging, authorizing or sending his or her child to sessions with me, if the child makes future appointments, the charges for all such appointments will be the responsibility of the parent who originally sought sessions for their child.

If you are seeking reimbursement for services under your health insurance policy, you will be required to sign an authorization that allows me to release information to your insurance company. I am required to supply whatever information your insurance company seeks, provided they have a signed release from you. Sometimes I am required to provide additional clinical information, such as treatment plans or summaries, or copies of your entire clinical record. I will make every effort to release as little information as possible. Such information will become part of the insurance company's files and will probably be stored in a computer. Though insurance companies typically seek 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 information with a national medical information databank or may share information within that system or with others. You always have the right to pay for my services yourself, to avoid any of the issues described above.

CONTACTING ME:

Due to my work schedule, I am not immediately available by telephone (630-879-8164). I will sometimes answer my phone when you call, but you can always leave a message on my confidential voicemail. I am the only person who retrieves these messages (unless I were to become severely incapacitated, in which case another psychologist would retrieve my calls.). If you leave a message, I will make every effort to return your call at my earliest opportunity. If your call is of a more urgent nature, you may try my cell phone (630-476-1155). **Please be aware that I cannot always respond to cell phone calls or texts. This is *one* way you can *try* to reach me, but you should not view my cell phone as a crisis line that I will always answer.** *Please use my cell phone for urgent matters only*. Please be aware that texting is not a good way to communicate with me. Appointments should be scheduled by using my office number. Because texting, faxing, and conventional email communications are inherently insecure, **the confidentiality of sensitive materials cannot be assured.** I will respond to you in the manner you use to contact me or request of me, but please be aware that mistakes happen in delivering or receiving communication and **confidentiality can be compromised if texting, email, or faxing are used.**

In cases of serious mental health emergency, you may try to reach me at my home phone (630-879-9124). You may also try to reach your psychiatrist or family physician. If your situation is too urgent for you to **wait for a returned call, go to the nearest emergency room. If you are experiencing a mental health emergency and believe you need immediate attention, call 911.** If I will be unavailable for an extended period, I will provide you with the number and name of a colleague to contact, if necessary.

QUESTIONS YOU MAY HAVE ABOUT PSYCHOTHERAPY

Please feel free to ask me any of these questions **or any other questions** that arise at any time during therapy:

- What will we do in therapy?
- How will you assess what I need in therapy? What will my treatment plan be?
- Can anything bad happen because of therapy?
- What will I notice when I am getting better?
- Do people with my type of problem usually get better? Do they ever get worse? Do people sometimes get better without therapy?
- How long will my therapy take?
- What should I do if I think therapy isn't working?
- What types of alternative therapies are available?
- How much training and experience do you have?
- Do you have a license?
- How does it work if you see more than one member of a family?

Patient Information Sheet

Patient Name _____ SSN ____-___-_____ DOB (mmddyy) ___/___/___

Gender (M or F) ___ Marital Status (M,S,D,W) ___ Phone: H(____)- ____-_____ cell (___)-____-____ work (___)-___-____

Address_____ Patient Employer:_____

_____

Emergency contact and phone number:_____

Primary Insurance

Insured's Name _____ Insured's employer_____

Insured's DOB (mmddyy) ____/____/____ Insured's address_____

_____

Release of Information

I authorize the release of information to my insurance company from my medical records to complete any claim for benefits. I understand that this information is confidential and protected by federal /state law.
I understand that I may revoke this authorization at any time in writing with respect to future disclosures.
No person or agency to whom any information is disclosed under the Illinois authorization law may redisclosed this information unless the person who consented to the disclosure specifically consents to the redisclosure.
I have the right to inspect and copy the information disclosed.
I also understand that I have the right to refuse to sign this document. It has also been explained to me if I refuse to sign this release of information, Amy MacDonald will not be able to bill my insurance company for me.

_____ _____
(Patient or Parent/Legal Guardian) (Date)

Financial Agreement

I agree I, not my insurance company or other entity, am fully responsible for, and I agree to pay Dr. MacDonald in accordance with her regular rates and terms irrespective of whether my insurance company does or does not pay any of those fees. If my account is referred for collection, I agree to pay Dr. MacDonald any cost of collection, including attorney's fees and court costs**. I know that if I cancel a scheduled appointment, the appointment must be cancelled 24 hours in advance or I will be charged the full session fee. I understand that I (not my insurance company or other party) am responsible for full payment of Dr. MacDonald's fees.**

Assignment of Benefits

I assign and transfer to the provider, benefits due under any contract of insurance or from any other source for the services provided. I authorize the provider to apply for benefits due for services provided. I further authorize a copy of this assignment to be used in place of the original. I acknowledge and understand that the provider is not responsible for determining the existence or extent of any insurance or other benefit that may be due for services provided, and that I am responsible for all charges not paid by insurance. I understand that I am responsible for checking my insurance benefits.

_____ _____
(Patient or responsible party) **(Date)**

Consent to Assessment and Treatment and Agreement to Policies: Please read and initial the following:

_____I am seeking psychotherapy with Amy MacDonald, PsyD. Dr. MacDonald has encouraged and answered my questions regarding psychotherapy, including questions about risks, benefits, or alternatives to psychotherapy or to her style of psychotherapy. No guarantees have been made or implied to me regarding my progress, improvement, or benefit from psychotherapy. I am choosing to enter into psychotherapy freely and know I can choose to terminate my therapy at any time.

_____Dr. MacDonald has advised me that there may be times she is unreachable or unavailable to take or return my call. I understand that I must have an alternative plan for managing a mental health crisis, such as calling my physician, going to the nearest emergency room, or calling 911.

