This packet includes 4 sections: Adult Client Informed Consent and Telehealth options, Client History, HIPPA

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Please 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, confidential psychotherapy, 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. Please sign each section and the final page.

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

MEETINGS

I normally conduct an evaluation that will last ninety minutes and includes your completion of all Adult 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, such as illness]. If it is possible, I will try to find another time to reschedule the appointment. The fee for missed appointments or cancellations with less than 24 hours notice is $200.00.

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 same 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 _____ Date:__________

BILLING AND PAYMENTS

You will be expected to pay for each session at the time it is held. I accept credit cards, checks and cash. 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 _______ Date:__________

CONTACTING ME

I am often not immediately available by telephone. I am usually in my office Monday - Friday. 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. Text/Email is used for scheduling only.

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.

Initial here if this section has been read and understood _____________________ Date:______

Assessment

Psychotherapists must conduct an initial and ongoing treatment assessment of adults to understand their psychological needs. It is essential that you support this assessment process by completing all forms and questionnaires provided to you. Therapists usually cannot tell when adults 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 _____________________ Date:______

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 individuals obtain little or no benefit from therapy or become worse and a different form of treatment is needed. Other treatment modalities such as 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 the client.

Given this knowledge, the decisions to begin, continue, or terminate therapy belong to the client/patient. These decisions may be evaluated with one's therapist. Clients 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 ___________________Date:______

Psychotherapy is confidential from outside parties with important exceptions:

1. Information may be released to designated parties by written authorization of the client.
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 clients or from collateral sources (other individuals involved in a client's psychotherapy, such as 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, and primarily only used for scheduling. 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 ______________________ Date:______

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. 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 ___________________ Date________

Adult Client: Informed Consent for Telepsychology:

- 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 others 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. I will call the phone number you provide 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 (phone/email):________________________ Please list your closest emergency room here:___________________

- 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.

Initial here if this section has been read and understood ______________________ Date:______

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Adult Client: History Form

Please print, complete this form, and bring it to Dr. Boller on your first session. Information you provide here is held to the same standards of confidentiality as therapy.

Client's name:____ Date:__________________

Gender __M __F Date of birth:________________Age:__________

Address:______________________________City:______________________State:_____Zip_____

Phone (cell)________________Phone (work)________________

Can we leave a message? _____yes_______no If yes, which number:______________________

Email:____

Emergency Contacts

(name and phone number):____

Preferred Way of Contact:

Note: Email and texts are not secure forms of communication.

Specify mode of contact preferred:____

Referral Source(required):____

If you need any more space for any of the questions please use the back of any sheet.

Primary reasons for seeking treatment:

____

____

____

What are your goals for treatment:

____

____

____

____

FAMILY INFORMATION

Relationship	Name	Age	Living Yes	Living No	Living with you Yes	Living with you No
MOTHER	__________	____	___	____	___	____
FATHER	__________	____	___	____	___	____
SPOUSE	__________	____	___	____	___	____
CHILDREN	__________	____	___	____	___	____
	__________	____	___	____	___	____
	__________	____	___	____	___	____

Significant others (e.g. brothers, sisters, grandparents, step-relatives, roommates). Please specify relationship).

Relationship	Name	Age	Living Yes	Living No	Living with you Yes	Living with you No
______________	________________	_____	____	____	_____	_____
______________	________________	_____	____	____	_____	_____
______________	________________	_____	____	____	_____	_____
______________	________________	_____	____	____	_____	_____
______________	________________	_____	____	____	_____	_____
______________	________________	_____	____	____	_____	_____

Marital Status

(Please circle all that apply)

Single Divorce in process Unmarried, living together

Legally married Divorced Widowed

Assessment of current relationship (if applicable)_______Good ____Fair ____Poor

*****Some of the following questions are sensitive in nature. If you prefer not to answer them, you can leave them blank.*

Development:

Are there special, unusual, or traumatic circumstances that affected your development?

_______Yes _______ No

If yes, please describe:

____
____
____
____

Other childhood issues:

____
____
____

Academic difficulties? If so, please specify:____

Social Relationships

Do you have friends you trust and consider close? Yes No

Do you have casual friends? Yes No

Who is your biggest emotional support during difficult times?_____________________________

Describe the frequency of social interactions, involvement with friends:____

Prior Assessments:

Have you had any prior psychological/psychiatric/educational assessments? If so, when, and where any diagnosis made?

____

Spiritual/Religious

How important to you are spiritual matters?

________Not __________Little ___________Moderate ___________Much

Are you affiliated with a spiritual or religious group?

________Yes __________No

If yes, describe:

Were you raised within a spiritual or religious group?

____________Yes _____________No

If yes, describe:

Would you like your spiritual/religious beliefs incorporated into the counseling?

_____________Yes ____________________No

If yes, describe:____

Current LegaL Status

Are you involved in any active cases (traffic, civil, criminal)?

Yes_____ No_______

If yes, please describe and indicate the court and hearing/trial dates and charges:___________________

Education

Fill in all that apply:

Years of education:___________Currently enrolled in school? _____Yes _____No

Post High School Education:____

Profession:_____________________

Employment

Currently: __FT ___PT _____Temp ____Laid-off _____Disabled _____Retired

___Social Security _____Student Other (describe):___________________________

Profession:_______________

Military

Military experience? ___Yes __No Combat experience? _____Yes _______No

Leisure/Recreational

Describe special areas of interest or hobbies (e.g., art, books, crafts, physical fitness, sports, outdoor activities, church activities, walking, exercising, diet/health, hunting, fishing, bowling, traveling, etc.)

Medications/Health

Current prescribed medications	Dose	Date Started	Purpose	Side Effects

Prescribing doctor:____________________

Medical Conditions/Diagnosis:______________________

Please circle behaviors and symptoms that currently occur for you more often than you would like them to take place:

Aggression	Dizziness	Drug dependence	Eating disorder
Elevated mood	Phobias/fears	Fatigue	Recurring thoughts
Gambling	Sexual addiction	Hallucinations	Sexual difficulties
Heart palpitations	Sick often	Depression	Sleeping problems
Hopelessness	Speech problems	Impulsivity	Suicidal thoughts
Irritability	Thoughts disorganized	Judgment errors	
Loneliness	Withdrawing	Memory impairment	Worrying
Mood shifts	Panic Attacks	Agoraphobia	Obsessions/Compulsions
Tics	Pulling Hair	Anxiety	Fearfulness

Other (specify):

I recognize that the above information will be used to inform both my treatment and diagnosis.

_______________ ___________

Sign Here if you understand **Today's date**

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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. **CONTINUED ON NEXT PAGE**
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___________________

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Informed Consent

Your signature below shows that you understand and agree to all the above listed terms and conditions on this complete document.

______________________________ __________________

Signature Date