John W. Wilson, PsyD

2250 N. Druid Hills Rd, Ste 233, Atlanta GA 30329
PH: 404-246-1257, FX: 404-506-9454, www.Wilson-Psychological.com

IDENTIFYING INFORMATION

Name: _____ Gender: _____

Address: _____ Race/Ethnicity: _____

_____ Sexual Orientation: _____

Email Address: _____. Phone Number: _____

Age: _____ Birthdate: ____/____/____

Emergency Contact Person (ECP): _____

Their relationship to you: _____

Their telephone number: _____

_____

Sign here to indicate that you understand I will only contact this individual in cases of life-threatening emergencies.

Who referred you to my office? _____

PRIMARY INSURANCE (complete only if you have Aetna insurance)

***All information in this block pertains to the primary cardholder and may or may not be the patient.*

Primary Card Holder: _____ Birthdate ____/____/____

Relationship to Client: _____ Telephone: _____

Address: _____

Insurance Plan Name: _____. Benefits & Claims Phone: _____

Member ID # _____ Group ID # _____

EDUCATION HISTORY

Highest level of education: _____ Typical grades: _____

Have you ever repeated a grade: _____ Special Education classes? _____

SOCIAL HISTORY

Where were you born? _____ Where were you raised? _____

Mother's Occupation: _____ Father's Occupation: _____

Any history of childhood abuse*? Y N* If yes, which type of abuse? *Physical Verbal Emotional Sexual*

Relationship Status?: *Single Dating Married Partnered Divorced Separated Widowed*

Siblings (gender and age): _____

Length of Your Present Relationship (if applicable): _____

Children? (Gender and age): _____

Who currently lives in your home with you? _____

PRESENTING PROBLEM(S)

What is/are the main reason(s) for your visit?

_____

_____

_____

_____

MEDICAL (non-psychiatric) HISTORY

Current non-psychiatric medical conditions: _____

_____

Current *non-psychiatric* medications:

Medication Name:	*Dosage:*	*Prescribed for:*	*Prescribed by:*

Hospital Admissions/Surgeries: _____

PSYCHIATRIC HISTORY

Have you ever been in therapy before? _____

Previous Therapist's Name	*Dates of Treatment*	*Reason for therapy/counseling?*

Have you ever been hospitalized for psychiatric treatment? _____

Name of Hospital	*Date / Length of Stay*	*Reason for hospitalization?*

Current *Psychiatric* Medications:

Medication Name:	*Dosage:*	*Prescribed for:*	*Prescribed by:*

Previous *Psychiatric* Medications:

Medication Name:	*Dosage:*	*Prescribed for:*	*Prescribed by:*

Family history of psychiatric illness? _____

Have you ever attempted to harm yourself or kill yourself?_____ If yes, please describe when and how:

Are you *currently* having thoughts about wanting to be dead, harming yourself or killing yourself? _____

SUBSTANCE USE HISTORY

All information is completely confidential

Do you drink alcohol? _____ If yes, how often? _____ How much do you drink when you drink? _____

Do you use recreational drugs? _____

If yes, what kind(s)? _____ How often? _____

_____ How often? _____

Do you use prescription drugs that you don't have a prescription for or prescription drugs that you are using more than prescribed? _____

If yes, what kind(s)? _____ How often? _____

_____ How often? _____

History of alcohol or drug abuse? _____ If yes, please give details: _____

_____

_____

_____

EMPLOYMENT

Present Employment or Student Status: _____

Length of Time: _____ Position/Title: _____

Current Source of income (if not working): _____

MESSAGES FOR DR. WILSON

Is there anything else you want me to know at this time?

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Symptom Checklist

Please rate each of the following statements as they apply to you over the past week:

0 = not at all 1 = a little bit 2 = moderately 3 = quite a bit 4 = completely true of me

_____	1. I tire quickly.
_____	2. I feel no interest in things.
_____	3. I feel stressed.
_____	4. I want to harm myself.
_____	5. I feel irritated.
_____	6. I feel unhappy in my marriage/significant relationship.
_____	7. I have thoughts of ending my life.
_____	8. I feel weak.
_____	9. I feel fearful.
_____	10. I feel sad.
_____	11. I feel lonely.
_____	12. I feel angry.
_____	13. I feel anxious.
_____	14. I feel worthless.
_____	15. I feel helpless to change things in my life.
_____	16. I feel hopeless about the future.
_____	17. I dislike myself.
_____	18. I have difficulty concentrating
_____	19. I have difficulty remembering things.
_____	20. I have difficulty falling asleep.
_____	21. I have difficulty staying asleep.
_____	22. I awaken early and can't go back to sleep.
_____	23. I have an upset stomach.
_____	24. I have headaches.
_____	25. I have sore muscles.
_____	27. I feel that something bad is going to happen.
_____	28. I have trouble getting along with friends and close acquaintances.
_____	29. My eating habits have changed.
_____	30. I can't shut off my mind.
_____	31. The above symptoms are negatively impacting my ability to function in daily activities.

