This packet includes 4 sections: Child Client Informed Consent and Telehealth options, Child Client History, Treatment During COVID, HIPAA

Anna K. Boller, Psy.D.
Clinical Psychologist
Boller Psychological Services, LLC
Telephone: (801)661-1992
Please print and return this completed form to Dr. Boller prior to your first appointment.

INFORMED CONSENT AND OUTPATIENT SERVICES CONTRACT

Welcome to my practice. This document contains important information about my professional services and business policies. Information on assessment, the need for children and adolescents to have confidential psychotherapy, treating children of separated or divorced families, collateral contacts, professional records, confidentiality from third parties, and related legal issues, risks and benefits of psychotherapy, diagnosis and treatment plans, psychotherapy fees, cancellations, and emergencies is reviewed. Please read it carefully, sign each section, and jot down any questions you might have so that we can discuss them at our first meeting. When you sign this document, it will represent an agreement between us, and you can sign the final page after any questions have been discussed.

Professional Services, Business Policies and Contact Information (including emergencies)

MEETINGS

I normally conduct an evaluation that will last 1 to 2 sessions and includes your completion of the of all Child Forms on this website. During this assessment we can both decide if I am the best person to provide the services you need in order to meet your treatment goals. If psychotherapy is begun, I will usually schedule one 50-minute session (one appointment hour of 50 minutes duration) per week at a time we agree on, although some sessions may be longer or more frequent. Once an appointment hour is scheduled, you will be expected to pay for it unless you provide 24 hours advance notice of cancellation [unless we both agree that you were unable to attend due to circumstances beyond your control]. If it is possible, I will try to find another time to reschedule the appointment.

PROFESSIONAL FEES

My initial treatment assessment is $300.00.

My hourly fee is $200.00. In addition to weekly appointments, I charge this amount for other professional services you may need, though I will break down the hourly cost if I work for periods of less than one hour. Other services include report writing, telephone conversations lasting longer than 10 minutes, attendance at meetings with other professionals you have

authorized, preparation of records or treatment summaries, and the time spent performing any other service you may request of me.

Fees Continued

If you become involved in legal proceedings that require my participation, you will be expected to pay for my professional time even if I am called to testify by another party, unless the court determines otherwise. [Because of the difficulty of legal involvement, I charge $700.00 per hour for preparation and attendance at any legal proceeding.] Letters and reports will be billed at that hourly rate and payment is due upon receipt.

I understand that payment is due at the end of each session and that I am responsible for any and all fees.

Initial here if this section has been read and understood _____

BILLING AND PAYMENTS

You will be expected to pay for each session at the time it is held. I accept credit cards. I do not bill insurance companies.

Effective January 1, 2022, the **No Surprises Act,** which Congress passed as part of the Consolidated Appropriations Act of 2021, is designed to protect patients from surprise bills for emergency services at out-of-network facilities or for out-of-network providers at in-network facilities, holding them liable only for in-network cost-sharing amounts. The No Surprises Act also enables uninsured patients to receive a good faith estimate of the cost of care. Review this document for an explanation of your rights and protections under this Act.

Initial here if this section has been read and understood _____

CONTACTING ME

I am often not immediately available by telephone. I am usually in my office Monday - Thursday. I will not answer the phone when I am with a patient. When I am unavailable, my telephone is answered by a confidential voicemail that I monitor frequently. I will make every effort to return your call within 24 hours, with the exception of weekends and holidays. If you are unable to reach me and feel that you can't wait for me to return your call, contact your family physician or the nearest emergency room and ask for the crisis psychologist [social worker,psychiatrist] on call. If I will be unavailable for an extended time, I will provide you with the name of a colleague to contact, if necessary.

Initial here if this section has been read and understood _____

EMERGENCIES: I AM NOT AVAILABLE to PROVIDE CRISIS/EMERGENCY COUNSELING

If you are unable to reach me and feel that you can't wait for me to return your call and it is an emergency, call 911 or go to the nearest emergency room and ask for the psychologist, social worker or psychiatrist on call. **I am not available to provide crisis/emergency counseling between sessions. Additional crisis hotlines are available here .**

Your signature below indicates that you have read all the above information in this document and agree to abide by its terms during our professional relationship.

