Distance Telepsychology Instructions
if we are meeting via telehealth

Please read these instructions carefully. We will be meeting via a Pro Zoom videoconferencing portal. I pay for this HIPAA compliant teleconferencing platform. Telepsychology requires attention to some details that do not exist when we meet in person.

Prior to our appointment:
Telepsychology requires that you have a computer, tablet or smartphone with a camera, microphone, and speakers or headphones.

Plan to attend our appointment in a place that is quiet and confidential. Please make sure you have childcare for any children in the home. *If this is not possible, please discuss this situation with me prior to your appointment.* I will not conduct an appointment with you if you are driving or in a situation that I deem unsafe or lacking in adequate confidentiality. Sitting in the privacy of your parked car is acceptable.

You will need private internet access. Do not log on to our meeting using a public WiFi. Please make sure your internet and computer is set up with a camera and enough bandwidth.

The email address you give me will be the address I use to send you a confidential link to our appointment. Please consider the appropriateness and potential risks of using a work email address. I will send unique meeting ID codes for each telepsychology appointment.

Please download Zoom to your device. There is no cost to you to do so. You only need to install it one time, sessions after that it will automatically open. Here are links to download Zoom to your computer:
For MAC: zoomusInstaller (9).pkg
For PC: ZoomInstaller (1).exe

There are also Zoom apps available for Smart Phones.

At the time of our appointment:
At the time of our appointment, please open the email invitation. Please click the link to join our session.

Select to launch application using Zoom.us

Please select to "join audio conference by computer" (that will use your computer's speaker and webcam).

You will wait for me in a virtual waiting room. I will admit you to our meeting when I can confirm that you are entering from the email address that I used to send the invitation.

If this is our first meeting, I will ask to see photo identification. I will ask to confirm your location. All parties for the appointment need to be visible on the computer screen. I also have the ability to lock the meeting so that no one else could gain access to our appointment if they somehow obtained the unique meeting ID code.

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Office Policies and Informed Consent

Welcome to my practice. I would like to take this opportunity to acquaint you with information relevant to treatment, confidentiality, and office policies. I will answer all questions you have, as openness and collaboration in our relationship is essential to the outcome of all treatment. I am a member of the Ohio Psychological
Association and the American Society for Reproductive Medicine, and I adhere to their ethical standards and their guidelines for continuing education. This is in addition to the codes of conduct and laws and rules that apply to psychologists as prescribed by the American Psychological Association, the Ohio State Board of Psychology and the Ohio Revised and Administrative Codes.

Aims and Goals and Informed Consent. Psychotherapy is based on psychological theory, research, and treatment methods. The major goal is to help you cope more effectively with problems in daily living. Most individuals find therapy beneficial in making positive changes in thoughts, feelings, and behaviors. Occasionally people believe therapy makes them feel worse. Even the most successful therapy may involve remembering unpleasant events, becoming aware of certain thoughts, or experiencing strong emotions. Therapy may also impact relationships with significant others. Please understand that there are potential risks posed by counseling and evaluation. These may include risks that are presently unknown or unidentified, and they may vary widely among individuals. It is impossible to accurately state the likelihood of your personal risk. I encourage you to share any concerns you any have about the therapy process with me so that I may respond to these concerns.

Appointments. Appointments are usually 55 minutes in duration. Arrangements can be made for either a 30 or 45 minute appointment by special request at reduced fees. Please recognize that when I make an appointment I have reserved that time especially for you. If you must cancel an appointment, please call my office to cancel at least 24 hours before your appointment. You may leave a voicemail message for me 24 hours a day. The charge for a late cancellation or missed appointment is $80 and insurance will not reimburse for missed appointments.

Confidentiality Laws protect the privacy of all communications between a client and a therapist. In most situations I can only release information about your treatment to others if you sign a written authorization. There are some situations where I am permitted or required to disclose information either with or without your consent or authorization. For example:

- If you are involved in a court proceeding and a request is made for information concerning your treatment, I cannot provide such information without your written authorization or a court order. If you are involved in or contemplating litigation, you should consult your attorney to determine whether a court would be likely to order me as your therapist to disclose information. Please note that I discourage all clients from subpoenaing me for any reason;
- If a government agency is requesting the information, I may be required to provide it;
- If you file a complaint or lawsuit against me, I may disclose relevant information about you in order to defend myself;
- If you file a worker's compensation claim, I may be required, upon appropriate request, to provide a copy of your records, or a report of your treatment.