"Over the past two weeks, my predominant mood has been_____."

"Right now I am feeling_____."

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MANAGED CARE CONSENT TO TREATMENT

(Omit this page if you do not have or plan to use Aetna Insurance)

I,_____, authorize and request that

Dr. John W. Wilson, PsyD provide psychological examinations, treatment and/or diagnostic procedures pursuant to the policies of the managed care company, Aetna Behavioral Health or Aetna Student Health (hereafter referred to simply as Aetna) which now or during the course of my care as a patient are advisable. I understand that the frequency and type of treatment will be decided between me, Aetna and Dr. Wilson.

I understand that sometimes managed care companies will only pay for brief treatment which might not be sufficient to meet my needs. I understand that the purpose of these procedures will be explained to me and be subject to my verbal agreement.

I understand that pursuant to the release of information which I have signed, Dr. Wilson will provide specific information regarding my condition and treatment to Aetna and that Dr. Wilson has no control over how this information might be used.

I understand that I am responsible for payment for any services not paid by Aetna including charges for missed or cancelled appointments. I understand that Aetna may determine not to pay for further services. In such a situation, I understand that I may have to decide whether to continue treatment and take responsibility for my own treatment costs.

I understand that there is an expectation that I will benefit from psychotherapy but there is no guarantee that this will occur. I understand that maximum benefit will occur with consistent attendance and that at times I may feel conflicted about my therapy as the process can sometimes be uncomfortable.

I have read and fully understand this Managed Care Consent for Treatment form.

Client Signature:_____ Date _____

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John W. Wilson, PsyD

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INFORMATION, AUTHORIZATION & CONSENT TO TREATMENT

(You must initial the bottom of each page. Please print and retain a copy for your records.)

BACKGROUND / CREDENTIALS

I am licensed by the state of Georgia to provide psychological services. I limit my services to adults aged 18 and over. I have training and specialized skills in treating a broad range of clinical disorders and conditions, including but not limited to mood disorders, cognitive disorders, behavioral disorders, adjustment disorders, relationship issues, and sexual identity development. I hold a doctorate and masters degree in clinical psychology from Argosy University, Atlanta, GA and a bachelors degree in psychology from Lee University, Cleveland, TN. I completed my internship and a postdoctoral fellowship at Emory University, Atlanta GA. I am a member of the American Psychological Association and the Georgia Psychological Association. I am a guest lecturer at the Emory School of Medicine and Emory School of Nursing.

PSYCHOLOGICAL SERVICES

Psychotherapy can have benefits and risks. Since therapy often involves discussing unpleasant aspects of your life, you may experience uncomfortable feelings like sadness, guilt, anger, frustration, loneliness, and helplessness. On the other hand, psychotherapy has also been shown to have many benefits. Therapy often leads to better relationships, solutions to specific problems, and significant reductions in feelings of distress. There are no guarantees of what you will experience. I practice within the ethics guidelines of the American and Georgia Psychological Associations and in compliance with Georgia state laws.

PSYCHOLOGIST-CLIENT SERVICES AGREEMENT

The Health Insurance Portability and Accountability Act (HIPAA) is a federal law that provides privacy protections and patient rights with regard to the use and disclosure of your Protected Health Information (PHI) used for the purpose of treatment, payment, and health care operations. HIPAA requires that I provide you with a Notice of Privacy Practices for use and disclosure of PHI for treatment, payment and health care operations. The Notice, which is included in your copy of this document and is considered to be part of this Agreement, explains HIPAA and its application to your personal health information in greater detail. The law requires that I obtain your signature acknowledging that I have provided you with this information at the end of this session. Although these documents are long and sometimes complex, it is very important that you read them carefully. We can discuss any questions you have about the procedures. When you sign the signature page of this form, your signature will represent an agreement between us. You may revoke this agreement in writing at any time. That revocation will be binding on me unless I have taken action in reliance on it; if there are

obligations imposed on me by your health insurer in order to process or substantiate claims made under your policy; or if you have not satisfied any financial obligations you have incurred.

