INFORMED CONSENT FOR TELEPSYCHOLOGY/TELEHEALTH

Jeffrey Becker, Ph.D. PSY3936

This Informed Consent for Telepsychology contains important information focusing on doing psychotherapy using the phone or the Internet. Please read this carefully, and let me know if you have any questions. When you sign this document, it will represent an agreement between us.

Benefits and Risks of Telepsychology

Telepsychology refers to providing psychotherapy services remotely using telecommunications technologies, such as video conferencing or telephone. One of the benefits of telepsychology is that the client and clinician can engage in services without being in the same physical location. This can be helpful in ensuring continuity of care if the client or clinician moves to a different location, takes an extended vacation, or is otherwise unable to continue to meet in person. It is also more convenient and takes less time. Telepsychology, however, requires technical competence on both our parts to be helpful. Although there are benefits of telepsychology, there are some differences between in-person psychotherapy and telepsychology, as well as some risks. For example:

- Risks to confidentiality. Because telepsychology sessions take place outside of the therapist's private office, there is potential for other people to overhear sessions if you are not in a private place during the session. On my end I will take reasonable steps to ensure your privacy. But it is important for you to make sure you find a private place for our session where you will not be interrupted. It is also important for you to protect the privacy of our session on your cell phone or other device. You should participate in therapy only while in a room or area where other people are not present and cannot overhear the conversation.

- Issues related to technology. There are many ways that technology issues might impact telepsychology. For example, technology may stop working during a session, other people might be able to get access to our private conversation, or stored data could be accessed by unauthorized people or companies.

- Crisis management and intervention. Usually, I will not engage in telepsychology with clients who are currently in a crisis situation requiring high levels of support and intervention. Before engaging in telepsychology, we will develop an emergency response plan to address potential crisis situations that may arise during the course of our telepsychology work.

- Efficacy. Most research shows that telepsychology is about as effective as in-person psychotherapy. However, some therapists believe that something is lost by not being in the same room. For example, there is debate about a therapist's ability to fully understand non-verbal information when working remotely.

Electronic Communications

We will decide together which kind of telepsychology service to use. You may have to have certain computer or cell phone systems to use telepsychology services. You are solely responsible for any cost to you to obtain any necessary equipment, accessories, or software to take part in telepsychology. The platform that will be used for Telepsychology will be ZOOM. If you are unable to use this platform, Apple FaceTime OR a phone call will be used. The ZOOM platform is *HIPPA* compliant.

For communication between sessions, I only use email communication and text messaging with your permission and only for administrative purposes unless we have made another agreement. This means that email exchanges and text messages with my office should be limited to administrative matters. This includes things like setting and changing appointments, billing matters, and other related issues. You should be aware that I cannot guarantee the confidentiality of any information communicated by email or text. Therefore, I will not discuss any clinical information by email or text and prefer that you do not either. These methods should not be used if there is an emergency.

Treatment is most effective when clinical discussions occur at your regularly scheduled sessions. But if an urgent issue arises, you should feel free to attempt to reach me by phone. I will try to return your call within 24 hours except on weekends and holidays. If you are unable to reach me and feel that you cannot wait for me to return your call, contact your family physician or the nearest emergency room and ask for the psychologist or psychiatrist on call. If I will be unavailable for an extended time, I will provide you with the name of a colleague to contact in my absence if necessary.

Confidentiality

I have a legal and ethical responsibility to make my best efforts to protect all communications that are a part of our telepsychology. However, the nature of electronic communications technologies is such that I cannot guarantee that our communications will be kept confidential or that other people may not gain access to our communications. I will try to use updated encryption methods, firewalls, and back-up systems to help keep your information private, but there is a risk that our electronic communications may be compromised, unsecured, or accessed by others. You should also take reasonable steps to ensure the security of our communications (for example, only using secure networks for telepsychology sessions and having passwords to protect the device you use for telepsychology).

The extent of confidentiality and the exceptions to confidentiality that I outlined in my Informed Consent Document signed at initial assessment still apply in telepsychology. Please let me know if you have any questions about exceptions to confidentiality.

Appropriateness of Telepsychology

From time to time, we may schedule in-person sessions to "check-in" with one another. I will let you know if I decide that telepsychology is no longer the most appropriate form of treatment for

you. We will discuss options of engaging in in-person counseling or referrals to another professional in your location who can provide appropriate services.

