Information for You/Contract

This document is an agreement between us that contains important information about my services and business policies. Please read the entire form and ask questions before signing.

By signing this form, you are giving consent for psychological treatment including, but not limited to clinical interview, evaluation, psychological testing, and psychotherapy. You are consenting and agreeing only to those mental health services that I am qualified to provide within the scope of my license, certification, and training. You acknowledge that you are an active participant in your treatment and have input regarding your treatment goals. You can decline any particular form of treatment that you are not comfortable with at any time.

Psychotherapy is a transformational journey involving internal change. In order to get the most from your treatment, mindful and sustained commitment is needed. Internal change, will be experienced outside the treatment room and inside our sessions, in many different ways. I will regularly ask you to bring on the mindful brain to "notice" and "attune" to these experiences. Sometimes the experiences will be enjoyable and easy to attune with. Other times, you may notice feelings of fear or anger. Your loved ones may experience side effects of your changes and have feelings too. Stay the course. These experiences are normal. Remind yourself why you started therapy. Trust *the* process; honor *your* process.

FEES:
My fee is $195 for 50 minute initial evaluation session. My fee for a psychotherapy session is $185 for 45 minutes. DOT SAP evaluation sessions are $325. All fees are payable at the time of service. To assure your full session time, please pay at the beginning of each session. PayPal, credit card, check or cash are acceptable forms of payment.

INSURANCE REIMBURSEMENT:
If I do not accept your health insurance plan in my practice, I can provide you with a "super bill" which you may submit to your insurance company for potential reimbursement. If you have health insurance, please note that the insurance contract is between you and your insurance company and the fee remains your responsibility (not your insurance company's) whether services are covered by your insurance company or not. The full fee is payable at the time services are rendered. If, for whatever reason your insurance company does not cover any or all of my services, you will be responsible for all uncovered fees. I will bill you for any unpaid balance. Please note, I do employ the use of a collection agency to collect unpaid balances older than three months.

Please be aware that if you decide to include your insurance company in your treatment, your contract with your health insurance company requires that I provide it with information relevant to the services that I provide to you. I am required to provide a clinical diagnosis, dates and place of services, and occasionally additional information. Additional information can take the form of treatment plans or summaries or copies of your entire Clinical File. I will make every effort to release only the minimum information about you that is necessary for the purpose requested. This information will become part of the insurance company files and will probably be stored in a computer. Though all insurance companies claim to keep such information confidential, I have no control over what they do with it once it is in their hands. In some cases, they may share the information with a national medical information databank.

By signing this Contract you agree that I can provide requested information to your carrier. You may, at any time request that I discontinue providing the insurance company with information about you. This, however will likely result in your insurance company discontinuing payment for my services. It is important to remember that you always have the right to pay for my services yourself to avoid the problems described above (unless prohibited by contract).

CANCELLATIONS:

No-show or canceled appointments will incur the full charge of $185 per session unless a 24-hour notice is given*.*

Since scheduling an appointment means reserving time specifically for you, if you must cancel, please let me know as soon as possible. You can leave a message any hour, on any day, including weekends. A minimum of 24 hours notice is required to reschedule or cancel an appointment without charge. However, if I am not notified of a cancellation at least 24 hours in advance of your scheduled appointment you will be charged the full $195 fee at that time. Please note, if your therapy is covered by any insurance or other third party reimbursement, I cannot bill them for failed appointments, and you will be responsible for the full fee for missed appointments or late cancellations. Please note, I do employ the use of a collection agency to collect unpaid balances older than three months.*

GENERAL AVAILABILITY AND PHONE CALLS:
I am available for office appointments weekly. Phone messages can be left on my voice mail at any time of the day or night. I make every effort to return routine calls as soon as possible on these days. There may be times when I am unable to return a routine call on the same business day. I will return routine calls as soon as possible. ALWAYS feel free to call back if you need to hear from me sooner.

EMERGENCIES:
If your situation is a non-life threatening emergency please leave me a voice mail message and a text saying "Call me please" I will return your call as soon as I retrieve the message from my system. **If you are in a life-threatening emergency, please call 911 immediately and then leave me a voice mail message if you are able. I will return your call as soon as I retrieve the message. You may also go directly to the emergency room.**

CONFIDENTIALITY:
I take your privacy and confidentiality very seriously. In general the information discussed within sessions is confidential and will not be disclosed to anyone without your written permission. However, there are some situations where I am permitted or required to disclose information without either your consent or Authorization. They are as follows:

- I may occasionally find it helpful to consult other health and mental health professionals about a case. During a consultation I make every effort to avoid revealing the identity of my patient. The other professionals are also legally bound to keep the information confidential. If you don't object, I will not tell you about these consultations unless I feel that it is important to our work together.
- 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 protected by psychologist-patient privilege law. I cannot provide any information without your (or your legally-appointed representative's) written authorization, a court order, or compulsory process (a subpoena) or discovery request from another party to the court proceeding where that party has given you proper notice (when required), has stated valid legal grounds for obtaining PHI, and I do not have grounds for objecting under state law (or you have instructed me not to object). If you are involved in, or contemplating litigation, you should consult with your attorney to determine whether a court would be likely to order me to disclose information.
- If a government agency is requesting the information for health oversight activities pursuant to their legal authority, I may be required to provide it for them.
- If a patient files a complaint or lawsuit against me, I may disclose relevant information regarding that patient in order to defend myself.
- If a patient files a worker's compensation claim I must, upon appropriate request disclose information relevant to the claimants' condition to the worker's compensation insurer.

Also, if you are using health insurance, please be aware that, at a minimum your name, dates of service, and medical diagnosis are required to submit a claim. If your insurance is a managed health plan, I will likely be required to disclose additional information.

* In accordance with your Group Therapy Agreements, there is no cancellation policy for group therapy; all cancelled and missed sessions are to be paid in full regardless of the amount of notice given.

Disclosure with or without your written consent may be legally required if:

- there is a reasonable suspicion of child or elder abuse or neglect,
- there is reasonable suspicion that you present an imminent danger of violence to others, or
- you are likely to harm yourself unless protective measures are taken.

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

MINORS AND PARENTS:
California law states that clients under 18 years of age who are not emancipated can consent to psychological services subject to the involvement of their parents or guardian unless I determine that parental involvement would be inappropriate. A client of age 12 may consent to psychological services if she or he is mature enough to participate intelligently in such services, and the minor either would present a danger of serious physical or mental harm to her/himself or others, or is the alleged victim of incest or child abuse. In addition, clients over age 12 may consent to alcohol and drug treatment in some circumstances.

However, unemancipated clients under 18 years of age and their parents should be aware that the law may allow parents to examine their child's treatment records unless I determine that access would have a detrimental effect on my professional relationship with the patient, or to her/his physical safety or psychological well being. Because privacy in psychotherapy is often crucial to successful progress, particularly with teenagers, and parental involvement is also essential, it is usually my policy to request an agreement with minors (over age 12) and their parents about access to information. This agreement provides that during treatment, I will provide parents with only general information about the progress of the treatment, and the patient's attendance at scheduled sessions. Any other communication will require the child's Authorization, unless I feel that the child is in danger or is a danger to someone else, in which case, I will notify the parents of my concern. Before giving parents any information, I will discuss the matter with the child if possible, and do my best to handle and objections he or she may have.

However, if the minor client is receiving psychological testing only and no psychotherapeutic treatment, I will share the test results with parents unless I determine the information would have a detrimental effect on the patient, or her/his physical safety or psychological well being. Again, before giving parents any information, I will discuss the matter with the child, if possible, and do my best to handle and objections he or she may have.

PROFESSIONAL RECORDS:
The laws and standards of my profession require that I keep Protected Health Information (PHI) about you in your Clinical Record. Except in unusual circumstances that disclosure would physically endanger you and/or others or makes reference to another person (unless such other person is a health care provider) and I believe that access is reasonably likely to cause substantial harm to such other person or where information has been supplied to me confidentially by others, you may examine and/or receive a copy of your Clinical Record if you request it in writing. Because these are professional records, they can be misinterpreted and/or upsetting to untrained readers. For this reason, I recommend that you initially review them in my presence, or have them forwarded to another mental health professional so you can discuss the contents. If I refuse your request for access to your records, you have a right of review (except for information supplied to me confidentially by other), which I will discuss with you upon request.

PATIENT RIGHTS:
HIPAA provides you with several new or expanded rights with regard to your Clinical Records and disclosures of protected health information. These rights include requesting that I amend your record; requesting restrictions on what information from your Clinical Records is disclosed to others; requesting an accounting of most disclosures of protected health information that you have neither consented to nor authorized; determining the location to which protected information disclosures are sent; having any complaints you make about my policies and procedures recorded in your records; and the right to a paper

copy of this Agreement, the attached Notice form, and my privacy policies and procedures. I am happy to discuss any of these rights with you.

TERMINATION:
As the client, you have the right to terminate treatment at any time. As the therapist, I can terminate treatment at anytime and facilitate a referral. If I determine you are not sufficiently benefiting from treatment, it is my ethical duty to refer you to alternative care.

NOTICE OF PRIVACY PRACTICES
Notice of Policies & Practices to Protect The Privacy of Your Protected 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.

I. Disclosures for Treatment, Payment, and Health Care Operations

As your psychologist, I may use or disclose your protected health information (PHI) for certain treatment, payment, and health care operations purposes without your authorization. In certain circumstances I can only do so when the person or business requesting your PHI gives a written request that includes certain promises regarding protecting the confidentiality of your PHI. To help clarify these terms, here are some definitions:

- "Use" applies only to activities within my practice such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.
- "Disclosure" applies to activities outside of my practice, such as releasing, transferring, or providing access to information about you to other parties.
- "PHI" refers to information in your health record that could identify you.
- "Treatment" is when I provide diagnosis or other therapy for you. An example of treatment would be when I consult with another health care provider, such as your family physician or another psychologist, regarding your treatment.
- "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" is when I disclose your PHI to your health care service plan (for example your health insurer), or to your other health care providers contracting with your plan, for administering the e plan, such as case management and care coordination.
- "Authorization" means written permission for specific uses or disclosures.