PROFESSIONAL RECORDS

The laws and standards of my profession require that I keep Protected Health Information (PHI) about you in your Clinical Record and that I preserve this record for seven years after your last session. Your paper records are kept in a locked file cabinet in my office and I alone have the key to this cabinet. My office uses *TherapyNotes, Inc*. for records storage, billing, scheduling, and appointment reminders. *TherapyNotes, Inc*. is certified HIPAA- and PHI-compliant, uses fully encrypted databases and has firewalls to protect servers. Except in unusual circumstances that involve danger to yourself and others or makes reference to another person (unless such other person is a health care provider) and I believe that access is likely to cause substantial harm to such other person or where information has been supplied to me confidentially by others, you may examine and/or receive a copy of your Clinical Record, if you request it in writing. Because these are professional records, they can be misinterpreted and/or upsetting to untrained readers. For this reason, I recommend that you initially review them in my presence, or have them forwarded to another mental health professional so you can discuss the contents. In most situations, I am allowed to charge a copying fee of $.50 cents per page (and for certain other expenses like postage). If I refuse your request for access to your records, you have a right of review (except for information provided to me confidentially by others) which I will discuss with you upon request. Pages 1 through 13 of this document are kept in your confidential file in my office. You will keep pages 14 through 19 for your own records.

LIMITS OF CONFIDENTIALITY

The majority of information discussed during the course of therapy with a psychologist is confidential and protected by law. However, there are several important exceptions when confidential information may be released to others without your permission. These exceptions are listed below:

1. There are times when someone's life is in danger. For example, "suicidal and/or homicidal intent" means placing someone in danger (either yourself or someone else) and under those conditions, I am required by law to take necessary action to protect that person. Such action may include hospitalization, notification of the police, notifying an intended victim, etc. PLEASE BE AWARE that I discuss suicidal and homicidal thinking with clients frequently without feeling the need to take action. Such thoughts tend to be more common than most people realize. Discussing the issue alone does not indicate the need for action. Action is taken only when I believe that actual harm may result from such thinking. To protect your life or someone else's is paramount.
2. There are times when I discover, or strongly suspect, that a minor child is being abused, either physically, sexually, or emotionally. State law requires me to report such information to the Department of Family and Children's Services in the county wherein the child resides. The law is designed to protect children from harm and the obligation to report actual or suspected abuse or neglect is clear.
3. If you are involved in litigation of any kind and inform the court of the services you receive(ed) from me (thereby making your mental health an issue before the court), you may be waiving your right to keep your records confidential. Please consult with your lawyer and your therapist before doing so. By all means, protect yourself from unnecessary intrusions into your privacy. *In Worker's Compensation cases, the law requires disclosure of available records before payment is made. In such cases, I attempt to provide a summary of treatment without specific details. This is not always successful.*

Please initial that you have read this page: _____

4. Should your treatment or psychological testing be "court ordered," you can assume that all the information which you divulge to us will be shared with the court. In such instances, you have a right to tellme only what you want disclosed. However, the withholding of information may harm your case.
5. In many cases, managed care companies require significant disclosure of clinical records so that they can make clinical judgments concerning the need for treatment. The managed care company is responsible for maintaining the utmost confidentiality of your records. However, I cannot guarantee or be responsible for what they may do with the information I provide them. For these reasons, I do not bill third party payers directly. Please see "fees" below for further information.
6. I prefer to coordinate your treatment with your primary physician. With your permission, I may contact and coordinate treatment with your personal physician.
7. Should therapy include your spouse, partner, or other family members, written permission will be required from EACH person before any records will be released.
8. Finally, should you desire that information be communicated about you to someone else, your written permission will be required.

INTERACTIONS WITH THE LEGAL SYSTEM

I, as your therapist, will not be involved in or engaged in any legal issues or litigation in which you, as my client, are party to at any time either during your counseling or after counseling terminates. This would include any interaction with the Court system, attorneys, Guardian ad Litems, psychological evaluators, alcohol and drug evaluators, or any other contact with the legal system. In the event that you wish to have a copy of your file, and you execute a proper release, I will provide you with a copy of your record, and you will be responsible for charges in producing that record. If you believe it necessary to subpoena me to testify at a deposition or a hearing, you will be responsible for my expert witness fees in the amount of $1,500.00 for one-half (1/2) day to be paid five (5) days in advance of any court appearance or deposition. Any additional time I spend over one-half (1/2) day will be billed at the rate of $375.00 per hour including travel time. Understand that if you subpoena me, I may elect not to speak with your attorney, and a subpoena may result in my withdrawing as your counselor.

