PSYCHOLOGICAL & BEHAVIORAL MEDICINE SERVICE CONTRACT

Welcome to our practice. We look forward to helping you reach your goals. This form provides you, the patient, with information that is additional to that detailed in the Notice of Privacy Practices and it is subject to HIPAA preemptive analysis. Initialing on the lines below each section indicates acceptance and understanding of the preceding material. Please do not hesitate to ask questions of your clinician or staff regarding this consent form.

CONFIDENTIALITY: All information disclosed within sessions and the written records pertaining to those sessions **are confidential** and may not be revealed to anyone by alo.ha psych associates, inc or your clinician without your written permission except where disclosure is required by law. These exceptions are:

1. The patient authorizes release of information.
2. As necessary for continuity of care
3. A judge issues a court order.
4. There is a medical emergency.
5. The patient presents a physical danger to self.
6. The patient presents a danger to others.
7. Child, elder or dependent adult abuse/neglect is suspected.

It is understood that in cases 6 and 7 that your clinician is required by law to inform potential victims and legal authorities so that protective measures can be taken. If you participate in group therapy it is understood that you are not to discuss any details of the group outside of the group therapy sessions. alo.ha psych associates, inc. and your clinician follows the "minimum necessary" rule for release of information.

If you place your mental status at issue in litigation initiated by you, the defendant may have the right to obtain the psychotherapy records and/or testimony by alo.ha psych associates, inc. and/or your clinician. In couple and family therapy, or when different family members are seen individually, even over a period of time, confidentiality and privilege do not apply between the couple or among family members, unless otherwise agreed upon. alo.ha psych associates, inc. and/or your clinician will use clinical judgment when revealing such information.

alo.ha psych associates, inc. and/or your clinician will not release records to any outside party unless authorized to do so by all adult parties who were part of the family therapy, couple therapy or other treatment that involved more than one adult patient.

I accept and understand the information presented above.

Initials: ___________

RELEASE OF INFORMATION: I authorize the release of information regarding my care to my health plan for the payment of claims, certification/case management decisions, and other purposes related to the administration of benefits of my health plan. I authorize my insurance benefits be paid directly to Alo.ha Psych Associates, Inc. . I understand that I am financially responsible for any balance. I also authorize my clinician., Alo.ha Psych Associates, Inc. and/or insurance company to release any information required to process my claims. I understand that my clinician works with Alo.ha Psych Associates, Inc., and therefore my PHI is accessible by all Alo.ha Psych Associates, Inc. clinicians and staff. I acknowledge receipt of the Notice of Privacy Practices. Additionally, I understand that if my treatment is a result of a referral from a physician for evaluation/treatment in a hospital, skilled nursing facility, intensive outpatient program, outpatient services, partial hospitalization program, or home setting my physician has ordered the services of my clinician and my clinician is authorized to share necessary medical/psychological information with my physician and immediate allied providers for the purpose of my healthcare. I ask that Medicare or other authorized insurance benefits be paid to alo.ha psych associates, inc. for rendering of psychological services. I authorize any holder of medical information about the patient to be released to the Centers for Medicare and Medicaid Services and its agents any information needed to determine these benefits or the benefits payable for related services.

I accept and understand the information presented above.

Initials: ___________

HEALTH INSURANCE & CONFIDENTIALITY OF RECORDS: Disclosure of confidential information may be required by your health insurance carrier or HMO/PPO/MCO/EAP in order to process the claims. If you so instruct your clinician, only the minimum necessary information will be communicated to the insurance carrier. Your clinician and Alo.ha Psych Associates, Inc. has no control over, or knowledge of, what insurance companies do with the information he submits or who has access to this information. You must be aware that submitting a mental health invoice for reimbursement carries a certain amount of risk to confidentiality, privacy or to future capacity to obtain health or life insurance or even a job. The risk stems from the fact that mental health information is likely to be entered into big insurance companies' computers and is likely to be reported to the National Medical Data Bank. Accessibility to companies' computers or to the National Medical Data Bank database is always in question as computers are inherently vulnerable to hacking and unauthorized access. Medical data has also been reported to have been legally accessed by law enforcement and other agencies, which also puts you in a vulnerable position.

I accept and understand the information presented above.