II. Uses and Disclosures Requiring Authorization

Under certain circumstances I may use or disclose PHI for purposes outside of treatment, payment, and health care operations when your appropriate authorization is obtained. In those instances, I will obtain an authorization from you before releasing this information. You may revoke or modify this authorization at any time; however, the revocation or modification is not effective until received.

III. Uses and Disclosures with Neither Consent nor Authorization

I may also use or disclose PHI without your consent or authorization in the following circumstances:

Child and Elder Abuse: If, in my professional capacity, I have observed, have knowledge of, or suspect that a child, elder, or dependent adult is the victim of abuse, abandonment, abduction, isolation, financial abuse, or neglect, I am legally bound to report such to a police department or sheriff's department, county probation department, local ombudsman, or county welfare department.

Also, if I have knowledge of or reasonably suspect that mental suffering has been inflicted upon a child or that his or her emotional well-being is endangered in any other way, I may report such to the above agencies. I do not have to report such an incident if: I have been told by an elder or dependent adult that he or she has experienced behavior constituting physical abuse, abandonment, abduction, isolation, financial abuse or neglect; I am not aware of any independent evidence that corroborates the statement that the abuse has occurred; The elder or dependent adult has been diagnosed with a mental illness or dementia, or is the subject of a court ordered conservatorship because of a mental

illness or dementia; and In the exercise of clinical judgment, I reasonably believe that the abuse did not occur.

Health Oversight: If a complaint is filed against me with the California Board of Psychology, the Board has the authority to subpoena confidential mental health information from me relevant to that 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 protected by psychologist-patient privilege law. I cannot provide any information without your (or your legally appointed representative's) written authorization, a court order, or compulsory process (a subpoena) or discovery request from another party to the court proceeding where that party has given you proper notice (when required), has stated valid legal grounds for obtaining PHI, and I do not have grounds for objecting under state law (or you have instructed me not to object). If you are involved in, or are contemplating litigation, you should consult with your attorney to determine whether a court would be likely to order me to disclose information.

Serious Threat to Health or Safety: If you communicate to me a serious threat of physical violence against an identifiable victim, I must make reasonable efforts to communicate that information to the potential victim and the police. If I have reasonable cause to believe that you are in such a condition as to be dangerous to yourself or others, I may release relevant information as necessary to prevent the threatened danger.

Worker's compensation: If you file a worker's compensation claim, I must furnish a report to your employer, incorporating my findings about your injury and treatment, within five working days from the date of your initial examination, and at subsequent intervals as may be required by the administrative director of the Worker's Compensation Commission in order to determine your eligibility for benefits.

IV. Patient's Rights and Psychologist's 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. Upon 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. Upon 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 for which you have neither provided consent nor authorization (as described in Section III of this Notice). 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.

Dr. Huelsenbeck'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.

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.

If I revise my policies and procedures and you are a current patient, I will attempt to notify you of the revisions on or after the effective date and you may request a written copy of the Revised Notice form this office.

V. Complaints
If you are concerned that I have violated your privacy rights, or you disagree with a decision I made about access to your records, you may contact me and if you believe your concerns are not addressed, you may contact the Board of Psychology at the California Department of Consumer Affairs.

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

VI. Effective Date, Restrictions, and Changes to Privacy Policy
This notice will go into effect on April 1, 2005.

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. You may request a copy of the revised notice on or after the effective date.

The above issues are important and allow for your informed consent to our professional relationship. Any time you have questions about our working relationship, please feel free to discuss them with me. Your signature below indicates that you have read this agreement and agree to its terms. It also serves as acknowledgement that you have received the HIPAA notice form described above.

____________________________________ _________________
Client's/guardian's signature Date

Sign below if you intend to utilize your insurance company. I hereby assign all medical (mental health) benefits to include major medical policy benefits to which I am entitled, and/or government sponsored programs, private insurance companies, and any other health plan to Regina Huelsenbeck, Ph.D. and/or Rituals of Healing, Inc. This assignment will remain in effect until revoked by me in writing. I understand that I am financially responsible for all legally contracted charges whether or not paid by my insurance company. I understand that Dr. Huelsenbeck may use of a collection agency to collect unpaid balances older than three months. I hereby authorize Regina Huelsenbeck, Ph.D. to release all information necessary to ensure payment of benefits. A copy of this agreement is as valid as the original.

_______________________________ _________________
Client's/Guardian's Signature Date

_______________________________ _______________________
Printed Name Social Security Number