Signature _____

Assessment

Psychotherapists must conduct an initial and ongoing treatment assessment of children to understand their psychological needs. It is essential that you support this assessment process by completing all forms, questionnaires, and psychological tests provided to you and by meeting with your child's therapist, with or without your child present, as your child's therapist indicates. Please be completely open and honest with your child's therapist about all influences that may be affecting your child, even if doing so is painful or embarrassing. Therapists usually cannot tell when parents or children deliberately conceal things. Therapists can only help with problems to the extent that they are provided with the whole truth.

Initial here if this section has been read and understood _____

Potential Benefits and Risks of Psychotherapy

The goal of therapy is to reduce problems and strengthen coping strategies. In most cases, therapy improves a sense of well-being and relationships. In some cases children obtain little or no benefit from therapy or become worse and a different form of treatment is needed. Other treatment modalities such as family therapy, group therapy, and/or medication may be helpful and will be discussed with you if the need arises. Whether or not to utilize any of these interventions is determined by parents.

Given this knowledge, the decisions to begin, continue, or terminate therapy belong to the parents . These decisions may be evaluated with one's therapist. Parents may also obtain independent consultation for a second opinion at any time.

If you have any questions about my procedures, we should discuss them whenever they arise. **Initial here if this section has been read and understood** _____

The Need for Children and Adolescents to have Confidential Psychotherapy

I will involve the parent or guardian of a child receiving psychotherapy in helping their child to the fullest extent possible.

In the treatment of adolescents, there are many issues that therapists have not opportunity to address unless adolescents trust that communication in therapy will not be shared with parents or guardians. These issues include use of cigarettes/vaping, alcohol and drugs, sexual concerns or behavior, cutting classes or truancy, school failure, unauthorized time with peers, and criminal activity. I will work to help him/her behave in ways that are not self-destructive, that may limit his/her options for the future, and that are considerate of others. If any of these issues rise to the level of serious, imminent danger to self or to others, parents and/or appropriate authorities will be notified.

Initial here if this section has been read and understood _____

Psychotherapy is confidential from outside parties with important exceptions:

1. Information may be released to designated parties by written authorization of parents or legal guardians. I can provide consent forms for parents wishing me to talk with other parties.
2. I do not take insurance. Upon request, I can provide an invoice of payments, for your records.
3. Psychotherapists are required to release information obtained from children or from collateral sources (other individuals involved in a client's psychotherapy, such as parents, guardians, and spouses) to appropriate authorities to the extent to which such disclosure may help to avert danger to a psychotherapy client or to others, e.g., imminent risk of suicide, homicide, or destruction of property that could endanger others.
4. Psychotherapists are required to report suspected past or present abuse or neglect of children, adults, and elders, including children being exposed to domestic violence, to the authorities, including Child Protection and law enforcement, based on information provided by the client or collateral sources.
5. If adults or children participate in psychotherapy in compliance with a court order, psychotherapists are required to release information to the relevant court, social service, or probation departments.
6. Your psychotherapist must release information, which may include all notes on your child's psychotherapy and contact with collateral sources, in response to a court order and may also be required to do so in response to a legitimate subpoena. Preparation for court ordered documents is billed to the requesting parent at $700.00 an hour.
7. Psychotherapists often consult with other professionals on cases and teach or write about the psychotherapy process, but disguise identifying information when doing so. Please indicate to your therapist if you wish to place restrictions on consultation, teaching, or writing related to your case.
8. As a psychotherapist, I reserve the right to release financial information to a collection agency, attorney, or small claims court if you are delinquent in paying your bill.
9. Cell phone and e-mail communications can be intercepted by third parties. These forms of communication are reserved for urgent or time-sensitive matters. Psychotherapists are required to make a record of each client contact. E-mail/text communications may be printed in full and become part of a client's file.

Initial here if this section has been read and understood _____

Treating Children of Separated or Divorced Parents

Psychotherapists treating children from families that are in the midst of separation and divorce, work to help children cope adaptively with the forces acting upon their lives. Treating children in these contexts can be difficult due to multiple factors.