Initials: ___________

RECORDS AND YOUR RIGHT TO REVIEW THEM: Both the law and the standards of your clinician's profession require that he keep treatment and/or the psychological testing records for at least seven (7) years. Unless otherwise agreed to be necessary, your clinician and Alo.ha Psych Associates, Inc. retains clinical records only as long as is mandated by California law. If you have concerns regarding the treatment and/or the psychological testing records, please discuss them with your clinician. As a patient, you have the right to review or receive a summary of your records at any time, except in limited legal or emergency circumstances or when your clinician assesses that releasing such information might be harmful in any way. In such a case, you clinician will provide the records to an appropriate and legitimate mental health professional of your choice. Considering all of the above exclusions, if it is still appropriate, and upon your request, your clinician or Alo.ha Psych Associates, Inc. will release information to any agency/person you specify unless your clinician assesses that releasing such information might be harmful in any way. When more than one patient is involved in treatment, such as in cases of couple and family psychological and behavioral medicine services, your clinician will release records only with signed authorizations from all the adult parties (or all those who legally can authorize such a release) involved in the treatment.

I accept and understand the information presented above.

Initials: ___________

MEDIATION & ARBITRATION: In the unlikely event of disputes arising out of, or in relation to, this agreement to provide psychological and behavioral medicine services, all matters shall first be referred to mediation, before, and as a pre-condition of, the initiation of arbitration. The mediator shall be a neutral third party chosen by agreement of your clinician/Alo.ha Psych Associates, Inc. and the patient(s). The cost of such mediation, if any, shall be split equally, unless otherwise agreed upon. In the event that mediation is unsuccessful, any unresolved controversy related to this agreement should be submitted to and settled by binding arbitration in San Diego County, California in accordance with the rules of the American Arbitration Association which are in effect at the time the demand for arbitration is filed.

Notwithstanding the foregoing, in the event that your account is overdue (unpaid) and there is no agreement on a payment plan, your clinician and/or Alo.ha Psych Associates, Inc. can use legal means (court, collection agency, etc.) to obtain payment if necessary. The prevailing party in arbitration or collection proceedings shall be entitled to recover a reasonable sum as and for attorney's fees. In the case of arbitration, the arbitrator will determine that sum.

Furthermore, due to the nature of the therapeutic process and the fact that it often involves making a full disclosure with regard to many matters which may be of a confidential nature, I agree that neither I nor my attorney nor anyone else acting on my behalf will call on my clinician or alo.ha psych associates, inc to become a witness to testify in court, communicate with child custody evaluator/s, or any other proceeding, or request a disclosure of psychological treatment and behavioral health services rendered by my clinician.
I accept and understand the information presented above.

Initials: ___________

CONSULTATION: my alo.ha psych associates, inc clinician consults regularly with other professionals regarding patients; however, each patient's identity remains **completely anonymous** and confidentiality is fully maintained.

I accept and understand the information presented above.

Initials: ___________

THE PROVISION OF PSYCHOLOGICAL AND BEHAVIORAL MEDICINE SERVICES/EVALUATION AND SCOPE OF PRACTICE: Participation in psychological and behavioral medicine services can result in a number of benefits to you, including improving interpersonal relationships and resolution of the specific concerns that led you to seek therapy. Working toward these benefits, however, requires effort on your part. Psychological and behavioral treatment requires your very active involvement, honesty, and openness in order to change your thoughts, feelings, and/or behavior. Your clinician will ask for your feedback and views on your therapy, its progress, and other aspects of the therapy and will expect you to respond openly and honestly.

Sometimes more than one approach can be helpful in dealing with a certain situation. During evaluation or treatment, remembering or talking about unpleasant events, feelings, or thoughts can result in you experiencing considerable discomfort or strong feelings of anger, sadness, worry, fear, etc., or experiencing anxiety, depression, insomnia, etc. Your clinician may challenge some of your assumptions or perceptions or propose different ways of looking at, thinking about, or handling situations, which can cause you to feel very upset, angry, depressed, challenged, or disappointed. Attempting to resolve issues that brought you to therapy in the first place, such as personal or interpersonal relationships, may result in changes that were not originally intended. Psychological and behavioral medicine treatment may result in decisions about changing behaviors, employment, substance use, schooling, housing, or relationships. Sometimes a decision that is positive for one family member is viewed quite negatively by another family member. Change will sometimes be easy and swift, but more often it will be slow and even frustrating. There is no guarantee that psychological and behavioral medicine treatment will yield positive or intended results. During the course of therapy, you clinician is likely to draw on various psychological approaches according to the problem that is being treated and his/her assessment of what will best benefit you. These approaches include, but are not limited to, behavioral, medical, cognitive-behavioral, cognitive, psychodynamic, existential, system/family, developmental (adult, child, family), humanistic or psycho-educational.

Your clinician does not provide custody evaluation recommendations when providing psychological and behavioral medicine treatment.

Your psychologist may make recommendations to your prescriber for prescription of medications, as described by the California Board of Psychology Statement on Medication. Medication options may be relayed to your prescriber by yourself or your psychologist.

