Claire Nicogossian, Psy.D.
Licensed Clinical Psychologist

1130 Ten Rod Rd. E101
North Kingstown, RI 02852
Phone: 401-921-5400 ext. 6
Fax: 401-921-5402
Website: cduarteandassociates.com

Acknowledgment of Required Intake Forms

I acknowledge that I have been given copies of:

- the *Psychotherapist-Patient Services Agreement* and
- the *HIPAA Privacy Notice*

to review and discuss with my therapist.

Please review and sign the *Psychotherapist-Patient Services Agreement*.

Please also review the *HIPAA Privacy Notice*. The *HIPAA Privacy Notice* does not require your signature.

Please let me know as soon as possible if you have any questions or concerns about doing this.

_____ _____
Signature of Patient (or Parent/ Legal Guardian) Date

_____
Relationship to Patient

INTAKE FORM Clinician's Name: Claire Nicogossian, Psy.D. Date_____

PERSONAL INFORMATION:

Patient Name _____ Date of Birth_____

Address_____

City/State/Zip_____

Phone Home (____)_____Cell (____)_____Office (____)_____

Who referred you to our office? _____

RESPONSIBLE PARTY: (fill in if under 18 or if someone other than patient is responsible for payment)

Name _____

Address_____

City/State/Zip_____

Home Phone (____)_____Business Phone (____)_____

INSURANCE INFORMATION:

Primary Insurance Company_____

Provider Phone (located on back of card) ( )_____

Subscriber Name (if other than patient) _____

Date of Birth:_____

Insurance ID#_____

FINANCIAL POLICY

Appointments cancelled with less than 24-hour notice will be charged to me at the full fee per hour.
I am responsible for the entire balance of services performed regardless of whether there is insurance coverage.
Secondary insurance will be billed as a courtesy.
I understand and agree to the above stated financial policy.

Signed _____ Date_____

AUTHORIZATION FOR RELEASE OF INFORMATION AND ASSIGNMENT OF BENEFITS FOR INSURANCE

I authorize the use or disclosure of my individually identifiable health insurance information necessary to process insurance claims. I understand that this authorization is voluntary. I understand that if the organization authorized to receive the information is not a health plan or healthcare provider, the released information may no longer be protected by federal privacy regulations.

Signed _____ Date_____

I authorize payment of medical benefits to my provider for services performed.

Signed _____ Date_____

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Psychotherapist-Patient Services Agreement

Welcome to my practice. This document (the Agreement) contains important information about my professional services and business policies. It also contains summary information about the Health Insurance Portability and Accountability Act (HIPAA), a new federal law that provides new privacy protections and new patient rights with regard to the use and disclosure of your Protected Health Information (PHI) used for the purposes of treatment, payment, and health care operations. HIPAA requires that I provide you with a Notice of Privacy Practices (the Notice) for use and disclosure of PHI for treatment, payment and health care operations. The Notice, which is given with this Agreement, explains HIPAA and its application to your personal health information in greater detail. The law requires that I obtain your signature acknowledging that I have provided you with this information at the end of this session. Although these documents are long and sometimes complex, it is very important that you read them carefully before our next session. We can discuss any questions you have about the procedures at that time. When you sign this document, it will also represent an agreement between us.

PSYCHOTHERAPY SERVICES

Psychotherapy is not easily described in general statements. It varies depending on the personalities of the psychotherapist and patient, and the particular problems you are experiencing. There are many different methods I may use to deal with the problems that you hope to address. Psychotherapy is not like a medical doctor visit. Instead, it calls for a very active effort on your part. In order for the therapy to be most successful, you will have to work on things we talk about both during our sessions and at home.

Psychotherapy can have benefits and risks. Since therapy often involves discussing unpleasant aspects of your life, you may experience uncomfortable feelings like sadness, guilt, anger, frustration, loneliness, and helplessness. On the other hand, psychotherapy has also been shown to have many benefits. Therapy often leads to better relationships, solutions to specific problems, and significant reductions in feelings of distress. But there are no guarantees of what you will experience.