For these reasons, these are the therapist's policies in treating children of separated or divorced

parents who share legal custody:

1. Both parents will be asked to consent to treatment, ideally before the first session with the child, or shortly thereafter. There may be situations where this is problematic and the therapist will individualize according to the situation.
2. Both parents will be offered “equal time” in face-to-face or phone contacts as much as realistically possible, unless this is contraindicated such as cases in which the therapist judges that contact with one or both parents might negatively affect the child (e.e., if there is a concern related to parents abuse or threats to the child).
3. Your child’s therapist will not communicate with attorneys for either parent or guardian.
4. Any information provided by one parent may be shared with the other parent by the child’s therapist.
5. Your child’s psychotherapist will not provide custody or visitation recommendations to the court, mediator, and or psychologist conducting a family psychological evaluation. If the child has a court representative (attorney, guardian ad litem, or other advocate) or if requested by both parents or ordered by the court, your child's therapist may discuss observations about the child with these parents. This is billed at $800.00 an hour.
6. These policies may not apply when a parent resides out of the area or is incarcerated, when a parent-child contract is limited by a court (Juvenile, Family, or Guardianship) or court representative (i.e. County Services Agency Social Worker), when there is substantial evidence that a parent might be physically or psychologically harmful or might damage the therapeutic relationship, or when a parent fails to respond to the therapist’s attempts to establish contact with that parent.

Initial here if this section has been read and understood: _____

Professional Records

Your record includes a copy of the signed informed consent form, acknowledgement of receipt of privacy policy and practices, progress notes, any releases of protected health information, and copies of your invoices. Records are kept in a secured digital file and some records are in my home office. Please note that my records remain in my possession from the moment I leave the office until I arrive home and are immediately placed in this confidential cabinet. In the event of my untimely death, a conservator will be responsible for the management of my records.

Initial here if this section has been read and understood _____

Psychotherapy Contract for Parents or Guardians of Child Clients

I have read the above information, have asked questions as needed, and understand the issues related to risks and benefits of psychotherapy, medical concerns, assessment, collateral contacts, the need for children and adolescents to have confidential psychotherapy, collateral contacts with parents and others, treating children of separated or divorced families, professional records, confidentiality from third parties, my child’s diagnosis and treatment plan, length of psychotherapy, fee for psychotherapy, emergencies, and cancellations.

Initial here if this section has been read and understood _____

Based on my understanding of these issues, I agree to proceed with treatment for my child.

Print Name of Child _____
Signature of Parent (s) or Legal Guardian _____Date _____

Child Form: Informed Consent for Telepsychology

This section is an addendum to the Child Informed Consent, that must also be completed before our first session, in the event Telepsychology becomes the requested format of sessions.

- There are potential benefits and risks of video-conferencing (e.g. limits to patient confidentiality) that differ from in-person sessions.
- Confidentiality still applies for telepsychology services, and nobody will record the session without the permission from the other person(s).
- We agree to use the video-conferencing platform selected for our virtual sessions, and I will explain how to use it.
- You need to use a webcam or smartphone during the session.
- It is important to be in a quiet, private space that is free of distractions (including cell phone or other devices) during the session.
- It is important that you do not include anyone in the session without first discussing it with me at the beginning of the session.
- It is important to use a secure internet connection rather than public/free Wi-Fi.
- It is important to be on time. If you need to cancel or change your tele-appointment, you must notify me in advance by phone or email.
- We need a back-up plan (e.g., phone number where you can be reached) to restart the session or to reschedule it, in the event of technical problems. Please list the phone number to call you at if technical problems occur. Phone:_____
- We need a safety plan that includes at least one emergency contact and the closest emergency room to your location, in the event of a crisis situation.

Please list your emergency contact here:_____
Please list your closest emergency room here:_____

- Adults must give permission for their child to participate in telepsychology, and be present at the beginning and end of each session.
- As your psychologist, I may determine that due to certain circumstances, my telepsychology sessions are no longer appropriate and we will identify alternative resources for you, that may include more intensive services, clinics or other therapists.

Name of Child:_____ **Date:_____**

Parent name:_____ **Parent Signature:_____**

Boller Psychological Services, LLC
770 E. South Temple, Suite 200, SLC, UT 84102

Phone: 801-661-1992

History Form: Child

Please print, complete, and bring to Dr. Boller to your first appointment. This is an important part of your child's intake assessment, and is held to the same level of confidentiality as therapy.