There are some situations in which I am legally obligated to take actions that I believe are necessary to attempt to protect others from harm, and in such cases I might have to reveal some information about your treatment. If such a situation arises, I will make every effort to fully discuss it with you before taking any action, if I deem that to be appropriate under the circumstances, and will limit disclosure to what is necessary.
For instance:

- If I have reason to believe that a child, a developmentally or physically disabled or elderly adult is being neglected or abused, the law may require me to report that information to the appropriate agency;
- If I believe you present a clear and substantial danger of harm to yourself and/or others, I may be obligated to take certain protective actions. This may include contacting family members, seeking hospitalization for you, notifying any potential victim(s), and/or notifying the police.

You agree that I may release information about your claim(s) to the Ohio Department of Insurance in connection with any insurance company's failure to properly pay a claim in a timely manner as well as to the Ohio Department of Commerce, which requires certain reporting of unclaimed funds. In those instances, only the minimal, required, information will be supplied.

You agree that from time to time I may have the need to consult with my practice attorney regarding legal issues involving your care (this is an infrequent occurrence, but does happen from time to time). My practice attorney is bound by confidentiality rules also. In addition, I will reveal only the information that I need to reveal to receive appropriate legal advice in connection with those contacts.

You should be aware that I may consult with other mental health professionals and that I may employ administrative staff. In most cases, I need to share protected information with these individuals for both clinical and administrative purposes, such as typing, scheduling, billing, and quality assurance. If I do that I will only release the information necessary in order for me to provide help to you, the client. All of the mental health professions are bound by the same rules of confidentiality.

Also, I may have a contract with a collection agency. I will have a formal business contract with this business, in which it promises to maintain the confidentiality of this data except where release of certain information is allowed in the contract or is required by law.

In addition, I may have a contract with a billing service. I will have a formal HIPAA business associate contract with this business, in which it promises to maintain the confidentiality of this data except where release of certain information is allowed in the contract or is required by law.

This summary is designed to provide an overview of confidentiality and its limits. It is important that you read the Notice of Privacy Practices form that has been provided to you for more detailed explanations, and that you discuss with me any questions or concerns that you have.

Legal Situations. I do not like to testify, however, if you become involved in legal proceedings that require my participation you will be expected to pay for all of my professional time, even if I am called to testify by another party. I will ask that a retainer be paid of half of the expected fees at least one week prior to providing these services, and the second half of expected fees and any additional fees that may have been accrued be paid within one week after services are delivered. Any unused amounts will be refunded. My professional time for legal proceedings may include preparation (document review or letter preparation), phone consultation with other professionals or you, record copying fees, and travel time to and from proceedings, testifying, and time that I wait in court prior to or after I may be called to testify).

Due to the time-consuming and often difficult nature of legal involvement, I charge $275.00 per hour for these services. You will also be responsible for any legal fees that I may incur in connection with the legal proceeding, which may include responding to subpoenas.

Professional Records. The laws and standards of my profession require that I keep Protected Health Information about you in your client file. Your records may include information about your reasons for seeking therapy, a description of the ways in which your problems affect your life, your diagnosis, the goals for treatment, your progress toward those goals, your medical and social history, your treatment history, results of clinical tests (including raw test data), any past treatment records that I receive from other providers, reports of any professional consultations, any payment records, and copies of any reports that have been sent to anyone. You may examine and/or receive a copy of all of your records if you request them in writing, unless I determine for clearly stated treatment reasons that disclosure of the records to you is likely to have an adverse effect on you, and in that event I may exercise the option of turning the records over to another mental health therapist designated by you. Because these are professional records they can be misinterpreted and/or upsetting to untrained readers, I therefore recommend that you initially review them with me, or have them forwarded to another mental health professional so you can discuss the contents. In most circumstances, I am allowed to charge fees set under Ohio and federal laws for copying and sending records. These fees may change every year, so I will let you know what the charge is at the time that a records request is made. If you desire to have the information sent to you electronically, if I maintain the information in an electronic format, I will provide the information in that format if you agree to accept the potential risks involved in sending the information that way.