FEES AND BILLING

The fee for the initial intake session (60-75 minutes) is $175. The fee for all subsequent sessions (45-50 minutes) is $155, whether individual, couple, or family. Sessions that run over the time allotment are billed on a prorated basis. My fee for additional paperwork (e.g., medical leave certification) is prorated at $155 per hour and is not billable to your insurance company; therefore, you will be expected to pay this fee as it incurs. Fees for expert witness, deposition, and court appearances are outlined in the above section entitled "Interactions With The Legal System." Fees for reading and returning texts and emails (unless related to scheduling or other logistical concerns) are prorated at $155 per hour.

Payment is expected at the end of each session, unless we agree otherwise prior to that session. Payment can be made by cash or check. Please be aware that if you are attempting to have your services covered through insurance, you are responsible for knowing your deductible and copay prior to the first appointment, and you are responsible for fees that you incur if your insurance company refuses your claim.

Please initial that you have read this page: _____

CANCELLING APPOINTMENTS

If you need to cancel your scheduled appointment, 24 hours notice prior to your session time is required. I require this notice so that your appointment time can be filled by another client. Without prior notification, the time cannot be filled. For that reason, you will be charged the full fee ($155) for missed sessions that were not cancelled within 24 hours of the session. Your insurance company will not pay for missed sessions. Missing an appointment due to a work conflict, a school conflict, or other circumstances for which you had prior knowledge is your responsibility, and you will be charged the full fee. Additionally, forgetting about your scheduled appointment will also result in being charged the full fee. Unless other arrangements are made, your case will be automatically closed if I do not hear from you within 30 days following your last appointment.

EMERGENCIES AND AFTER HOURS CALLS

I am located in the Southeast and I abide by Eastern Standard Time. My practice is considered to be an outpatient facility, and I am set up to accommodate individuals who are reasonably safe and resourceful. I do not carry a beeper nor am I available at all times. If at any time this does not feel like sufficient support, please inform me and we can discuss additional resources or transfer your case to a therapist or clinic with 24-hour availability. Generally, I will return phone calls, texts and emails within 24 hours. However, I do not return calls, texts or emails on weekends or holidays. If you are having a mental health emergency and need immediate assistance, please select one or more of the following options for emergency assistance:

- Call Behavioral Health Link/GCAL: 800-715-4225
- Call Ridgeview Institute at 770.434.4567
- Call Peachford Hospital at 770.454.5589
- Call Lifeline at (800) 273-8255 (National Crisis Line)
- Call 911
- Go to the emergency room of your choice.

CONSENT TO TREATMENT

Please print, date, and sign your name below indicating that you have read and understand the contents of this form, you agree to these policies, you have received a copy of the HIPAA Notices of Privacy Practices, and you are authorizing me to provide psychological services to you according to these policies.

_____ _____

Client Name (Please Print) **Date**

_____

Client Signature

My signature below indicates that I have discussed this form with you and that I have answered any questions you have regarding this information.

_____ _____

Therapist's Signature **Date**

John W. Wilson, PsyD

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INFORMATION, AUTHORIZATION, & CONSENT TO TELE-MENTAL HEALTH SERVICES

(You must initial at bottom of each page. Please print and retain a copy for your records)

Thank you for choosing the services that I provide. This document is designed to inform you about what you can expect from me regarding confidentiality, emergencies, and several other details regarding your treatment as it pertains to TeleMental Health. TeleMental Health is defined as follows:

> *"TeleMental Health means the mode of delivering services via technology-assisted media, such as but not limited to, a telephone, video, internet, a smartphone, tablet, PC desktop system or other electronic means using appropriate encryption technology for electronic health information. TeleMental Health facilitates client self-management and support for clients and includes synchronous interactions and asynchronous store and forward transfers." (Georgia Code 135-11-.01)*

TeleMental Health is a relatively new concept despite the fact that many therapists have been using technology-assisted media for years. Breaches of confidentiality over the past decade have made it evident that Personal Health Information (PHI) as it relates to technology needs an extra level of protection. Additionally, there are several other factors that need to be considered regarding the delivery of TeleMental Health services in order to provide you with the highest level of care. Therefore, I have completed specialized training in TeleMental Health. I have also developed several policies and protective measures to assure your PHI remains confidential. These are discussed below.

