Allison Fagan, Psychologist LLC
6264 S. Sunbury Rd., Suite 400
Westerville, OH 43081
(614)398-9624

***Acknowledgement of Informed Consent to Treatment***

**Client Name** (Please Print): ____________________________________________________________

**Client Name** (Please Print)____________________________________________________________

I voluntarily agree to receive mental health assessment, care, treatment, or services and authorize you to provide such care, treatment or services as are considered necessary and advisable. I further authorize the submission of information to an insurance company, third party payer, to obtain reimbursement unless I direct otherwise.

I understand and agree that I will participate in the planning of my care, treatment, or services and that I may stop such care, treatment or services that I receive through you at any time. I also understand that there are no guarantees that treatment will be successful.

______By initialing here, I am indicating that I understand the risks involved in unencrypted electronic communications and agree to accept such risks in communications from either me to you or you to me that involve scheduling and/or therapy.

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I acknowledge that I have received a copy of the Notice of Privacy Practices for Allison Fagan, Psychologist.

By signing this Acknowledgment of Informed Consent to Treatment, I, the undersigned client, acknowledge that I have both read and understood all the terms and information contained herein and I agree to be bound by the provisions in this agreement. Ample opportunity has been offered to me to ask questions and seek clarification of anything unclear to me.

Signature ______________________________________________ Date ____________________

Signature ______________________________________________Date ____________________

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**Registration Information (please print)**

Name______________________________________________ Date of birth___________________ Age_________

Address__________________________________________ City, State, Zip ______________________________

Phone: _______________________ May I leave a message? _________ May text you at this number? ___________

Email address _______________________________________________ Sex: __Male__ Female __Transgender

Sexual Orientation________________ Marital Status: ____________Race/ethnicity__________________________

Children and ages: ___________________________________________________________________________

Occupation________________________________Employer:____________________________________________

***Emergency contact:*** *In case of an emergency, I authorize Dr. Allison Fagan to contact*

Name ____________________________________________________________________________

Relationship__________________________ Phone:________________________________________

Signature ____________________________________________________Date_________________

***Health History:*** General Medical Health: _____Poor _____Fair _____Good ______Excellent

Approximate date of last physical exam ________________ Height______________ Weight________________

Current health problems and any medications you are taking: ___________________________________________

____________________________________________________________________________________________

How often do you exercise? _________________________ How often do you meditate? _____________________

Stress Level: __Low __Medium __High What are the primary sources of your stress? _____________________

____________________________________________________________________________________________

Current consumption of:

Caffeine: # of Servings____per day/week/month Alcohol: # of Servings____per day/week/month

Marijuana: # of Servings____per day/week/month Nicotine : # of Servings____per day/week/month

Other recreational drugs you are now using: ________________________________________________________

Prior use of alcohol and other recreational drugs: ____________________________________________________

If you are currently in counseling/psychological treatment or have been in the past, please list the names of the mental health provider(s), approximate treatment dates, and reason(s) for seeking treatment:

____________________________________________________________________________________________

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Other recreational drugs you are now using: ________________________________________________________

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If you are currently in counseling/psychological treatment or have been in the past, please list the names of the mental health provider(s), approximate treatment dates, and reason(s) for seeking treatment:

____________________________________________________________________________________________

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**Consultation for Third Party Assisted Reproductive Treatment**

**Printed Client(s) Name(s):** ________________________________________________________________

I am/we are (select one) ____ intended parent _____intended donor _____intended gestational carrier

Name, phone, and address of physician or agency that you are working with:

________________________________________________________________________________________

________________________________________________________________________________________

*********************************************************************************************

**<u>For intended parents only:</u>**
What is your current infertility diagnosis: _______________________________________________________

What third party assisted reproductive technologies are you considering at this time?

