Full Disclosure Statement & Agreement For Services

Introduction

This document is intended to provide important information to you regarding your treatment. Please read the entire document carefully, and be sure to ask your therapist any questions that you may have regarding its contents. Your therapist is ***Terryann Sanders, a Licensed Marriage and Family Therapist, MFC41760***. You are free to ask questions at any time about your therapist's background, experience and professional orientation.

Fees and Insurance

The fee for service is $__175.00_____ per individual therapy session.

The fee for service is $___175.00____ per conjoint (marital /family) therapy session.

Individual and conjoint (marital /family) sessions are usually 50-60 minutes in length. Fees are payable at the time that services are rendered, and may be paid by cash, check or credit card. Fees will be charged for consultation with other providers that may be necessary during the course of treatment. Fees for consultation will be calculated in 15-minute increments, and billed at the session rate. A fee will be charged for telephone contact between you and your therapist in excess of 10 minutes, and will be calculated at the same rate as session fees. A $25.00 fee will be charged for all returned checks. ***Please be advised, the full session rate will be charged for cancellations without 24-hour notice.***

Insurance is not accepted. Your therapist will provide you with a monthly statement that can be used for insurance reimbursement. We are unable to guarantee whether your insurance company will provide payment for the services provided to you, and suggest you contact your insurance company in advance to determine reimbursement rates.

If for some reason you find that you are unable to continue paying for your therapy, you should inform your therapist. Your therapist will help you to consider any options that may be available to you at that time.

Confidentiality

All communications between you and your therapist will be held in strict confidence unless you provide written permission to release information about your treatment. If you participate in marital or family therapy, your therapist will not disclose confidential information about your treatment unless all person(s) who participated in the treatment with you provide their written authorization.

Please note that messages sent by email or text are not completely secure or confidential, and the privacy of communication cannot be guaranteed. It is the policy of your therapist to use email and text messages only for scheduling purposes, or to inform clients of upcoming groups or workshops that may be of interest to them. Please be aware that if you use email to provide information to your therapist, your therapist cannot guarantee the confidentiality of that information and you do so at your own risk.

Professional consultation is an important part of treatment planning and your therapist attends professional consultation groups in which cases are discussed in a confidential manner. When appropriate, your therapist may recommend other treatment professionals and work in conjunction with them to provide a holistic treatment plan. Your therapist reserves the right to require monitoring by a medical professional as a condition of treatment when it is your therapist's professional judgment that medical monitoring is necessary to the treatment process. By signing the summary of this agreement you acknowledge your awareness that your therapist may discuss information about your treatment with other professionals when deemed appropriate or necessary to your treatment. Your therapist will take all reasonable measures to ensure the confidentiality of your private health information.

There are limitations to the confidentiality of your private health information. For example, therapists are required to report instances of suspected child or elder abuse. This could include incidents in which a person knowingly develops, duplicates, prints, downloads, streams, accesses through any electronic or digital media, or exchanges a film, photograph, or video in which a child is engaged in an act of sexual conduct. Therapists are also required, or permitted, to breach confidentiality when they have determined that a patient presents a serious danger to him or herself or others. In addition, a federal law known as The Patriot Act of 2001 requires therapists,

in certain circumstances, to provide FBI agents with books, records, papers, documents and other items, and prohibits the therapist from disclosing to the patient that the FBI sought or obtained the items under the Act.

INFORMED CONSENT

Minors and Confidentiality
Communication between therapists and patients who are minors are confidential. However, parents and other guardians who provide authorization for their child's treatment may be involved in their treatment. Consequently, your child's therapist, in the exercise of his or her professional judgment, may discuss the treatment progress of a minor patient with the parent or caretaker. However, in the interest of developing a trusting therapeutic relationship, your therapist will not discuss the details of therapy sessions or conversations that take place between your child and the therapist. Parents and patients who are minors are urged to discuss any questions or concerns that they have on this topic with their therapist.

Appointment Scheduling and Cancellation Policies
Sessions are typically scheduled for once a week at the same time and day if possible. Your therapist may suggest more or less frequent sessions depending on the nature and severity of your symptoms. Your consistent attendance greatly contributes to a successful outcome. In order to cancel or reschedule an appointment, you are expected to notify your therapist at least 24 hrs. in advance. If you do not provide at least 24 hour advance notice of cancellations you will be responsible for payment of the missed session. Please understand that your insurance company will not pay for missed or cancelled sessions.

Therapist Availability/Emergencies
Telephone consultations between office visits may be necessary at times. However, your therapist will attempt to keep those contacts brief due to our belief that important issues are better addressed within regularly scheduled sessions. Any telephone contact over 10 minutes in duration will be charged to you at the same rate as the session fees.