Additionally, it is important that your clinician remain in contact with your care providers regarding your progress as it is pertinent to their practice. Prior to the start of services, it is your responsibility to have medical records forwarded from your care provider(s) as deemed by them to be necessary and/or beneficial to your psychological and health treatment. This can include physical exam, psychological assessment/reports, current and past medication prescriptions, physical and laboratory test results, X-ray and magnetic imaging, medical assessments, etc. **It is your responsibility to communicate with your provider and have these forms forwarded to alo.ha psych associates, inc. and your clinician office prior to the start of psychological and health services.**

I accept and understand the information presented above.

Initials: ___________

TREATMENT PLANS: Within a reasonable period of time after the initiation of treatment, your clinician will discuss with you his/her working understanding of the problem, treatment plan, therapeutic objectives, and his/her view of the possible outcomes of treatment. If you have any unanswered questions about any of the procedures used in the course of your treatment, their possible risks, your clinician's expertise in employing them, or about the treatment plan, please ask and you will be answered fully. You also have the right to ask about other treatments for your condition and their risks and benefits.

I accept and understand the information presented above.

Initials: ___________

EMERGENCY DURING TREATMENT: If there is an emergency during rendering of services, or in the future after termination, where your clinician becomes concerned about your personal safety, the possibility of you injuring someone else, or about you receiving proper psychiatric care, your clinician will do whatever he can within the limits of the law, to prevent you from injuring yourself or others and to ensure that you receive the proper medical care. For this purpose, your clinician may also contact the person whose name you have provided on the biographical sheet.

I accept and understand the information presented above.

Initials: ___________

TELEPHONE & EMERGENCY PROCEDURES: If you need to contact your clinician between sessions, please leave a message with the clerical staff at (619) 996-3195 and your call will be returned as soon as possible. Alo.ha psych associates inc. staff checks messages a few times during the daytime only, unless your clinician is out of town. If an emergency situation arises, indicate it clearly in your message and if you need to talk to someone right away call the 24-hour Access and Crisis Line for San Diego County: **1-888-724-7240,** or the Psychiatric Emergency Response Team (PERT): **911**. Please do not use e-mail or faxes for emergencies. Your clinician does not always check e-mail or faxes daily. *I accept and understand the information presented above.*

Initials: ___________

TERMINATION: As set forth above, after the first couple of meetings, your clinician will assess if he/she can be of benefit to you. Your clinician does not accept patients who, in his/her opinion, he/she cannot help. In such a case, the clinician will give you a number of referrals whom you can contact. If at any point during psychological and behavioral medicine treatment, your clinician assesses that he/she is not effective in helping you reach the therapeutic goals or that you are not adhering to the treatment, he/she is obligated to discuss it with you and, if appropriate, to terminate treatment. In such a case, he/she would give you a number of referrals that may be of help to you. If you request it and authorize it in writing, your clinician will talk to the provider of your choice in order to help with the transition. If, at any time, you want another professional's opinion or wish to consult with another provider, your clinician will assist you with referrals, and, if he/she has your written consent, he will provide her or him with the essential information needed. You have the right to terminate therapy at any time. If you choose to do so, and if appropriate, your clinician will offer to provide you with names of other qualified professionals.

I accept and understand the information presented above.

Initials: ___________

SOCIAL NETWORKING AND INTERNET SEARCHES: At times, your may conduct a web search on his/her patients before the beginning of therapy or during therapy as is common practice among providers. If you have concerns or questions regarding this practice, please discuss them with your clinician. Your clinician does not accept friend requests from current or former patients on social networking sites, such as Facebook. Your clinician believes that adding patients as friends on these sites and/or communicating via such sites is likely to compromise their privacy and confidentiality. For this same reason, your clinician requests that patients not communicate with him/her via any interactive or social networking web sites.

I accept and understand the information presented above.

Initials: ___________

ELECTRONIC COMMUNICATION AND TELEMEDICINE TREATMENT: It is very important to be aware that computers and e-mail communication can be relatively easily accessed by unauthorized people and hence can compromise the privacy and confidentiality of such communication. Faxes can easily be sent erroneously to the wrong address. E-mails, in particular, are vulnerable to unauthorized access due to the fact that Internet servers have unlimited and direct access to all e-mails that go through them.

Your clinician and Alo.ha Psych Associates, Inc. computers are equipped with a firewall, a virus protection, and a password and he also backs up all confidential information from his computers on a regular basis. However, emails are not encrypted. Due to the risks involved, your clinician does not regularly communicate with his/her patients via email. Please do not use email to communicate information pertaining to your treatment.

If you communicate confidential or private information via e-mail, your clinician will assume that you have made an informed decision and will view it as your agreement to take the risk that such communication may be intercepted.