Date:_____
Child's Full Legal Name:_____
Date of Birth:_____ Age:_____
Current Grade:_____ School:_____
Child Currently lives with: _____
Siblings and ages:_____
Family Address(include Street Address/City/State/ Zip Code):
_____
Who has legal custody if parents are divorced?_____
Primary email:_____
Phone (mother) Home:_____ Cell: _____ Work:_____
Phone (father) Home:_____ Cell:_____ Work:_____
Can we leave a message_____yes _____no If yes, which number?
Emergency Contacts:_____
Person Completing Form:_____ Relationship to Child:_____
Preferred Way of Contact:
Note: Email and texts are not secure forms of communication.
Specify mode of contact preferred:_____

Referred to Dr. Boller by:_____

What are your child's strengths:

What concerns you most about your child?:

What are your goals for treatment?:

Family History

Is there any history of the following in the child's biological relatives

Mother's side of family:

_____Learning Problems _____School Problems _____ADHD
_____Anxiety _____Obessive-Compulsive Disorder
_____Depression _____Tourette Syndrome
_____ Picking/Hair Pulling _____Alcoholism/Drug Abuse
_____ Autism Spectrum _____Bipolar Disorder
_____ Genetic Disorder _____Metabolic Disease _____Other(specify)

Is there any history of the following in the child's biological relatives:

Father's side of family:

_____Learning Problems _____School Problems _____ADHD
_____Anxiety _____Obessive-Compulsive Disorder
_____Depression _____Tourette Syndrome
_____ Obsessive Picking/Hair Pulling _____Alcoholism/Drug Abuse
_____ Autism Spectrum _____ Bipolar Disorder
_____ Genetic Disorder _____Metabolic Disease _____Other

Have any of your child's biological relatives experienced problems similar to those your child is experiencing? If so, please describe:

Describe any problems between patient and siblings:

Describe overall, general family relationships:

Pregnancy and Birth History:

How many weeks did pregnancy last?
If birth was premature, please explain (include any complications):

Please describe reason for and medical interventions/hospitalizations following birth:

Developmental History:

List age for each milestone achieved. Approximate if unsure:

Crawled _____ Walked_____ First words:_____

First Sentences:_____ Toilet Trained (night):_____ Toilet Trained (Day)_____

Please describe any difficulties with any of the above milestones:

Did your child exhibit any of these behaviors in the pat, but no longer does? Please circle all that apply:

Difficult to calm/pacify Irritability/easily agitated Did not like to be held
Clumsy/uncoordinated Highly active Difficulty making eye contact
Staring or avoiding looking at things Rocking or head bangining
Walking on tiptoes Unusual play behaviors Flapping hands or spinning
Difficulty interacting with others Shy
Poor eye contact
Explanations/Early interventions/Pediatric Assessment:

Current Symptom Checklist

Please circle the behaviors your child CURRENTLY EXHIBITS to a heightened degree that it interferes with success at school, home, extra-curricular activities or friends:

High Activity Impulsive Behavior (poor self control) Interrupts Frequently
Poor Attention Span Acts as if "driven by a motor" Difficulty Finishing Tasks
Disorganized Low frustration tolerance Aggressive
Temper Outbursts Does not seem to listen Difficulty with sleep
Daytime accidents Bedwetting Worried/anxious
Problems with multi-step directions Does not think logically Poor awareness of time
Problems understanding jokes Problems expressing self
Talking around issues, doesn't come to a point Does/says things repeatedly
Problems changing activities or making transitions
Difficulty with unexpected changes in schedule Pulling out own hair, picking
tics/twitching drugs/substance abuse Cruelty to animals
Vandalism/stealing Lying/cheating Trouble making friends
Poor eye contact

Difficulties with:

Self Harm (please explain):

Concerns about diet/eating (please explain):

History of sexual or physical abuse (please briefly explain):

Which specific behaviors interfere with family functioning?

Parenting Styles:

How would you describe your parenting style? Do both parents agree on type of discipline to use?

Is discipline effective? Yes_____No (if no, please explain)

Friendships and Social Skills

What are your child's strengths in social relationships outside the family?(describe):

Do other children seek out your child to socialize? Yes No
Does your child relate well to other children? Yes No
Does your child seem to understand the rules of social interaction? Yes No
Does your child report feeling lonely? Yes No
Has your child been described as: Bossy? Withdrawn? Disinterested in friends?
Are your child's friends: Same age Older Younger

Please circle any areas of difficulty with peers:

initiating play Making new friends Keeping old friends Group Play
Compromising Sharing Being accepted Individual Play

Please explain any concerns you have about your child's friendships or lack of them:

What does your child enjoy doing most?

What does your child dislike doing that is part of their daily life?