The Different Forms of Technology-Assisted Media Explained

Telephone via Landline:

It is important for you to know that even landline telephones may not be completely secure and confidential. There is a possibility that someone could overhear or even intercept your conversations with special technology. Individuals who have access to your telephone or your telephone bill may be able to determine who you have talked to, who initiated that call, and how long the conversation lasted. If you have a landline and you provided me with that phone number, I may contact you on this line from my own landline in my office or from my cell phone, typically only regarding setting up an appointment if needed. If this is not an acceptable way to contact you, please let me know. Telephone conversations (other than just setting up appointments) are billed at my hourly rate.

Cell phones:

In addition to landlines, cell phones may not be completely secure or confidential. There is also a possibility that someone could overhear or intercept your conversations. Be aware that individuals who have access to your cell phone or your cell phone bill may be able to see who you have talked to, who initiated that call, how long the conversation was, and where each party was located when that call occurred. However, I realize that most people have and utilize a cell phone. I may also use a cell phone to contact you, typically only regarding setting up an appointment if needed. Telephone conversations (other than just setting up appointments) are billed at my hourly rate. Additionally, I keep your phone number in my cell phone, but it is listed by your initials only and my phone is password protected. If this is a problem, please let me know, and we will discuss our options.

Please initial that you have read this page: _____

Text Messaging:

Text messaging is not a secure means of communication and may compromise your confidentiality. However, I realize that many people prefer to text because it is a quick way to convey information. **Nonetheless, please know that it is my policy to utilize this means of communication strictly for appointment confirmations.** Please do not bring up any therapeutic content via text to prevent compromising your confidentiality. You also need to know that I am required to keep a copy or summary of all texts as part of your clinical record that address anything related to therapy.

If we choose to use texting as part of your treatment, I utilize a special text messaging software called *HipaaBridge* for your added protection. I have chosen this technology because it is encrypted to the federal standard, HIPAA-compatible, and the company has signed a HIPAA Business Associate Agreement (BAA). The BAA means that the company is willing to attest to HIPAA compliance and assume responsibility for keeping your PHI secure. I encourage you to also utilize this software if you do not wish for others to have access to our communications. I also strongly suggest that you only communicate through a device that you know is safe and technologically secure (e.g., password protected).

Email:

Email is not a secure means of communication and may compromise your confidentiality. However, I realize that many people prefer to email because it is a quick way to convey information. **Nonetheless, please know that it is my policy to utilize this means of communication strictly for appointment confirmations.** Please do not bring up any therapeutic content via email to prevent compromising your confidentiality. You also need to know that I am required to keep a copy or summary of all emails as part of your clinical record that address anything related to therapy.

If we choose to utilize email as part of your treatment, I utilize a secure email platform that is hosted by *HipaaBridge* for your added protection. I have chosen this technology because it is encrypted to the federal standard, HIPAA compatible, and the company has signed a HIPAA Business Associate Agreement (BAA). The BAA means that the company is willing to attest to HIPAA compliance and assume responsibility for keeping your PHI secure. I encourage you to also utilize this software for protection on your end.

I also strongly suggest that you only communicate through a device that you know is safe and technologically secure (e.g., has a firewall, anti-virus software installed, is password protected, not accessing the internet through a public wireless network, etc.). If you are in a crisis, please do not communicate this to me via email because I may not see it in a timely matter. Instead, please see below under "Emergency Procedures."

Email (other than just setting up appointments) is billed at my hourly rate for the time I spend reading and responding to them. If you are in a crisis, please do not communicate this to me via email because I may not see it in a timely matter. Instead, please see below under "Emergency Procedures." Finally, you also need to know that I am required to keep a copy or summary of all email as part of your clinical record that address anything related to therapy.

Social Media - Facebook, Twitter, LinkedIn, Instagram, Pinterest, Etc:

It is my policy not to accept "friend" or "connection" requests from any current or former client on my **personal** social networking sites such as Facebook, Twitter, Instagram, Pinterest, etc. because it may compromise your confidentiality and blur the boundaries of our relationship. However, my practice has a professional Facebook page. You are welcome to "follow" me on any of these professional pages where I post psychology and counseling information. However, please do so only if you are comfortable with the general public being aware of the fact that your name is attached to my professional page. Please refrain from making contact with me using social media messaging systems such as Facebook Messenger or Twitter. These methods have insufficient security, and I do not watch them closely. I would not want to miss an important message from you.