Emergencies and Technology

Assessing and evaluating threats and other emergencies can be more difficult when conducting telepsychology than in traditional in-person therapy. To address some of these difficulties, we will create an emergency plan before engaging in telepsychology services. I will ask you to identify an emergency contact person who is near your location and who I will contact in the event of a crisis or emergency to assist in addressing the situation. I will ask that you sign a separate authorization form allowing me to contact your emergency contact person as needed during such a crisis or emergency.

If the session is interrupted for any reason, such as the technological connection fails, and you are having an emergency, I will first attempt to call you to complete our session via phone.
If you are having an emergency, please call 911 and call me back after you have called or obtained emergency services. My phone number is: (408) 921-5181.

If there is a technological failure and we are unable to resume the session by phone, you will only be charged the prorated amount of actual session time.

Fees

The same fee rates will apply for telepsychology as apply for in-person psychotherapy. However, insurance or other managed care providers may not cover sessions that are conducted via telecommunication. If your insurance, HMO, third-party payor, or other managed care provider does not cover electronic psychotherapy sessions, you will be solely responsible for the entire fee of the session. Please contact your insurance company prior to our engaging in telepsychology sessions in order to determine whether these sessions will be covered.

Records

The telepsychology sessions shall not be recorded in any way unless agreed to in writing by mutual consent. I will maintain a record of our session in the same way I maintain records of in-person sessions in accordance with my policies.

Informed Consent

This agreement is intended as a supplement to the general informed consent that we agreed to at the outset of our clinical work together and does not amend any of the terms of that agreement. Your signature below indicates agreement with its terms and conditions.

Patient	Date
Jeffrey Becker, Ph.D. PSY3936	Date

Joint Task Force for the Development of Telepsychology Guidelines for Psychologists (2013). Guidelines for the practice of telepsychology. *American Psychologist, 68*. 791-800. Retrieved from https://www.apa.org/pubs/journals/features/amp-a0035001.pdf

Jeffrey Becker,Ph.D License #3936
1625 The Alameda Suite #512
San Jose, CA 95126

AGREEMENT FOR SERVICE/INFORMED CONSENT

This agreement is intended to provide _____ (Client) with important information regarding the practices and procedures of Jeffrey Becker,Ph.D,Licensed Psychologist. (Therapist)

Confidentiality: The information disclosed by Client is confidential and will not be released to any third party without the written authorization from Client, except where required or permitted by law. Exceptions to confidentiality include, but are not limited to, reporting child, elder and/or dependent adult abuse, when a client makes a serious threat of violence towards a reasonably identifiable victim, or when a client is dangerous to him/herself or the person or property of another.

Professional consultation is an important part of psychotherapy. As a Psychologist,Therapist may feel it is in the Client's best interest for Therapist to seek consultation with other appropriate professionals. By signing this agreement Client authorizes Therapist to discuss clinical issues regarding Client with colleagues as deemed appropriate by Therapist.

Fees: Client will pay the full session fee for any sessions missed or not cancelled at least 24 hours in advance. Therapist reserves the right to periodically adjust the fee, and Client will be notified in advance. **Clients are expected to pay for services at the time services are rendered.** Therapist accepts payments by cash, check or credit card.

Insurance: Client is responsible for any and all fees not reimbursed by his/her insurance company, managed care organization, or any other third-party payor. Client is responsible for verifying and understanding the limits of his/her coverage, as well as his/her co-payments and deductibles. If Therapist is not a contracted provider with Client's insurance company, Client is responsible to pay the fee at the time of service. Therapist will provide Client with a statement of fees paid which Client can submit to their insurance company for reimbursement.

Therapist Availability: Therapist's office is equipped with a confidential voice mail system that allows Client to leave a message at any time. Therapist will make every effort to return calls within 24 hours (or by the next business day), but cannot guarantee that calls will be returned immediately. Therapist is unable to provide 24-hour crisis service. In the event that Client is feeling unsafe or requires immediate medical or psychological assistance he/she should call 911 or go to the nearest emergency room.

Records: Therapist is required to maintain confidential records regarding Client's treatment. These records are the sole property of Therapist. Therapist will not alter records or record keeping procedures at Client's request. Any request made by Client for copies of Therapist's record must be made in writing. Therapist reserves the right, under California law, to provide Client with a treatment summary or refuse to produce a copy under certain circumstances.