_____I understand that if I need to cancel an appointment, I must do so 24 hours in advance or I will be responsible for paying the full psychotherapy fee. I understand that I am fully responsible for paying Dr. MacDonald's fees in accordance with her terms. I know she is in-network with Blue Cross/Blue Shield traditional PPO only, not Blue Choice or any other insurance type.

_____I understand that texting, faxing, conventional email, or cell phone usage are not secure forms of communication and that I should only leave voicemail messages on Dr. MacDonald's office line (630-879-8164) to increase security. I understand that if I use a non-secure form of communication with Dr. MacDonald and want her to respond using the same mode, protection of information cannot be ensured.

Occasionally, Dr. MacDonald or her billing service will need to contact you by phone.
_____Please call me with any type of message at this number_____

_____I authorize Dr. MacDonald or her representative or billing service or collection service to use any phone numbers or other method of contact including, but not limited to work numbers, cell phone numbers, emergency contact numbers, addresses, or any and all other modes of communication to reach me in a crisis or for purposes of collection of fees. If fees are overdue and collection is being sought, I agree for Dr. MacDonald, her representative or collection service to leave messages for me regarding collection at any number they choose to use.

_____YES, I would like Dr. MacDonald to contact my physician to discuss my diagnosis and treatment in order to coordinate care. My physician's name and number are:_____
_____NO, I will ask in the future if I want Dr. MacDonald to call my physician.

I have received the "Patient-Therapist Service Agreement" and "Notice of HIPAA" information. I understand, consent, and agree to all terms and conditions of this agreement.

_____ _____
Patient and/or parent/guardian **date**

Authorization to release information within an affiliated group
I hereby give my consent to Amy MacDonald, PsyD, to release, exchange, or request clinical information to, with, or from my spouse, child, parent, sibling, or other family (or affiliated group) member for the purposes of enhanced treatment planning and/or psychotherapy or assessment. I understand that I may revoke (in writing) this consent at any time and that no consequences will ensue if I refuse to sign this consent.

_____
Signatures **date**

Agreement to Pay Professional Fees: I agree to pay in full the professional fees of Amy MacDonald, PsyD on behalf of another party, in accordance with her regular rates and terms. I understand that the person I am paying for must cancel appointments 24 hours in advance or they will be charged the full psychotherapy session fee for those appointments.

Appointment Reminders and Electronic Billing*

APPOINTMENT REMINDERS:

____Yes, I would like to receive appointment reminders via email.

Please use this email address for appointment reminders_____

____No, I would not like to receive appointment reminders via email.

____Yes, I would like to receive appointment reminders via text message.

Please use this cell phone number for appointment reminders_____

____No, I would not like to receive appointment reminders via text message.

PATIENT STATEMENTS:

___Yes, I would like to receive bills/patient statements via email.

Please use this email address for bills and statements_____

____No, I prefer to receive statements via conventional U.S. mail.

I understand that no electronic communication is guaranteed to be completely secure, I understand that if I choose to receive communications electronically, errors that compromise security can occur.

_____

Patient or Guardian **Date**

***Therapyappointment (the system we use for appointment reminders and email statements) represents their system as secure, encrypted, and HIPAA compliant. However, no electronic system can be guaranteed by Prairie Psychotherapy Services to be 100% secure. If you have any security concerns, please choose the conventional mail option.**

Couples and Families in Psychotherapy and Consultation

There are benefits and limitations to conducting psychotherapy or consultation with multiple members of the same family.* It is important that the benefits and limitations of different ways of providing consulting and therapy services are considered.

One clinician may provide services to more than one member of a family. Such an arrangement might involve couple's counseling, family counseling, individual therapy for more than one person in a family, a combination of these treatments, or other clinical scenarios. There is an advantage to such an arrangement in that the clinician may be able to collect more detailed background information, aid an individual in processing perceptions of others and of understanding him or herself; may be able to develop a richer understanding of personalities, relational dynamics, and needs and feelings of all family members; may have the ability to perceive distortions, misunderstandings, or miscommunications between members; and may have an increased opportunity to build connections, aid in solving problems, and foster healthy communication, increased intimacy, and more satisfying relationships between members in a way that would not be possible if only one family member were seen. Even if members are seen by different therapists who consult with one another, greater subtleties may be discerned when services are provided by only one clinician as opposed to being provided by multiple practitioners who consult with one another.

When a clinician provides services to only one member of the family and refers others to different practitioners, there is greatly increased privacy for each individual, as a clinician **seeing multiple members of a family will almost always create a decrease in confidentiality for all members.** When each family member has his or her own therapist, each may feel a greater level of comfort regarding disclosing information; may have an increased feeling of being understood only from his or her point of view; and may feel an important sense of having his or her needs and feelings be the only priority in the session. Unresolvable conflict between family members may necessitate one or all parties being referred to another provider, which may be disruptive to their progress, comfort, and attachment in therapy. If all members of a family have goals and agendas that are not at odds with those of others in the group, a referral should not be necessary, but may be chosen at any time by the clinician or a group member. **When multiple members of a family seek therapy or consultation in this practice, they are agreeing. to abide by the judgment of their clinician regarding what is or is not shared with other members.** Clinicians may intentionally or accidentally reveal some private information to another family member or may choose not to disclose something another member would like to have known. If two people who are both being treated by the same practitioner decide to divorce, therapy for both will likely be terminated and they will be referred to other practitioners.

Both models of practice have benefits and each has limitations. If you are electing to use the model of one practitioner for your family or affiliated group, it is important that you ask questions or raise concerns if necessary regarding understanding these strengths and limitations. At any time, another option can always be pursued,

* "Families," herein, refers to all families and otherwise affiliated people.

I have had an opportunity to ask questions about benefits and limitations of different practice models regarding members of the same family. I know I can ask questions at any time they should arise. I agree to the terms and conditions of this document.

Names dates