Please initial that you have read this page: _____

Video Conferencing (VC):

Video Conferencing is an option for us to conduct remote sessions over the internet where we not only can speak to one another, but we may also see each other on a screen. I utilize *Doxy.Me*, a free VC platform that is encrypted to the federal standard, HIPAA-compliant, and has signed a HIPAA Business Associate Agreement (BAA). The BAA means that *Doxy.Me* is willing to attest to HIPAA-compliance and assumes responsibility for keeping our VC interaction secure and confidential. If we choose to utilize this technology, I will give you detailed directions regarding how to log-in securely. I also ask that you please sign on to the platform at least five minutes prior to your session time to ensure we get started promptly. Additionally, you are responsible for initiating the connection with me at the time of your appointment. I strongly suggest that you only communicate through a computer or device that you know is safe (e.g., has a firewall, anti-virus software installed, is password protected, not accessing the internet through a public wireless network, etc.).

Client Portal:

I have a client portal, housed at *TherapyNotes.com*, that is accessible via an emailed invitation from me. *TherapyNotes, Inc*. ensures this portal is encrypted to the federal standard, HIPAA-compatible, and has signed a HIPAA Business Associate Agreement (BAA). The BAA means that TherapyNotes, Inc. is willing to attest to HIPAA-compliance and assumes responsibility for keeping our interactions secure and your PHI confidential. If you choose to utilize this technology, I will give you detailed directions regarding how to log-in securely. I also strongly suggest that you only communicate through a device that you know is safe (e.g., has a firewall, anti-virus software installed, is password protected, not accessing the internet through a public wireless network, etc.).

Additionally, through the client portal, you have the option of receiving automatic text and/or email reminders of your appointments with me.

If you would like to receive email appointment reminders, initial here: _____. _____
Print email address here

If you would like to receive text appointment reminders, initial here: _____. _____
Write phone number here

Recommendations to Websites or Applications (Apps):

During the course of your treatment, I may recommend that you visit certain websites for pertinent information or self-help. I may also recommend certain apps that could be of assistance to you and enhance your treatment. Please be aware that websites and apps may have tracking devices that allow automated software or other entities to know that you've visited these sites or applications. They may even utilize your information to attempt to sell you other products. Additionally, anyone who has access to the device you used to visit these sites/apps, may be able to see that you have been to these sites by viewing the history on your device. Therefore, it is your responsibility to decide if you would like this information as adjunct to your treatment or if you prefer that I do not make these recommendations. Please let me know by checking (or not checking) the appropriate box at the end of this document.

Electronic Record Storage:

Your communications with me will become part of a clinical record of treatment, and is referred to as Protected Health Information (PHI). Your PHI will be stored electronically with *TherapyNotes, Inc*, a secure storage company who has signed a HIPAA Business Associate Agreement (BAA). The BAA ensures that they will maintain the confidentiality of your PHI in a HIPAA-compatible secure format using point-to-point, federally approved encryption**.** *TherapyNotes, Inc.* is certified HIPAA - and PCI-compliant, uses fully encrypted databases and has firewall to protect their servers.

Please initial that you have read this page: _____

Electronic Transfer of PHI for Billing Purposes:

If I am credentialed as a provider for your insurance, please know that I utilize an electronic billing service who has access to your PHI. Your PHI will be securely transferred electronically via *TherapyNotes, Inc.* who has signed a HIPAA Business Associate Agreement (BAA). The BAA ensures that they will maintain the confidentiality of your PHI in a HIPAA-compatible secure format using point-to-point, federally approved encryption. Additionally, if your insurance provider is billed, you will generally receive correspondence from your insurance company.

Electronic Transfer of PHI for Certain Credit Card Transactions:

My office utilizes *Square* to process credit/debit cards and *Zelle* for direct transfer of funds for telemental health sessions. In-person sessions are payable via cash, personal checks and Zelle (no credit cards). These companies may send the credit card-holder a text or an email receipt indicating that you used that credit card for my services, the date you used it, and the amount that was charged. This notification is usually set up two different ways - either upon your request at the time the card is run or automatically. Please know that it is your responsibility to know if you or the credit card-holder has the automatic receipt notification set up in order to maintain your confidentiality if you do not want a receipt sent via text or email. Additionally, please be aware that the transaction will also appear on your credit-card bill. The name on the charge will appear as John W. Wilson, PsyD.