Does your child participate in sports activities? No Yes (Describe)

Does your child participate in other extracurricular activities (art, music,lessons, etc.)
No Yes (Describe)

Academic History

Did/does your child receive Early Intervention? No Yes
Does your child enjoy school? No Yes
Has your child ever been held back or has retention ever been suggested?
If yes, please explain:

Circle any problems reported by your child's current teacher:

Daytime sleepiness	Attention/concentration	Distractibility
Hyperactivity/impulsivity	Aggression	Oppositional behavior
Poor Memory	Following directions	Not turning in assignments
Doesn't get along well	Withdrawal	Few friends
Anxious	Sad	Angry
Handwriting	Reading/Math problems	Other:

Describe the process of doing homework each night with your child:

Present Medical Status

Is your child healthy overall?
Current medical problems for which your child is being treated (include medications):

Does your child have any difficulties with sleep?
If so, does he/she (circle all that apply):

Awakens in middle of night	Nightmares (how often)	
Struggles to fall asleep	Moves excessively in sleep	Sleepwalks

Night Terrors (how often, has pediatrician assessed?)
Snores Appears tired in the day or takes naps

Has your child ever been in therapy before?If yes, complete the following:

Therapist(s) name:	Duration of treatment(s):
Diagnosis:	Response to treatment/outcome:

Comments about past therapy:

Has your child had psychological testing done? When/by whom?
*Please attach an assessments

Adoption Addendum (Please skip if this does not apply)
Age at adoption: Country/State of birth:
Foster placements prior to adoption? Yes No
If yes, please describe:

Please describe any concerns at the time of adoption:

Please circle all that apply to your adopted child:
History of abuse History of Neglect Drug/Alcohol use by biological mother
Social Withdrawal Over-friendly with Strangers

INFORMED CONSENT FOR IN-PERSON SERVICES DURING THE COVID-19 PUBLIC HEALTH CRISIS

This document contains important information about our decision (yours and mine) to begin/resume in-person services in light of the COVID-19 public health crisis. Our decision is based in part on recommendations by the Center for Disease Control (CDC), but other factors may be considered. Some of these include but are not limited to: whether we and our families have been vaccinated, our health or the health of those we are in close contact with, and risk of exposure outside of this setting. There may be other concerns that we can talk about.

Please read this carefully and let me know if you have any questions. When you sign this document, it will be an official agreement between us.

Decision to Meet Face-to-Face

We have agreed to meet in person for some or all future sessions. If there is a resurgence of the pandemic or if other health concerns arise, however, I may require that we meet via telehealth. If you have concerns about meeting through telehealth, we will talk about it first and try to address any issues. You understand that, if I believe it is necessary, I may determine that we return to telehealth for everyone's well-being.

If you decide at any time that you would feel safer staying with, or returning to, telehealth services, I will respect that decision, as long as it is feasible and clinically appropriate. Reimbursement for telehealth services is also determined by the insurance companies and applicable law, so we'll discuss any financial implications if needed.

Risks of Opting for In-Person Services

You understand that by coming to the office, you are assuming the risk of exposure to the coronavirus (or other public health risk). This risk may increase if you travel by public transportation, cab, or ridesharing service.

Your Responsibility to Minimize Your Exposure

To obtain services in person, you agree to take certain precautions which will help keep everyone (you, me, and our families, [my other staff] and other patients) safer from exposure, sickness and possible death. If you do not adhere to these safeguards, it may result in our starting / returning to a telehealth arrangement. Initial each to indicate that you understand and agree to these actions:

- You will tell me if you've been vaccinated. If you haven't, we'll talk about the reasons and whether it's possible to meet safely in person.
- You will only keep your in-person appointment if you are symptom free.
- You will cancel your appointment if you have been in contact with someone who has tested positive within the last 14 days.

- You will wait in your car or outside [or in a designated safer waiting area] until no earlier than 5 minutes before our appointment time.
- You will wash your hands or use alcohol-based hand sanitizer when you enter the building.
- You will adhere to the safe distancing precautions we have set up in the waiting room and testing/therapy room. For example, you won't move chairs or sit where we have signs asking you not to sit.
- As mask mandates have been lifted, they are not required in this setting. However, if you would like your therapist to wear a mask during the session, the therapist will gladly agree to do so.
- If you are bringing your child, you will make sure that your child follows all of these sanitation and distancing protocols.
- You will take steps between appointments to minimize your exposure to COVID.
- If you have a job that exposes you to other people who are infected, you will immediately let me [and my staff] know.
- If your commute or other responsibilities or activities put you in close contact with others (beyond your family), you will let me [and my staff] know.
- If a resident of your home tests positive for the infection, you will immediately let me [and my staff] know and we will then [begin] resume treatment via telehealth.