You may leave a message for your therapist at any time on voicemail. Your therapist cannot guarantee that calls will be returned immediately, but will make every effort to respond as soon as possible. Your therapist is unable to provide 24-hour crisis service. In the event that you or your child is feeling unsafe, or you require immediate medical or psychological assistance, you should call 911 or go to the nearest emergency room.

About the Therapy Process
It is your therapist's intention to provide services that will assist you or your child in reaching your goals. Based upon the information that you provide to your therapist and the specifics of your situation, your therapist will provide recommendations to you regarding your treatment. We believe that therapists and patients are partners in the therapeutic process. You have the right to agree or disagree with your therapist's recommendations. Due to the varying nature and severity of problems and the individuality of each patient, your therapist is unable to predict the length of your therapy or to guarantee a specific outcome or result.

Client Litigation
Your therapist will not voluntarily participate in any litigation or custody dispute in which you and another individual, or entity, are parties. Your therapist has a policy of not communicating with your attorney, and generally will not write or sign letters, reports, declarations, or affidavits to be used in your legal matters. Your therapist will not provide records or testimony unless compelled to do so. If your therapist is court ordered to appear as a witness in an action involving you, you agree to reimburse your therapist for time spent for preparation, travel, or making a court appearance at the same rate as the session fees.

Termination of Therapy
The length of your treatment and the timing of the eventual termination of your treatment depend on the specifics of your treatment plan and the progress you achieve. It is a good idea to plan for your termination in collaboration with your therapist. Your therapist will discuss a plan for termination with you as you approach the completion of your treatment goals.

You may discontinue therapy at any time. It is important for you to notify your therapist if you are terminating treatment, otherwise you may incur missed appointments fees. If you or your therapist determines that you are not benefiting from treatment, either of you may elect to initiate a discussion of your treatment alternatives. Treatment alternatives may include, among other possibilities, referral to another treatment professional,

changing your treatment plan or goals, or terminating your therapy.

By signing the Disclosure Statement and Agreement for Services, you acknowledge receipt of this Full Disclosure Statement and Agreement for Service, and you agree to abide by this agreement. Please feel free to discuss the contents of this agreement with your therapist.

_____ _____

PRINTED NAME DATE

_____

SIGNATURE

TELEHEALTH ADDENDUM (If Applicable Please Sign)

I understand that "telemedicine" 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 or mental health 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) All laws regarding the confidentiality of health care information and a patient's rights to his or her medical information shall apply to telemedicine interactions. This information has been provided in detail to me in the original Agreement for Service.
(3) I understand that there are risks and consequences from telemedicine, 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.
(4) I understand that while I may benefit from telemedicine, positive results cannot be guaranteed or assured. I also understand that my psychotherapist may decide at any time that I may be better served by in-person psychotherapy services, and if so will provide me with appropriate referrals.

I understand it is my responsibility to protect the privacy of my psychotherapy by making reasonable efforts to conduct sessions in a secure and private environment with the least amount of potential interruptions. I also understand it is the responsibility of my psychotherapist to provide a reasonably secure and confidential environment on their end to ensure the protection and privacy of my personal health information.

I agree that for my protection and the protection of my private health information, recording of sessions will not be allowed.

I have read and understand the information provided above. I consent to the conditions of telemedicine, and all of my questions have been answered to my satisfaction.

_____ _____

Signature of client Date

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.

I am required by law to maintain the privacy and security of your protected health information ("PHI") and to provide you with this Notice of Privacy Practices ("Notice"). I must abide by the terms of this Notice, and I must notify you if a breach of your unsecured PHI occurs. I can change the terms of this Notice, and such changes will apply to all information I have about you. The new Notice will be available upon request, in my office, and on my website.

Except for the specific purposes set forth below, I will use and disclose your PHI only with your written authorization ("Authorization"). It is your right to revoke such Authorization at any time by giving me written notice of your revocation.

Uses (Inside Practice) and Disclosures (Outside Practice) Relating to Treatment, Payment, or Health Care Operations Do Not Require Your Written Consent. I can use and disclose your PHI without your Authorization for the following reasons:

1. **For your treatment**. I can use and disclose your PHI to treat you, which may include disclosing your PHI to another health care professional. For example, if you are being treated by a physician or a psychiatrist I can disclose your PHI to him or her to help coordinate your care, although my preference is for you to give me an Authorization to do so.
2. **To obtain payment for your treatment**. I can use and disclose your PHI to bill and collect payment for the treatment and services provided by me to you. For example, I might send your PHI to your insurance company to get paid for the health care services that I have provided to you, although my preference is for you to give me an Authorization to do so.
3. **For health care operations**. I can use and disclose your PHI for purposes of conducting health care operations pertaining to my practice, including contacting you when necessary. For example, I may need to disclose your PHI to my attorney to obtain advice about complying with applicable laws.

Certain Uses and Disclosures Require Your Authorization.

1. **Psychotherapy Notes**. I do keep "psychotherapy notes" as that term is defined in 45 CFR § 164.501, and any use or disclosure of such 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 other 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.
2. **Marketing Purposes**. As a psychotherapist, I will not use or disclose your PHI for marketing purposes**.**
3**. Sale of PHI**. As a psychotherapist, I will not sell your PHI in the regular course of my business.

Certain Uses and Disclosures Do Not Require Your Authorization. Subject to certain limitations in the law, I can use and disclose your PHI without your Authorization for the following reasons:

1. When disclosure is required by state or federal law, and the use or disclosure complies with and is limited to the relevant requirements of such law.
2. For public health activities, including reporting suspected child, elder, or dependent adult abuse, or preventing or reducing a serious threat to anyone's health or safety.
3. For health oversight activities, including audits and investigations.
4. For judicial and administrative proceedings, including responding to a court or administrative order, although my preference is to obtain an Authorization from you before doing so.
5. For law enforcement purposes, including reporting crimes occurring on my premises.
6. To coroners or medical examiners, when such individuals are performing duties authorized by law.
7. For research purposes, including studying and comparing the mental health of patients who received one form of therapy versus those who received another form of therapy for the same condition.
8. Specialized government functions, including ensuring the proper execution of military missions; protecting the President of the United States; conducting intelligence or counter-intelligence operations; or, helping to ensure the safety of those working within or housed in correctional institutions.
9. For workers' compensation purposes. Although my preference is to obtain an Authorization from you, I may provide your PHI in order to comply with workers' compensation laws.
10. 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.

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 person that you indicate is involved in your care or the payment for your health care, unless you object in whole or in part. The opportunity to consent may be obtained retroactively in emergency situations.

YOUR RIGHTS REGARDING YOUR PHI: You have the following rights with respect to your PHI:

1. The Right to Request Limits on Uses and Disclosures of Your PHI. You have the right to ask me not to use or disclose certain PHI for treatment, payment, or health care operations purposes. I am not required to agree to your request, and I may say "no" if I believe it would affect your health care.
2. The Right to Request Restrictions for Out-of-Pocket Expenses Paid for In Full. You have the right to request restrictions on disclosures of your PHI to health plans for payment or health care operations purposes if the PHI pertains solely to a health care item or a health care service that you have paid for out-of-pocket in full.
3. The Right to Choose How I Send PHI to You. You have the right to ask me to contact you in a specific way (for example, home or office phone) or to send mail to a different address, and I will agree to all reasonable requests.
4. The Right to See and Get Copies of Your PHI. Other than "psychotherapy notes," you have the right to get an electronic or paper copy of your medical record and other information that I have about you. I will provide you with a copy of your record, or a summary of it, if you agree to receive a summary, within 30 days of receiving your written request, and I may charge a reasonable, cost based fee for doing so.
5. The Right to Get a List of the Disclosures I Have Made. You have the right to request a list of instances in which I have disclosed your PHI for purposes other than treatment, payment, or health care operations, or for which you provided me with an Authorization. I will respond to your request for an accounting of disclosures within 60 days of receiving your request. The list I will give you will include disclosures made in the last six years unless you request a shorter time. I will provide the list to you at no charge, but if you make more than one request in the same year, I will charge you a reasonable cost based fee for each additional request.
6. The Right to Correct or Update Your PHI. If you believe that there is a mistake in your PHI, or that a piece of important information is missing from your PHI, you have the right to request that I correct the existing information or add the missing information. I may say "no" to your request, but I will tell you why in writing within 60 days of receiving your request.
7. The Right to Get a Paper or Electronic Copy of this Notice. You have the right get a paper copy of this Notice, and you have the right to get a copy of this notice by e-mail. And, even if you have agreed to receive this Notice via e-mail, you also have the right to request a paper copy of it.

HOW TO COMPLAIN ABOUT MY PRIVACY PRACTICES

If you think I may have violated your privacy rights, you may file a complaint with me, as the Privacy Officer for my practice, and my address and phone number are:

Terryann Sanders
Licensed Marriage and Family Therapy
Certified Eating Disorder Specialist
1624 Santa Clara Drive, Suite 110
Roseville, CA 95661
terryannsanders.com
408 410-9370
terryannsanderslmftt@sbcglobal.net

You can also file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by:

1. Sending a letter to:

U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, D.C. 20201; or

2. Calling 1-877-696-6775; or

3. Visiting www.hhs.gov/ocr/privacy/hipaa/complaints.

I will not retaliate against you if you file a complaint about my privacy practices.

EFFECTIVE DATE OF THIS NOTICE:
This notice went into effect on September 20, 2013.