Our first few sessions will involve an evaluation of your needs. By the end of the evaluation, I will be able to offer you some first impressions of what our work will include and a treatment plan to follow, if you decide to continue with therapy. You should evaluate this information along with your own opinions of whether you feel comfortable working with me. Therapy can involve a large commitment of time, money, and energy, so you should be very careful about the therapist you select. If you have questions about my procedures, we should discuss them whenever they arise. If your doubts persist, I will be happy to help you set up a meeting with another mental health professional for a second opinion.

MEETINGS

I typically conduct an evaluation that lasts from 2 to 4 sessions. Sessions usually last for 45 to 50 minutes, although they may be longer in some cases. I will do my best to try to start and finish sessions on time, and I ask you to do the same. Please understand that occasionally an emergency may interfere with our ability to start promptly.

APPOINTMENT CANCELLATION POLICY

If it is ever necessary to cancel or reschedule an appointment, I ask that you contact me as soon as possible. If you give me more than 24 hours notice, there will be no charge for the cancelled session. If you call to cancel an appointment with less than 24 hours notice, or do not show for a scheduled appointment, you will be charged the full fee for the appointment, which is $150.00. Please note that I cannot bill your insurance company for missed or cancelled sessions.

PROFESSIONAL FEES

My hourly fee is $220.00 for the initial child diagnostic interview, $200.00 for the initial adult diagnostic interview, and $150.00 per hour for most other services. 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, extended and/or frequent telephone conversations, consulting with other professionals with your permission, preparation of records or treatment summaries, and the time spent performing any other service you may request of me. If you become involved in legal proceedings that require my participation, you will be expected to pay for all of my professional time, including preparation and transportation costs, even if I am called to testify by another party.

CONTACTING ME

The most appropriate time to discuss any issues of concern is during our scheduled sessions. Due to my work schedule, I am often not immediately available by telephone. While I am usually in my office during regular business hours, I typically do not answer the phone when I am with a client. When I am unavailable, my telephone is answered by voicemail or an answering service (for emergency situations), which will then contact me. While I want to be able to respond to your emergency call when you need me, please understand that I may not always able to do so. In the event of a clinical emergency, if you are unable to reach me immediately and cannot wait for me to return your call, you should contact your primary care physician (or child's pediatrician) and/or proceed to your nearest hospital emergency room.

LIMITS ON CONFIDENTIALITY

The law protects the privacy of all communications between a patient and a psychotherapist. In most situations, I can only release information about your treatment to others if you sign a written authorization form that meets certain legal requirements imposed by HIPAA. There are other situations that require only that you provide written, advance consent. Your signature on this Agreement provides consent for those activities, 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. I will note all consultations in your Clinical Record (which is called "PHI" in my Notice of Psychotherapist's Policies and Practices to Protect the Privacy of Your Health Information).

- You should be aware that I practice with other mental health professionals and that I employ administrative staff. In most cases, I need to share protected information with these individuals

for both clinical and administrative purposes, such as scheduling, billing, and quality assurance. All of the mental health professionals are bound by the same rules of confidentiality. All staff members have been given training about protecting your privacy and have agreed not to release any information outside of the practice without my permission.

- I also have a contract with a billing service. As required by HIPAA, I have a formal business associate contract with this business, in which it promises to maintain the confidentiality of this data except as specifically allowed in the contract or otherwise required by law. If you wish, I can provide you the name of this organization and/or a blank copy of this contract. I also will ask for your permission before having the billing service contact you.

- Disclosures required by health insurers or to collect overdue fees are discussed elsewhere in this Agreement.

- If a patient threatens to harm himself/herself, I may be obligated to seek hospitalization for him/her, or to contact family members or others who can help provide protection.

There are some situations where I am permitted or required to disclose information without either your consent or Authorization:

- If you are involved in a court proceeding and a request is made for information concerning my professional services, such information is protected by the psychotherapist-patient privilege law. I cannot provide any information without your (or your legal representative's) written authorization, or a court order, or a subpoena of which you have been officially notified and failed to inform me that you are opposing the subpoena. 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, 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, information that is directly related to that claim must, upon appropriate request, be provided to the Workers' Compensation Commission.

There are some situations in which I am legally obligated to take actions, which I believe are necessary to attempt to protect others from harm and I may have to reveal some information about a patient's treatment. These situations are unusual in my practice.