Client Litigation: Therapist will not voluntarily participate in any litigation or custody dispute in which Client and another individual, or entity, are parties. Therapist has a policy of not communicating with Client's attorney and will generally not write or sign letters, reports, declarations, or affidavits to be used in Client's legal matters. Therapist will not provide records or testimony unless compelled to do so. If Therapist is subpoenaed, or ordered by a court of law, to appear as a witness in an action involving Client, Client agrees to reimburse Therapist for time spent for preparation, travel, or making a court appearance at Therapist's current hourly rate.

Termination of Therapy: Therapist reserves the right to terminate therapy at his/her discretion. Reasons for termination include, but are not limited to, nonpayment of fees, conflicts of interest, failure to participate in therapy or comply with treatment recommendations, client needs are outside Therapist's scope of competence, or Client is

Jeffrey Becker,Ph.D License #3936
1625 The Alameda Suite #512
San Jose, CA 95126

not making progress in therapy. Client may terminate therapy at any time and will be responsible for payment of all services rendered at that time. Upon decision to terminate therapy Therapist will recommend that Client participate in at least one termination session in an attempt to ensure a smooth transition for Client.

Acknowledgement: By signing below, Client acknowledges that he/she fully understands and agrees to abide by the terms and conditions of this Agreement and consents to participate in psychotherapy with Therapist. Client agrees to hold Therapist harmless from any claims, demands, or suits for damages from injury or complications, save negligence, that may result from such treatment. Client further understands that Client is financially responsible to Therapist for all charges, including unpaid charges by Client's insurance company or any other third-party payor.

_____ _____
Signature of Client Date

I have received a paper copy of Notice Of Privacy Practices for this office: (please initial here)_____

Please read email/text policy and sign your agreement below:

eMail address:_____

Confidentiality of communication by email/text cannot be guaranteed. Email/text correspondence is generally used for the purpose of scheduling appointments. This office does not share email address or phone number information with others. **If you do not want contact by email/text, please do not provide your email address and check here:**

_____

I understand and agree with this email policy:

_____

Jeffrey Becker, PhD (PSY3936)
1625 The Alameda #512, San Jose, CA 95126
408-293-6313

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 not keep "psychotherapy notes" as that term is defined in 45 CFR § 164.501; rather, I keep a record of your treatment and you may request a copy of such record at any time, or you may request that I prepare a summary of your treatment. There may be reasonable, cost-based fees involved with copying the record or preparing the summary.
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 mandated by 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. 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.

(continued on back)

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 YOUR 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 telephone number are: 1625 The Alameda #512, San Jose, CA 95126 408-293-6313.

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 200 Independence Avenue, S.W., Washington, D.C. 20201;
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.

Jeffrey Becker, Ph.D.
1625 The Alameda, Ste. 512
San Jose, CA 95126

Welcome, the following information is necessary to insure accurate billing and is **strictly confidential**.

PLEASE PRINT CLEARLY Patient's Social Security #: _____-_____-_____

Patient Name _____ Birthdate ____-____-____ Sex F M
First Middle Int. Last

Address _____
Number Street Apt. # City State Zip

Home phone (_____)_____-_____ Work phone (_____)_____-_____ ext._____ Cell phone (_____)_____-_____

Patient's Employer _____ Occupation_____

Spouse's Name _____ Birthdate _____-_____-_____
First Middle Int. Last

Spouse's Social Security #: _____-_____-_____ Spouse's Employer _____

Referred by _____ Referring Dr.'s phone no.(_____)_____

All other persons in the home

Name	Date of Birth	Relationship	Employer or School

Presenting Problems

_____

_____

_____

Date Symptoms First Began_____

Is Illness Work Related? _____Yes _____No

SEE OTHER SIDE

INSURANCE INFORMATION:

INS. CO. NAME _____

PHONE # (_____)_____-_____

Address _____
Number Street

_____
City State Zip

Name of Insured _____

ID#: _____

Group#:_____

Social Security #_____

DO YOU HAVE OTHER INSURANCE? ____Yes ____No

I authorize release of any information required by my insurance company.

Signed _____ Date _____

I authorize direct payment from my insurance company to Jeffrey Becker, Ph.D.