_____Donor Sperm Source________________________________________________________

_____Donor Egg Source________________________________________________________

_____Donor Embryo Source________________________________________________________

_____Gestational Carrier Source________________________________________________________

*********************************************************************************************

***SIGNATURES***
By signing this Third-Party Assisted Reproductive Technology Psychological Evaluation that supplements the Office Policies and Informed Consent and the Notice of Privacy Practices Forms Acknowledgment of Informed Consent to Treatment, I/we, the undersigned client (s), acknowledge that I/we have both read and understood all the terms and information contained herein and I/we agree to be bound by the provisions in this agreement. Ample opportunity has been offered to ask questions and seek clarification of anything unclear.

Signature _______________________________________________________Date ________________________

Signature _______________________________________________________Date ________________________

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**Billing Information**

Printed Name(s)_______________________________________________________ ___________________________

Party responsible for fees, if someone other than you*:* ____________________________________________________

**COMPLETE ONLY ONE SECTION**

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**OPTION: INSURANCE** (Complete only if this service is eligible for insurance reimbursement.)

*Please confirm the following information with your insurer prior to our first appointment:*

Do you have insurance coverage for the treatment of infertility? ________________________________________

Is Precertification for this consultation required? _________ Amount of your deductible_________________

Have you met your deductible? _________ Co-Pay Amount _________________

Name of Primary Insured Person_______________________________________________________________

Insured's Date of Birth ____________________ Relationship to you ________________________________

Address (if different than above) _______________________________________________________________

Insured's Employer___________________________________________________________________________

Name of Insurance Company __________________________________________________________________

Address where claims should be submitted: ________________________________________________________

__________________________________________________________________________________________

Identification or Policy #________________________________________________________________________

Group # _______________________________________________________ Effective Date: _______________

*Assignment of Insurance and Release of Information*

I authorize my insurance benefits be paid directly to Allison Fagan, Psychologist, LLC. I understand that I am financially responsible for non-covered services. I authorize Allison Fagan, Psychologist LLC to release any information required to process this claim to my insurance carrier and understand that my records may be subject to audit by my insurer.

Signature____________________________________________________________Date_______________

******************************************************************************************

**OPTION: NO INSURANCE** I do not want to use my insurance benefits for professional services, or this service is not eligible for insurance reimbursement. I have not given my insurance information to Allison Fagan, Psychologist. I understand that payment in full will be expected at the time of service. I understand that I will notify Dr. Fagan to change payment arrangements for future appointments, but changes cannot be made retroactively.

Signature____________________________________________________________Date______________________

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**Authorization to Use and Disclose Protected Health Information**

I am completing this form to allow the use and sharing of protected health information.

Printed name(s) of client(s):

_______________________________________________________________Date of birth __________________

_______________________________________________________________Date of birth __________________

I/we authorize Allison Fagan, Ph.D. to disclose and exchange any protected health information including psychological evaluation(s), reports, assessments, treatment notes, summaries or other documents with diagnoses, prognosis, recommendations, testing records, behavioral observations and any other protected health information with ***(Please select who I may disclose your information to)***

________**Ohio Reproductive Medicine** (Brooke Rossi, MD, Grant Schmidt, MD, Elizabeth Kennard, MD, Laura Londra, MD, Chad Friedman, MD or other associate) and medical professionals involved with my/our care at Ohio Reproductive Medicine, 4830 Knightsbridge Blvd, Columbus, OH 43214, 614-451-2280 (phone) 614-451-4352 (fax).

_______ **Reproductive Gynecology Incorporated** (Akas Jain, M.D., David Nash, M.D. or other associate) and medical professionals involved with my/our care at 540 N. Cleveland Avenue, Westerville, OH 43082, 614-895-3333(phone), 614-895-3338 (fax).

______Other. Please print Name of Agency, Name, Address, Phone, Fax and Email:

_____________________________________________________________________________________________

_____________________________________________________________________________________________

**The following modalities of communication may be used:**

_**X**__telephone __**X**_email (document password protected and encrypted) **_X__**fax **X**_in person

The specific purpose of this release is to report on my readiness to participate in assisted reproductive treatment and/or progress in counseling for said treatment. This authorization is valid from the date of this signature for a period of 1 year and may be revoked by me at any time prior to this date. After this date, no information can be discussed or released unless a new Authorization is signed. Neither the revocation of this Authorization nor its expiration can rescind information already released.