Facsimile:

My office uses *eFax Corporate* for sending and receiving facsimiles. This fax solutions company has signed a HIPAA Business Associate Agreement (BAA) which ensures that they will maintain the confidentiality of your PHI in a HIPAA-compatible secure format using point-to-point, federally approved encryption**.**

Your Responsibilities for Confidentiality & TeleMental Health

Please communicate only through devices that you know are secure as described above. It is also your responsibility to choose a secure location to interact with technology-assisted media and to be aware that family, friends, employers, co-workers, strangers, and hackers could either overhear your communications or have access to the technology that you are interacting with. Additionally, you agree not to record any TeleMental Health sessions.

Communication Response Time

I'm required to make sure that you're aware that I'm located in the Southeast and I abide by Eastern Standard Time. My practice is considered to be an outpatient facility, and I am set up to accommodate individuals who are reasonably safe and resourceful. I do not carry a beeper nor am I available at all times. If at any time this does not feel like sufficient support, please inform me, and we can discuss additional resources or transfer your case to a therapist or clinic with 24-hour availability. I will return phone calls, texts and emails within 24 hours. However, I do not return calls, texts or emails on weekends or holidays. If you are having a mental health emergency and need immediate assistance, please follow the instructions below.

Emergency Procedures Specific to TeleMental Health Services

There are procedures in addition to those described in the Consent to Treatment form that we need to have in place specific to TeleMental Health services. These are for your safety in case of an emergency and are as follows:

Please initial that you have read this page: _____

- You understand that if you are having suicidal or homicidal thoughts, experiencing psychotic symptoms, or in a crisis that we cannot solve remotely, I may determine that you need a higher level of care and TeleMental Health services are not appropriate.
- I require an Emergency Contact Person (ECP) who I may contact on your behalf in a life-threatening emergency only. Please write this person's name and contact information below. Either you or I will verify that your ECP is willing and able to go to your location in the event of an emergency. Additionally, if either you, your ECP, or I determine necessary, the ECP agrees take you to a hospital. Your signature at the end of this document indicates that you understand I will only contact this individual in the extreme circumstances stated above. Please list your ECP here:
  Name: _____ Phone: _____
- You agree to inform me of the address where you are at the beginning of every TeleMental Health session.
- You agree to inform me of the nearest mental health hospital to your primary location that you prefer to go to in the event of a mental health emergency (usually located where you will typically be during a TeleMental Health session). Please list this hospital and contact number here:
  Hospital: _____ Phone: _____

In Case of Technology Failure

During a TeleMental Health session, we could encounter a technological failure. The most reliable backup plan is to contact one another via telephone. Please make sure you have a phone with you, and that I have that phone number.

If we get disconnected from a video conferencing or chat session, end and restart the session. If we are unable to reconnect within ten minutes, please call me.

If we are on a phone session and we get disconnected, please call me back or contact me to schedule another session. If the issue is due to *my* phone service, and we are not able to reconnect, I will not charge you for that session.

Structure and Cost of Sessions

I offer primarily face-to-face counseling. However, based on your ability to make in-person sessions, I may provide phone, text, email, chat, or video conferencing if your treatment needs determine that TeleMental Health services are appropriate for you. If appropriate, you may engage in either face-to-face sessions, TeleMental Health, or both. We will discuss what is best for you.

The structure and cost of TeleMental Health sessions are exactly the same as face-to-face sessions described in my general "Information, Authorization, and Consent to Treatment" form. You must initiate the call at the start time of your session –I do not call you. I agree to provide TeleMental Health therapy for the fee of $155 per 45-50 minute session. Texting and emails (other than just setting up appointments) are billed at my hourly rate for the time I spend reading and responding. I require a credit card ahead of time for TeleMental Health therapy for ease of billing. Please sign the Credit Card Payment Form, which I will send to you separately and indicates that I may charge your card without you being physically present. Your credit card will be charged at the conclusion of each TeleMental Health interaction. **This includes any therapeutic interaction other than setting up appointments.** All major credit cards and HSA/Flex cards are acceptable for payment, and I will provide you with a receipt of payment and the services that I provided. The receipt of payment & services completed may also be used as a statement for insurance if applicable to you (see below).