- If I have reason to know or suspect that a child has been abused or neglected, or has been a victim of sexual abuse by another child, the law requires that I file a report with the Department for Children, Youth and Families. Once such a report is filed, I may be required to provide additional information.

- If I believe that a patient presents a risk to a person or his/her family, I may be required to take protective actions including warning the potential victim(s), contacting the police, or seeking hospitalization of the patient.

If such a situation arises, I will make every effort to fully discuss it with you before taking any action and I will limit my disclosure to what is necessary.

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.

PROFESSIONAL RECORDS

You should be aware that, according to the rules of HIPAA, I keep Protected Health Information about you in two sets of professional records. One set constitutes your Clinical Record. It includes information about your reasons for seeking therapy, a description of the ways in which your problem impacts on your life, your diagnosis, the goals that we set for treatment, your progress towards those goals, your medical and social history, your treatment history, any past treatment records that I receive from other providers, reports of any professional consultations, your billing records, and any reports that have been sent to anyone, including reports to your insurance carrier. In addition, I also keep a set of Psychotherapy Notes. These Notes are for my own use and are designed to assist me in providing you with the best treatment, While the content of Psychotherapy Notes vary from client to client, they can include notes regarding the contents of our conversations, my analysis of those conversations, and how they impact on your therapy. They also can contain particularly sensitive information that you may reveal to me that is not required to be included in your Clinical Record. These Psychotherapy Notes are kept separate from your Clinical Record. While insurance companies can request and receive a copy of your Clinical Record, they cannot receive a copy of your Psychotherapy Notes without your signed, written Authorization. Insurance companies cannot require your Authorization as a condition of coverage nor penalize you in any way for your refusal. You may examine and/or receive a copy of both sets of records, 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. In most circumstances, I am allowed to charge a fee for copying records. The exceptions to this policy are contained in the Privacy Notice form.

PATIENT RIGHTS

HIPAA provides you with several new or expanded rights with regard to your Clinical Record and disclosures of protected health information. These rights include requesting that I amend your record; requesting restrictions on what information from your Clinical Record 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 Privacy Notice form, and my privacy policies and procedures. I am happy to discuss any of these rights and/or issues with you.

MINORS & PARENTS

Patients under 18 years of age who are not emancipated and their parents should be aware that the law may allow parents to examine their child's treatment records. Because privacy in psychotherapy is often crucial to successful progress, particularly with teenagers, it is sometimes my policy to request an agreement from parents that they consent to give up their access to their child's records. If they agree, during treatment, I will typically provide them only with general information about the progress of the child's treatment, and his/her attendance at scheduled sessions. I also may provide parents with a summary of their child's treatment when it is complete. Most 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 information, I will discuss the matter with the child, if possible, and do my best to handle any objections he/she may have.

BILLING AND PAYMENTS

You will be expected to pay your fee, deductible, or co-pay for each session at the time it is held, unless we agree otherwise or unless you have insurance coverage that requires another arrangement. In certain situations (e.g., psychological testing, extensive evaluations, or document preparation), I may ask for a deposit toward the expected charges at the beginning of my services.

If your account has not been paid for more than 30 days and arrangements for payment have not been agreed upon, I have the option of using legal means to secure the payment. This may involve hiring a collection agency or going through small claims court which will require me to disclose otherwise confidential information. In most collection situations, the only information I release regarding a patient's treatment is his/her name, the nature of services provided, and the amount due. I reserve the choice to include any costs I incur in collecting unpaid fees. In the case of delinquent accounts, I may also assess additional charges for monitoring your account and preparing and sending statements to you.

INSURANCE REIMBURSEMENT

This section applies only if you chose to use your health insurance.

In order for us to set realistic treatment goals and priorities, it is important to evaluate what resources you have available to pay for your treatment. If you have a health insurance policy, it will usually provide some coverage for mental health treatment. I will fill out forms and provide you with whatever assistance I can in helping you receive the benefits to which you are entitled; however, *you* (not your insurance company) are ultimately responsible for full payment of my fees.

It is very important that you find out exactly what mental health services are covered by your specific insurance policy. You are always responsible fort all charges for services that are not paid by your insurance plan. If you should change insurance plans, if the terms of your existing insurance plan should change, or if you lose your insurance, you must notify me as soon as possible so that we will have the best opportunity to collect the benefits which are available to you.