Signature of client_____________________________________________________________Date______________

Signature of client_____________________________________________________________Date______________

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## Authorization to Charge Credit Card and to Keep Card On-File

Accepted forms of payment are cash, check, debit card, credit card and health savings account debit cards. The preferred form of payment is to place a card on file with your account that can be used to pay for session costs, co-pay, co-insurance, or no-show fees ($80 for less than 24-hour cancellation).

A cancellation fee is not considered a qualified medical expense that can be paid for using Health Savings Account funds.

Charges will appear on your statement as being submitted by Jituzu or My Clients Plus.

PLEASE PRINT CLEARLY:

Client Name: ______________________________________________________Date of Birth: ___________

Name as it appears on your Credit/Debit Card: ________________________________________________________

Is this an HSA Account: ____Yes _____No

Credit Card Number: ________________________________________________________________________

Expiration Date: ____________________________________Security Code/CCV: _____________________

Address where bills for this credit card are sent:

Street Address: _____________________________________________________________________________

City______________________________________________________________ State: ______Zip:_________

My signature below indicates that I have read, been advised of, and understand the above information and that I consent to pay for either session costs or applicable co-pay/co-insurance at the time of service. I understand that the amount I am responsible for is dependent upon my personal insurance plan coverage and may be less than but will never exceed the rates set by Dr. Fagan. I acknowledge that ultimately it is my responsibility to know my insurance plan/policy and how it affects my out-of-pocket expenses. By signing below, I acknowledge that the credit card I authorize Dr. Fagan to charge is valid. I understand the card information will be kept securely by the card processing company. This card authorization will remain in effect until I cancel this authorization.

_____________________________________________________________ ____________________________

**Signature of Card Holder** **Date**

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# INFORMED CONSENT FOR TELEPSYCHOLOGY

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 if we have agreed to meet via telepsychology.

**Benefits and Risks of Telepsychology:** Telepsychology refers to providing psychology services remotely using telecommunications technologies, such as video conferencing. One of the benefits of telepsychology is that the client and clinician can engage in services without being in the same physical location. Due to licensing restrictions, you will need to be in the State of Ohio at the time of our meeting. Telepsychology also requires technical competence on both our parts to be helpful. Details about how to log in to my HIPAA compliant videoconferencing Zoom portal are in "*Distance Telepsychology Instructions"*.

**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 still apply in telepsychology. Please let me know if you have any questions about exceptions to confidentiality.

**Emergencies and Technology:** Assessing and evaluating threats and other emergencies can be more difficult when conducting telepsychology than in-person meetings. In the event of an emergency, I will call emergency services and disclose your address to the dispatcher, and/or I will reach out to the emergency contact you provide to me on my registration forms. If the session is interrupted for any reason, such as the technological connection fails, and you are having an emergency, do not call me back; instead, call 911, or go to your nearest emergency room. Call me back after you have called or obtained emergency services.

*If the session is interrupted and you are not having an emergency,* disconnect from the session and I will wait one (1) minute and then re-contact you via the telepsychology platform on which we agreed to conduct therapy. If you do not receive a call back within two (2) minutes, then call me on the phone at 614-398-9624. If there is a technological failure and we are unable to resume the connection, 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 appointments. However, third-party payers 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.

**Important requirements**: You agree to attend session in a place that is quiet and confidential. You will arrange for childcare for any children in the home. You will not attend session while driving. If this meeting requires the involvement of more than one person, all people will need to be visible on the computer screen throughout our

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(*INFORMED CONSENT FOR TELEPSYCHOLOGY, CONTINUED*)

appointment. Please make sure your internet and computer is set up with a camera and adequate bandwidth. I must have an accurate email on file for you because this how you will receive a link to our session.

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

________________________________________________________________

Client Printed Name

________________________________________________________________

Signature and Date

________________________________________________________________

Client Printed Name

________________________________________________________________

Signature and Date