At times your clinician may find treatment sessions via video conference or telephone as an effective method, if personal visitations are not possible for any reason. The video conferencing account from which your clinician will conduct these sessions, if necessary, is a professional account for sessions only. Your clinician is not available for personal or unscheduled communications through this account.

Treating people exclusively via phone/video conference may put care providers at a disadvantage because they cannot detect nonverbal cues, may not be able to accurately diagnose, may not always be aware of the resources available locally, and may not be able to intervene as effectively as necessary in emergency situations. Therefore, video and telephone sessions will not be relied on as the sole method for treatment with your clinician.

Please notify your clinician if you decide to avoid or limit in any way the use of any or all communication devices, such as e-mail, cell phone, or faxes. Please do not use e-mail, faxes, or a video conferencing host for general correspondence or emergencies. In case of emergencies, please call 911.

I accept and understand the information presented above.

Initials: ___________

DUAL RELATIONSHIPS: Despite a popular perception, not all dual or multiple relationships are unethical or avoidable, for example being co-members in community organizations. Psychological and behavioral medicine treatment **never** involves sexual or any other dual relationship that impairs your clinician's objectivity, clinical judgment or can be exploitative in nature. Your clinician will assess carefully before entering into non-sexual and non-exploitative dual relationships with patients. It is important to realize that in some communities, particularly small towns, military bases, university campus, etc., multiple relationships are either unavoidable or expected. Your clinician will never acknowledge working with anyone without his/her written permission.

Many patients have chosen your clinician as their provider because they knew him/her before they entered treatment with him, and/or are personally aware of his/her professional work and achievements. Nevertheless, your clinician will discuss with you the often-existing complexities, potential benefits and difficulties that may be involved in dual or multiple relationships. Dual or multiple relationships can enhance trust and treatment effectiveness but can also detract from it and often it is impossible to know which ahead of time. It is your responsibility to advise your clinician if the dual or multiple relationship(s) becomes uncomfortable for you in any way. Your clinician will always listen carefully and respond to your feedback and will discontinue the dual relationship if he/she finds it interfering with the effectiveness of the therapy or your welfare and, of course, you can do the same at any time.

I accept and understand the information presented above.

Initials: ___________

PAYMENTS & INSURANCE REIMBURSEMENT: Patients are expected to pay the standard fee of $200.00 per 45 minute at the beginning of each session unless other arrangements have been made. A standard fee of $75.00 will be charged for completing standard disability claim/progress forms. More complex forms and communication with insurance carriers may be subject to further charges, of which you will be notified prior to.

Telephone conversations, site visits, writing and reading of reports, consultation with other professionals, release of information, reading records, longer sessions, travel time, etc. will be charged at the rates listed below, unless indicated and agreed upon otherwise. Please notify your clinician if any problems arise during the course of therapy regarding your ability to make timely payments.

Not all issues/conditions/problems, which are dealt with in the provision of psychological and behavioral medicine services, are covered by insurance companies. It is your responsibility to verify the specifics of your coverage. If your account is overdue (unpaid) and there is no written agreement on a payment plan, your clinician and Alo.ha Psych Associates, Inc. can use legal or other means (courts, collection agencies, etc.) to obtain payment.

FEE SCHEDULE*

Service Provided (Time Allotted)	**Fees**
Initial Individual Evaluation and Consultation (60 Minutes)	$300.00
Individual Psychotherapy (45-50 Minutes)	$200.00
Family or Conjoint Family Psychotherapy (45-50 Minutes)	$275.00
Psychological Testing (per 60 Minutes)	$200.00
Preparation of Written Psychological Report (per 60 Minutes)	$200.00
Consultation by phone (per 10 Minutes)	$50.00
Hospital/Skill Nursing Consultation (per 30 Minutes)	$200.00
Late Cancelation/No Show Fee	$85.00

*Sliding Scale Available

I accept and understand the information presented above.

Initials: ___________

CANCELLATION: Since the scheduling of an appointment involves the reservation of time specifically for you, a minimum of 24 hours (1 day) notice is required for re-scheduling or canceling an appointment. Unless we reach a different agreement, an $85.00 will be charged. Insurance companies do not reimburse for missed sessions.

I accept and understand the information presented above.

Initials: ___________

I have read the above Psychological and Behavioral Medicine Service Contract carefully (a total of 6 pages). I have been given the opportunity to ask questions and have them answered by my clinician or his/her staff. I fully understand the policies and agree to comply with them:

Patient's Name (print)

____

Signature ____
Date ____________________

Provider's Name (print)

____

Signature ____
Date ____________________

IF PATIENT IS A MINOR

Patient's Name (print)

____

Parent/Guardian's Name (print)

____

Parent/Guardian's Signature____
Date ____________________

Provider's Name (print)

____

Signature ____
Date ____________________