Signed _____ Date _____

I assume full responsibility for payment. In case of default in payment and legal action is required, I agree to pay court costs and reasonable attorney fees. Interest (1 ½ %) may be charged on accounts over 30 days.

Signed_____ Date_____

PATIENT RECORD

ADMINISTRATIVE (*Page one to be completed by patient prior to first session*)

Patient:_____ Date of Birth:__/__/___

Address: _____

City:_____ State: _____ Zip: _____

Work Telephone: (___) _____ Home Telephone: (___) _____

Sex: ☐ Male ☐ Female Subscriber S.S.#: _____-_____-_____

Employer/School: _____

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed

Emergency Contact:_____ Telephone:(___) _____

Relevant medical conditions (history, current condition, changes in condition):

_____

_____

Medications (dosage, dates of initial prescriptions, name of prescribing professional):

_____

_____

_____

_____

Allergies/adverse reactions to treatment:

_____

Primary Care Physician Name: _____

Address:_____ City_____ Zip_____
Telephone: (___) _____

Reason for seeking counseling today (Include any prior history of counseling for mental health, alcohol or other drug problems):

_____

_____

_____

Clinician's name/degree _____ Signature _____
(please print)

Date _____

***Note that starred items are CIMS kit. CIMS kit should be included as part of the patient record.*

Jeffrey Becker, Ph.D.
PSY: 3936
1625 The Alameda, Suite 512
San Jose, CA 95126
Office (408) 293-6313 ♦ Fax (408) 291-0488 ♦ Pager (408) 995-7305

AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION (PHI) FOR TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS

The Notice of Privacy Practices which you have read and acknowledged in writing describes the permitted uses and disclosure of your Protected Health Information in detail. Federal regulations (HIPAA) allow me to use or disclose your PHI in order to provide treatment, obtain payment for services and for other professional activities without specific authorization. Nevertheless, I ask your consent in order to make this permission explicit. Please read and sign the following statement:

I understand that the health information disclosed pursuant to this authorization is beyond Dr. Becker's control and may be subject to re-disclosure by the recipient (medical insurer or other designated agency or individual). The Federal Privacy Rule may then no longer protect such information, although the re-disclosure of such information may be protected by applicable California law.

I understand that I have a right to receive a copy of this authorization and that any cancellation or modification of it must be in writing. I understand that I have the right to revoke this authorization at any time unless Dr. Becker has taken action in reliance upon it. I also understand that such revocation must be in writing to the above address and must be received by Dr. Becker to be effective. I understand that Dr. Becker cannot condition treatment upon my signing this authorization.

I may request limitations on the uses and/or disclosure of my health information that otherwise would be disclosed for treatment, payment or health care questions to a designated recipient; however, I understand that Dr. Becker does not have to agree to these restrictions. If agreed to, these limitations will be binding. My request must be written.

I hereby authorize Dr. Becker to use and or disclose my Private Health Information for the purposes described above and under the conditions described above from this date until one year after the conclusion of treatment.

_____
Client Name

_____
Client Signature

_____
Date

Jeffrey Becker, Ph.D.
PSY: 3936
1625 The Alameda, Suite 512
San Jose, CA 95126
Office (408) 293-6313 ♦ Fax (408) 291-0488 ♦ Pager (408) 995-7305

♦ ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

By signing this form, you acknowledge reviewing of the *Notice of Privacy Practices* that I have given to you. My *Notice of Privacy Practices* provides information about how I may use and disclose your protected health information. I encourage you to read it in full.

My *Notice of Privacy Practices* is subject to change. If I change my notice, you may obtain a copy of the revised notice from me by contacting me at (408) 293-6313.

If you have any questions about my *Notice of Privacy Practices,* please contact me at the address, phone, fax or e-mail listed above:

___ I do not wish to receive *Notice of Privacy Practices* of Dr. Jeffrey Becker.

___ I acknowledge receipt of the *Notice of Privacy Practices* of Dr. Jeffrey Becker.

_____ _____

Signature: Date:
(client/parent/conservator/guardian)

♦ AGREEMENT TO OUTPATIENT/PSYCHOTHERAPY SERVICES CONTRACT AND CONSENT TO TREATMENT WITH DR. JEFFREY BECKER.

_____ _____

Signature: Date:
(client/parent/conservator/guardian)