I may change the above precautions if additional local, state or federal orders or guidelines are published. If that happens, we will talk about any necessary changes.

My Commitment to Minimize Exposure

My practice has taken steps to reduce the risk of spreading the coronavirus within the office and we have posted our efforts on our website and in the office. Please let me know if you have questions about these efforts.

If You or I Are Sick

You understand that I am committed to keeping you, me, [my staff] and all of our families safe from the spread of this virus. If you show up for an appointment and I [or my office staff] believe that you have a fever or other symptoms, or believe you have been exposed, I will have to require you to leave the office immediately. We can follow up with services by telehealth as appropriate.

If I [or my staff] test positive for the coronavirus, I will notify you so that you can take appropriate precautions.

Your Confidentiality in the Case of Infection

If you have tested positive for the coronavirus, I may be required to notify local health authorities that you have been in the office. If I have to report this, I will only provide the minimum information necessary for their data collection and will not go into any details about the reason(s) for our visits. By signing this form, you are agreeing that I may do so without an additional signed release.

Informed Consent

This agreement supplements the general informed consent/business agreement that we agreed to at the start of our work together.

Your signature below shows that you agree to these terms and conditions.

_____ _____ Patient/Client Date

Please read and sign:

HIPAA

NOTICE OF PSYCHOLOGISTS' POLICIES AND PRACTICES TO PROTECT THE PRIVACY OF YOUR HEALTH INFORMATION

THIS NOTICE DESCRIBES HOW PSYCHOLOGICAL AND MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

1. I. Uses and Disclosures for Treatment, Payment, and Health Care Operations I may use or disclose your protected health information (PHI), for treatment, payment, and health care operations purposes with your consent. To help clarify these terms, here are some definitions:
   A "PHI" refers to information in your health record that could identify you.
   "Treatment, Payment and Health Care Operations"
   – Treatment is when I provide, coordinate or manage your health care and other services related to your health care. An example of treatment would be when I consult with another health care provider, such as your family physician or another psychologist.
   – Payment is when I obtain reimbursement for your healthcare. Examples of payment are when I disclose your PHI to your health insurer to obtain reimbursement for your health care or to determine eligibility or coverage.
   – Health Care Operations are activities that relate to the performance and operation of my practice. Examples of health care operations are quality assessment and improvement activities, business-related matters such as audits and administrative services, and case management and care coordination.
   "Use" applies only to activities within my office, such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.
   A "Disclosure" applies to activities outside of my office, such as releasing, transferring, or providing access to information about you to other parties.
2. II. Uses and Disclosures Requiring Authorization
   I may use or disclose PHI for purposes outside of treatment, payment, and health care operations when your appropriate authorization is obtained. An "authorization" is written permission above and beyond the general consent that permits only specific disclosures. In those instances when I

am asked for information for purposes outside of treatment, payment and health care operations, I will obtain an authorization from you before releasing this information. I will also need to obtain authorization before releasing your psychotherapy notes. “Psychotherapy notes” are notes I have made about our conversation during a private, group, joint, or family counseling session, which I have kept separate from the rest of your medical record. These notes are given a greater degree of protection than PHI.

You may revoke all such authorizations (of PHI or psychotherapy notes) at any time, provided each revocation is in writing. You may not revoke an authorization to the extent that (1) I have relied on that authorization; or (2) if the authorization was obtained as a condition of obtaining insurance coverage, and the law provides the insurer the right to contest the claim under the policy.

3. III. Uses and Disclosures with Neither Consent nor Authorization I may use or disclose PHI without your consent or authorization in the following circumstances:

§ Child Abuse: If I have reason to believe that a child has been subjected to incest, molestation, sexual exploitation, sexual abuse, physical abuse, or neglect, or I observe a child being subjected to conditions or circumstances which would reasonably result in sexual abuse, physical abuse, or neglect, I must immediately notify the nearest peace officer, law enforcement agency, or the Office of the Utah Division of Child and Family Services.