You should carefully read the section in your insurance coverage booklet that describes mental health services. If you have questions about the coverage, call your plan administrator. Of course, I will provide you with whatever information I can based on my experience and will be happy to help you in understanding the information you receive from your insurance company. If it is necessary to clear confusion, with your permission, I or my staff will call the company on your behalf.

Due to the rising costs of health care, insurance benefits have increasingly become more complex. It is sometimes difficult to determine exactly how much mental health coverage is available. "Managed Health Care" plans such as HMOs and PPOs often require authorization before they provide reimbursement for mental health services. These plans sometimes place very arbitrary limits on the kinds of problems and the approaches they cover. Most insurance plans do not provide coverage for the full range of services psychotherapists can provide to help people. While much can be accomplished within the limits imposed by most health insurance plans and managed care organizations, some people feel that they need or would like services beyond the coverage provided by their insurance. If this is the case, we can discuss these issues and related costs as circumstances warrant. If necessary, I will do my best to assist you in finding more affordable, alternative sources for services and treatment.

You should also be aware that 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. Sometimes I am required to provide additional clinical information such as treatment plans or summaries, or copies of your entire clinical record. In such situations, 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. I will provide you with a copy of any report I submit, if you request it. By signing this Agreement, you agree that I can provide requested information to your insurance carrier.

Once we have all of the information about your insurance coverage, we will discuss what we can expect to accomplish with the benefits that are available and what will happen if they run out before you feel ready to end your sessions. It is important to remember that you always have the right to pay for my services yourself to avoid the problems described above.

YOUR SIGNATURE BELOW INDICATES THAT YOU HAVE READ THIS AGREEMENT AND AGREE TO ITS TERMS AND ALSO SERVES AS AN ACKNOWLEDGEMENT THAT YOU HAVE RECEIVED THE HIPAA PRIVACY NOTICE DESCRIBED ABOVE.

_____
Patient's Name

_____
Patient's Signature (or Parent/ Legal Guardian)

_____
Date

Claire Nicogossian, Psy.D.
Licensed Clinical Psychologist

1130 Ten Rod Rd. E101
North Kingstown, RI 02852
Phone: 401-921-5400 ext. 6
Fax: 401-921-5402
Website: cduarteandassociates.com

Authorization to Release Protected Health Information

I authorize Dr. Nicogossian, and her administrative staff to □ request from and □ release to information from □ my clinical record and/or □ the clinical record of _____ (DOB: _____). If requested, specify information to be disclosed:

_____

_____

This information is to be released to OR received by: (name, address, and telephone number to whom the information is to be released and/or received):

_____

_____

_____

I am requesting my therapist to release this information for the following reasons ("at the request of the individual" is all that is required if you are my client and you do not desire to state a specific purpose):

_____

This authorization shall remain in effect until (date) _____ or until (a reason):

_____

You have the right to revoke this authorization, in writing, at any time by sending such written notification to my office address. However, your revocation will not be effective to the extent that I have taken action in reliance on the authorization, or if this authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

I understand that my therapist may not condition clinical services upon my signing an authorization unless the clinical services are provided to me for the purpose of creating health information for a third party.

I understand that information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient of your information and no longer protected by the HIPAA Privacy Rule.

_____ _____

Signature of Patient (or Parent/ Legal Guardian) Date

_____

Relationship to Patient

C. Duarte & Associates
1130 Ten Rod Rd. Suite 101
North Kingstown, RI 02852

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1. I am aware that if I cancel an appointment with less than 24 hours, I will be charged **$75.00**.

   Signature: _____

2. Credit Card Authorization I, the undersigned, authorize Psychotherapy Practices of North Kingstown, LLC. (PP of NK) to charge my credit card for psychological services. I also authorize PP of NK to charge my credit card **$75.00** if I (or the party for whom I am financially responsible) fail to show for a scheduled appointment, or do not notify your clinician at least 24 business hours in advance for a cancelled appointment.

3. I authorize charges to my credit card for the full amount due on outstanding account balances. I understand that PP of NK will be required to disclose information about my attendance and/or cancellation to my credit card company should a dispute arise. This form will be securely stored in a clinical file and, upon request, may be updated at any time. Card Type:

Visa/ MasterCard Card #:
_____

Expiration Date: _____ Verification/Security Code: _____

Name (as printed on card): _____

Billing Address: _____
(Street; City, State & Zip)

Signature: _____
(Patient or financially responsible party)

Date: _____

Faith LaMunyon, LICSW
Licensed Independent Clinical Social Worker

1130 Ten Rod Rd. E101
North Kingstown, RI 02852
Phone: 401-294-6900 ext. 8
Fax: 401-294-6690
Website: cduarteandassociates.com

HIPAA Privacy Notice

Notice of Psychotherapists' Policies and Practices to Protect the Privacy of Your Health Information

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

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:

- "*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 psychotherapist.
    - *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.

- "*Disclosure*" applies to activities outside of my office, such as releasing, transferring, or providing access to information about you to other parties.

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 an 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.

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 reasonable cause to know or suspect that any child has been abused or neglected, as defined below, or is a victim of sexual abuse by another child, I must, within 24 hours, transfer that information to the Rhode Island Department of Child, Youth and Families, or its agent.

  Child abuse and/or neglect is defined as a child whose physical or mental health or welfare is harmed, or threatened with harm when his or her parent or other person responsible for his or her welfare:

  - Inflicts, or allows to be inflicted physical or mental injury;
  - Creates or allows to be created a substantial risk of physical or mental injury;
  - Commits or allows to be committed an act of sexual abuse, sexual assault against, or exploitation of the child;
  - Fails to supply the child with adequate food, clothing, shelter, or medical care;
  - Fails to provide the child with a minimum degree of care or proper supervision or guardianship because of his/her unwillingness or inability to do so; and abandons or deserts the child.

- **Health Oversight:** If a complaint is filed against me with the Rhode Island Board of Psychology, the Administrator of Professional Regulation (of the Division of Health) 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 provided to you and the records thereof, such information is privileged under state law, and I will not release this information without: 1) written authorization by you or your legal representative; or 2) a subpoena of which you have received official notification and you have failed to inform me that you are opposing the subpoena; or 3) a court order. The privilege does not apply when you are being evaluated for a third party or where the evaluation is court ordered. You will be informed in advance if this is the case.

- **Serious Threat to Health or Safety:** I may release your confidential health care information to appropriate law enforcement personnel, or to a person, if I believe that person or their family to be in danger from you.

- **Workers' Compensation**: If you file a worker's compensation claim, I must release your relevant mental health care information for the proceedings.

There may be additional disclosures of PHI that I am required or permitted by law to make without your consent or authorization; however, the disclosures listed above are the most common.

IV. Patient's Rights and Psychotherapist'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. On your request, I will discuss with you the details of the request 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.

Psychotherapist'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, I will inform you either in person or by mail.

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 and wish to file a complaint, or have other concerns about your privacy rights, you may discuss these with me at 1130 Ten Rod Road, E101 North Kingstown, RI 02852, 401-294-6900.

You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services. I can provide you with the appropriate address upon request.

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

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

This notice will go into effect on September 5, 2006.

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. At such time I will notify you of this change either in person or by mail. The current version of this document will always be available to you at my office.

C. Duarte & Associates
Psychotherapy & Consultation

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INFORMED CONSENT CHECKLIST FOR TELEPSYCHOLOGICAL SERVICES

Prior to starting video-conferencing services, we discussed and agreed to the following:

- There are potential benefits and risk 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 the psychologist 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 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 the psychologist 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 reschedule it, in the event of technical problems.
- We need a safety plan that includes at least one emergency contact and the closest ER to your location, in the event of a crisis situation.
- If you are not an adult, we need the permission of your parent or legal guardian (and their contact information) for you to participate in telepsychology sessions.
- You should confirm with your insurance company that the video session will be reimbursed; if they are not reimbursed, you are responsible for full payment.

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- As your psychologist, I may determine that due to certain circumstances, telepsychology is no longer appropriate and that we should resume our sessions in-person.

Psychologist Name / Signature: _____

Patient Name: _____

Signature of Patient/Patient's Legal Representative: _____

Date: _____