As your therapist, I may also keep a set of psychotherapy notes which are for my own use and which are designed to assist me in providing you with the best treatment. These notes are kept separate from the rest of your records. In order for psychotherapy notes to be released to third parties, you must sign a separate authorization in addition to one for the rest of your records. I will discuss with you whether or not I am maintaining psychotherapy notes on you.

Minors and Parents. I do not work with children under the age of 18.

Relationship. My relationship with clients is a professional and therapeutic relationship. In order to preserve this relationship, it is imperative that I not have any other type of relationship with you. Personal and/or business relationships undermine the effectiveness of the therapeutic relationship. Please do not attempt to "friend" me on Facebook or on any other social media site.

Fees. My fee is $175 for the initial psychotherapy session. **Individual counseling:** The fee for each subsequent session of 55-60 minutes is $160. Briefer sessions of either 30 minutes or 45 minutes are billed at reduced rates of $90 and $140 respectively. Administration and scoring of psychological tests will be billed according to the test given. These rates will be provided to you before any necessary testing. Some insurance companies do not pay for **Couple counseling**, where the fees are $160 for a 50 minute session or $175 for an extended session of 75 minutes. If I determine that it is proper to proceed with one person as a client, rather than the relationship as the client, with a second person entering the sessions to assist me in work with that client, the client must have a diagnosis in order for insurance to provide coverage. **Consultation** may be appropriate in situations where no diagnosis is present but my expertise is requested (eg infertility decision making, couple communication issues) and is billed at $160 for a 50 minute session.

Typically there is no charge for brief informational phone conversations between scheduled therapy sessions. Consultations made on behalf of the client over 15 minutes in length with other professionals

and agencies will be charged at the $160/hour rate and billed per minute following the first 15 minutes. Charges may be made for telephone calls with you with when the call becomes part of the therapy and is not informational.

If it is necessary for our office to fill out forms, write letters, or engage in extensive consultation with other professionals or agencies that last more than 15 minutes, you will be billed at the rate of $40 for each 15 minutes or fraction thereof. These fees cannot be submitted to insurance.

Payments. Insurance: If you provide me with your insurance information and sign the *Assignment of Insurance and Release of Information,* my office will file your insurance claim. If you do not provide me with the insurance information and do not sign the on the signature page, you must inform me that you do not want me to file any claims with your insurer, even if I am an in-network provider. While using your insurance benefits can be cost effective, the consequence of doing so means that my office is required to disclose some basic information to your insurer, including a diagnosis. They also retain the right to audit my records, as indicated in your insurance contract with your insurance company. Signing the consent to submit claims to your insurance company means that you understand this choice. This decision is your privilege.

All co-pays and deductible amounts must be paid at the beginning of each visit unless special arrangements have been made before the scheduled session. If your insurance is denied, regardless of the reason, you will be held responsible for any charges. HSA or FSA funds may be used for individuals who are your financial dependents.

Private Payment: Using health insurance benefits requires disclosure of information to your health insurer. You have the right to elect to pay privately for services and thus retain your rights of privacy. HSA or FSA funds can be used if you elect this option and you are responsible for ensuring that no information is sent to your insurance company. If you elect this option, you must pay in full for each service at the time service is provided and I will not provide any information to your insurance company.

Delinquent Account: If your account has not been paid for more than 60 days and arrangements for payment have not been agreed upon, I have the option of using legal means to secure payment. This may involve hiring a collection agency or going through small claims court which will require us to disclose otherwise confidential information. In most situations, the only information I release regarding a patient's treatment is his/her name, the nature of services provided, and the amount due.

Payment methods: I accept credit/debit cards, cash, and checks for services. There will be a $25.00 fee for returned checks. Replacement of any returned check and the additional charges incurred must be made with a money order, cashier's check, or cash. If a bill from my office must be resubmitted the following month due to lack of payment, a $5 rebilling charge will be posted for each month this is necessary.

Change of Personal Information. Please inform me if you change work and/or home addresses, telephone numbers, email address, or insurance carrier during therapy. You are advised to discuss any pending changes in your insurance coverage prior to making a change, as it may affect coverage and your financial obligation.

Emergencies. In a medical or psychological emergency, you are advised to call 911 or go to your nearest emergency room**:** Mt. Carmel St. Ann's Hospital, (614)898-4000, Ohio State University (614) 293-8333, Riverside Hospital Emergency Room, (614) 566-5056 or contact NetCare Access at (614) 276-2273.

Incapacity or Death of Therapist. In the event that I am incapacitated or die, it will be necessary for another therapist to take possession of your file and records. By signing this form you consent to allow another licensed mental health professional whom I designate to take possession of your file and records, provide you with copies upon request, or to deliver them to a therapist of your choice.

Email, Texting, and Electronic Communications. I do not like to use e-mail, texting, or electronic communications unless we both agree that is appropriate. If you decide you want to utilize any form of electronic communication, you acknowledge that there are confidentiality risks inherent in such communications if they are unencrypted and you agree to accept those risks.

Office Policies and Informed Consent for Third-Party Assisted Reproductive Technology Psychological Consultation

(Supplement to Office Policies and Informed Consent and the Notice of Privacy Practices Forms of Allison Fagan, Psychologist LLC)

It is my privilege to be involved in your assisted reproductive medical treatment. Our appointment is required by your physician for your participation in procedures involving the use of donor sperm, donor egg, donated embryos, or a gestational surrogate. I am a member of the Mental Health Professional Group of the American Society for Reproductive Medicine and I adhere to their ethical standards and their guidelines for continuing education. This is in addition to the codes of conduct that apply to psychologists as prescribed by the American Psychological Association, the Ohio Psychological Association, and the Ohio State Board of Psychology.

Informed Consent. Not every potential participant for third-party assisted reproductive medical procedures will be accepted for treatment by their physician. You accept that Allison Fagan, Ph.D. Psychologist cannot guarantee that you will be accepted by your physician for treatment as she is required to provide impartial information.
There are potential risks posed by counseling and evaluation. These may include risks that are presently unknown or unidentified. Any psychological and emotional risks may vary widely among individuals, so it is not possible to accurately state the likelihood of your personal risk.

Limits to Confidentiality. More specific information on this issue is provided in the Office Policies and Informed Consent and Notice of Privacy Practices forms. It is expressly understood and agreed that if you are a member of a couple undergoing this consultation together, any information conveyed to me by either of you may be shared by me with the other member of the couple. In addition, confidentiality may be waived by client request. In order to be helpful to you and your physician, I will need each of to you to sign an Authorization to Disclose Protected Health Information, otherwise I will not be able to conduct the assessment. By signing this form, you are waiving your privilege to confidentiality only to the party named on that form.

Fees. This consultation is required by your physician for continued management of your infertility and to pursue third-party assisted reproductive medical treatment. My fees reflect time spent with you in a health and behavior assessment, the administration, scoring and interpretation of any psychological test(s) that are deemed necessary, and report writing and consultation with your physician to facilitate your medical treatment.

Insurers do not cover the costs associated with the evaluation or screening of potential donors or gestational carriers and are inconsistent in their willingness to pay for these expenses for intended parents.

If insurance coverage is provided, it is usually for the health and behavior assessment appointment time and sometimes for the administration of any psychological tests administered to the intended parent(s*).*

Health insurance does not cover the evaluation of donor candidates or gestational carrier evaluations, nor report writing fees for intended parents, and thus will not be accepted for these services.

Payment arrangements are required at the time of service. If I am a network provider with your insurer, I can submit a claim to your insurance company. If I am out-of-network with your insurance provider, in lieu of me filing a claim on your behalf a billing statement can be given to you for you to forward to your insurer for direct reimbursement. I request that you keep a credit/debit card on file with me for payment of your portion of the fees. Be aware that the necessary coding for this claim will disclose your diagnosis and treatment of infertility to the insurer.

The fees below are estimates and are dependent on the actual time I spend on your consultation/evaluation and will typically fall within the range provided.

Type of Consultation	**Fee**
Consultation with intended parent(s) using donor sperm, ovum, embryos or a gestational carrier. Fee includes health and behavior appointment time ($200) and report writing and consultation with physician ($100).	**$300**
Evaluation of donors (and spouse): Fee includes evaluation and psychoeducation, test administration and scoring, report writing and consultation with physician or referring agency.	**$500-$750**
Evaluation of gestational carrier (and spouse): Fee includes appointment time for evaluation and psychoeducation, test administration and scoring, report writing and consultation with referring physician, attorney, or agency.	**$750-$1000**
Meeting with intended parents and known donor or gestational carrier/spouse	**$160-$250**
Additional Psychological testing, if deemed necessary, fee per person	**$150**

More information on fees and payments is detailed in the Office Policies and Informed Consent form.