§ Adult and Domestic Abuse: If I have reason to believe that a vulnerable adult (defined below) is suffering from abuse, neglect, abandonment or exploitation, I am required by law to make a report to either the Utah Adult Protective Services intake, or the nearest law enforcement agency as soon as I become aware of the situation.

A “vulnerable adult” means an elder adult, or an adult who has a mental or physical impairment which substantially affects his or her ability to: (a) provide personal protection; (b) provide necessities such as food, shelter, clothing, or mental or other health care; (c) obtain services necessary for health, safety, or welfare; (d) carry out the activities of daily living; (e) manage his or her own resources; or (f) comprehend the nature and consequences of remaining in a situation of abuse, neglect, abandonment or exploitation.

§ Communicable Disease: If I have reason to believe that you are suspected of having or are suffering from a disease that is communicable, I am required by law to report this to the local health department.

§ Health Oversight: If you file a complaint against me with the Utah Division of Occupational and Professional Licensing, I may disclose to them information from your records relevant to the complaint.

§ Judicial or administrative proceedings: If you are involved in a court proceeding and a request is made for information about the professional services that I have provided you and/or the records thereof, such information is privileged under state law, and I must not release this information without written authorization from you or your personal or legally appointed representative, or a court order. This privilege does not apply when you are being evaluated for a third party or where the evaluation is court ordered. I will inform you in advance if this is the case.

§ Serious Threat to Health or Safety: If you communicate to me an explicit threat to kill or inflict serious bodily injury upon a reasonably identifiable person, and you have the apparent intent and ability to carry out that threat, I have the legal duty to take reasonable precautions. These precautions may include disclosing relevant information from your mental health records which is essential to protect the rights and safety of others. I also have such a duty if you have a history of physical violence of which I am aware and I have reason to believe there is a clear and

imminent danger that you will attempt to kill or inflict serious bodily injury upon a reasonably identifiable person.

§ Worker's Compensation: If you file a workers compensation claim, I must furnish mental health records to: (1) you or your dependents, (2) your employer, (3) the employers workers compensation insurance carrier, (4) the Uninsured Employers Fund, (5) the Employers Reinsurance Fund, (6) the Labor Commission, and (7) any attorney representing any of the above in an industrial injury or occupational disease claim.

IV. Patients Rights and Psychologists Duties Patient's Rights:

* Right to Request Restrictions – You have the right to request restrictions on certain uses and disclosures of protected health information about you. However, I am not required to agree to a restriction you request.

* Right to Receive Confidential Communications by Alternative Means and at Alternative Locations – You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations. (For example, you may not want a family member to know that you are seeing me. Upon your request, I will send your bills to another address.) * Right to Inspect and Copy – You have the right to inspect or obtain a copy (or both) of PHI in my mental health and billing records used to make decisions about you for as long as the PHI is maintained in the record. I may deny your access to PHI under certain circumstances, but in some cases you may have this decision reviewed. On your request, I will discuss with you the details of the request and denial process.

* Right to Amend – You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. I may deny your request. On your request, I will discuss with you the details of the amendment process.

* Right to an Accounting – You generally have the right to receive an accounting of disclosures of PHI regarding you. On your request, I will discuss with you the details of the accounting process.

* Right to a Paper Copy – You have the right to obtain a paper copy of the notice from me upon request, even if you have agreed to receive the notice electronically.

Psychologist's Duties:

I am required by law to maintain the privacy of PHI and to provide you with a notice of my legal duties and privacy practices with respect to PHI.

A I reserve the right to change the privacy policies and practices described in this notice. Unless I notify you of such changes, however, I am required to abide by the terms currently in effect. A If I revise my policies and procedures, I will apprise you of any revisions in writing at your next appointment.

4. V. Questions and Complaints

   If you have questions about this notice, disagree with a decision I make about access to your records, believe that your privacy rights have been violated, or have other concerns about your privacy rights, please bring your concerns or complaint to my attention immediately, in either verbal or written form.

   You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services.

   You have specific rights under the Privacy Rule. I will not retaliate against you for exercising your right to file a complaint.

5. VI. Effective Date, Restrictions and Changes to Privacy Policy

   This notice will go into effect on 16 April 2003. I reserve the right to change the terms of this notice and to make the new notice provisions effective for all PHI that I maintain. If you are an

active patient when I make a change, I will provide you with a revised notice at your next appointment within two weeks of making such a change. If you are not active, but are requesting your PHI, I will provide you with a notice of changes when you make that request.

Signature _____ Date_____