Insurance companies have many rules and requirements specific to certain benefit plans. At the present time, many do not cover TeleMental Health services. Unless otherwise negotiated, it is your responsibility to find out your insurance company's

policies. I will be glad to provide you with a statement for your insurance company and to assist you with any questions you may have in this area.

You are also responsible for the cost of any technology you may use at your own location. This includes your computer, cell phone, tablet, internet or phone charges, software, headset, etc.

Limitations of TeleMental Health Therapy Services

TeleMental Health services should not be viewed as a complete substitute for therapy conducted in my office, unless there are extreme circumstances that prevent you from attending therapy in person. It is an alternative form of therapy or adjunct therapy, and it involves limitations. Primarily, there is a risk of misunderstanding one another when communication lacks visual or auditory cues. For example, if video quality is lacking for some reason, I might not see a tear in your eye. Or, if audio quality is lacking, I might not hear the crack in your voice that I could easily pick up if you were in my office.

There may also be a disruption to the service (e.g., phone gets cut off or video drops). This can be frustrating and interrupt the normal flow of personal interaction.

Please know that I have the utmost respect and positive regard for you and your wellbeing. I would never do or say anything intentionally to hurt you in any way, and I strongly encourage you to let me know if something I've done or said has upset you. I invite you to keep our communication open at all times to reduce any possible harm.

Face-to Face Requirement

If we agree that TeleMental Health services are the **primary** way we choose to conduct sessions, **I require one face-to-face meeting at the onset of treatment.** I prefer for this initial meeting to take place in my therapy office. If that is not possible, we can utilize video conferencing as described above. During this initial session, I will require you to show a valid picture ID and another form of identity verification such a credit card in your name. **At this time, you will also choose a password, phrase, or number which you will use to identify yourself in all future sessions. This procedure prevents another person from posing as you.**

Consent to TeleMental Health Services

Please check the TeleMental Health services you are authorizing me to utilize for your treatment or administrative purposes. Together, we will ultimately determine which modes of communication are best for you. However, you may withdraw your authorization to use any of these services at any time during the course of your treatment just by notifying me in writing. If you do not see an item discussed previously in this document listed for your authorization below, this is because it is built-in to my practice, and I will be utilizing that technology unless otherwise negotiated by you.

- ☐ Texting
- ☐ Email
- ☐ Video Conferencing
- ☐ Client Portal (for scheduling appointments and receiving automatic reminders)
- ☐ Telephone
- ☐ Recommendations to Websites or Apps

Please initial that you have read this page: _____

In summary, technology is constantly changing, and there are implications to all of the above that we may not realize at this time. Feel free to ask questions, and please know that I am open to any feelings or thoughts you have about these and other modalities of communication and treatment.

Please print, date, and sign your name below indicating that you have read and understand the contents of this form, you agree to these policies, and you are authorizing me to utilize the TeleMental Health methods discussed.

_____ _____

Client Name (Please Print) **Date**

_____

Client Signature

My signature below indicates that I have discussed this form with you and have answered any questions you have regarding this information.

_____ _____

Therapist's Signature **Date**

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John W. Wilson, PsyD

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HIPAA NOTICE OF PRIVACY PRACTICES (NPP)

(Please retain for your records)

This notice will tell you how I handle information about you. It tells how I use this information in this office, how I share it with other professionals and organizations and how you can see it. I want you to know all this so that you can make the best decisions for yourself and your family. I am also required to tell you about this because of the privacy regulations of a federal law, the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Because this law and the laws of Georgia are very complicated and I don't want to make you read a lot that may not apply to you, I have simplified some parts. If you have any questions or want to know more about anything in this Notice, please read the complete Notice or ask me for more explanation or more details.

What do I mean by your "medical information"?

Each time you visit me, or any other health care provider, information is collected about you and your physical and mental health. It may include information about your past or present health or conditions, or treatment you received from me or others, or about payment for health care. This information is known legally as **Protected Health Information**, or PHI. This information goes into your medical or health care record or a file at the office. In this office, PHI is likely to include -

- Your history - which may include childhood, school, work, marital and personal information
- Reasons you came for treatment - which may include problems, complaints, symptoms, needs, and goals
- Diagnoses - diagnoses are the medical or psychological terms for your problems or symptoms.
- Treatment Plan - these are the treatments and services that I think would best help you
- Progress notes - Each time you come in, I write down how you are doing, what I observe about you and what you tell me
- Records I get from others who treated you
- