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

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 consult, I will only release the information necessary in order for me to provide help to you, the client. All 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 $100 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. While some insurance companies pay for the modality of couples counseling, it requires that one person in the relationship is identified as a patient and the therapy is being done to treat a mental health diagnosis in that individual. 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. My fees are $160 for a 55-minute session or $175 for an extended session of 75 minutes.
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 55 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 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.

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.

Payment methods: I accept credit/debit cards, cash, and checks for services. I am also able to submit invoices to you from no-reply@jituzu.com and/or keep a credit/debit card on file for you.

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.

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Acknowledgement of Informed Consent to Treatment

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.

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 _____

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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_____

Current Health*:* 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: _____

Are you currently working with another therapist (e.g. for couples counseling)? If so, please list the names of the mental health provider(s) and reason(s) for seeking treatment:

_____

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Psychological Health History Client name _____

Symptoms. Please circle "P" for Past Concerns and "C" for Current concerns; Circle both if applicable.

1.	Headaches	P	C	32. Self-Injury/Cutting	P	C
1.	Muscle Tension	P	C	33. Tremors/shaking	P	C
2.	Worry/Anxiety	P	C	34. Postpartum Depression	P	C
3.	Visual Hallucinations	P	C	35. Postpartum Anxiety	P	C
4.	Hearing Voices	P	C	36. Increased Appetite	P	C
5.	Digestive Concerns	P	C	37. Decreased Appetite	P	C
6.	Chronic Pain	P	C	38. Racing Thoughts	P	C
7.	Fatigue	P	C	39. Reduced need for Sleep	P	C
8.	Sexual Concerns	P	C	40. Impulsivity	P	C
9.	Low libido	P	C	41. Excessive Spending	P	C
10.	Insomnia	P	C	42. Increased Risk Taking	P	C
12. Sleeping too much		P	C	43. Road Rage	P	C
13. Excessive exercise		P	C	44. Violent Behavior	P	C
14. Food binging		P	C	45. Gambling Behavior	P	C
15. Food purging		P	C	46. Anger	P	C
16. Body Image concerns		P	C	47. Nightmares	P	C
17. Anorexia		P	C	48. Irritability	P	C
18. Overeating		P	C	49. Panic Attacks	P	C
19. Chest Pains		P	C	50. Obsessive Thoughts	P	C
20. Breathing problems		P	C	51. Compulsive Behavior	P	C
21. Concentration Issues		P	C	52. Phobia(s)	P	C
22. Heart Palpitations		P	C	53. Social Anxiety	P	C
23. Poor Memory		P	C	54. Stuttering	P	C
24. PMS		P	C	55. Feeling Withdrawn	P	C
25. Vision problems		P	C	56. Dizziness	P	C
26. Hearing problems		P	C	57. Confusion	P	C
27. Increased Sweating		P	C	58. Increased Smoking	P	C
28. Feeling of Sadness		P	C	59. Increase in alcohol/drug use	P	C
29. Desire to Cry		P	C	60. Hives	P	C
30. Feel Restless/Trapped		P	C	61. Nausea	P	C
31. Feeling Fearful		P	C	62. Difficulty sleeping	P	C

Please list family members who have struggled with psychological issues. Name diagnosis or describe symptoms.

_____

_____

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(Psychological Health History, continued) Client name _____

Have you ever had suicidal thoughts? Yes _____ No _____ If yes, when? _____

Are you currently having any suicidal thoughts? _____ If yes please describe. _____

_____

Have you ever had homicidal thoughts? Yes _____ No ____ If yes, when? _____

Are you currently having any homicidal thoughts? _____ If yes please describe. _____

_____

Have you ever been treated for chemical dependency/substance abuse? Yes____ No_____ If yes, when, where, and for how long?

_____

_____

Do your family or friends think you have a problem with substance abuse now? _____

Have you ever received prior counseling? _____ If yes when, with whom, and for how long? _____

_____

Was it inpatient or outpatient? _____

What issues were you working on in prior counseling? _____

What about prior counseling was helpful to you? _____

_____

PRESENTING CONCERN

Why have you sought counseling at this time? _____

_____

When did these particular problems begin? _____

What have you done to try to solve them? _____

Where do you get support? _____

What strengths do you have? _____

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Adverse Childhood Experiences Questionnaire Client Name_____

While you were growing up, during your first 18 years of life:

1. Did a parent or other adult in the household often swear at you, insult you, put you down, or humiliate you, or act in a way that made you afraid that you might be physically hurt?
___Yes _____No If yes, who was that person? _____

2. Did a parent or other adult in the household often push, grab, slap, or throw something at you, or ever hit you so hard that you had marks or were injured?
___Yes _____No If yes, who was that person? _____

3. Did an adult or person at least 5 years older than you ever touch or fondle you or have you touch their body in a sexual way or try to or actually have oral, anal, or vaginal sex with you?
___Yes _____No If yes, how old were you when this happened? _____
Who was that person? _____

4. Did you often feel that no one in your family loved you or thought you were important or special or your family didn't look out for each other, feel close to each other, or support each other?
___Yes _____No

5. Did you often feel that you didn't have enough to eat, had to wear dirty clothes, and had no one to protect you or your parents were too drunk or high to take care of you or take you to the doctor if you needed it?
___Yes _____No

6. Were your parents ever separated or divorced?
___Yes _____No If yes, how old were you when this happened? _____

7. Was your mother or stepmother often pushed, grabbed, slapped, or had something thrown at her, or sometimes or often kicked, bitten, hit with a fist, or hit with something hard, or ever repeatedly hit over and over for at least a few minutes or threatened with a gun or knife?
___Yes _____No

8. Did you live with anyone who was a problem drinker or alcoholic or who used street drugs?
___Yes _____No If yes, who was that person? _____

9. Was a household member depressed or mentally ill or did a household member attempt suicide?
___Yes _____No If yes, who was that person? _____

10. Did a household member go to prison?
___Yes _____No If yes, who was that person? _____

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Billing Information

Printed Name(s)_____ _____

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

COMPLETE ONLY ONE SECTION

****

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 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**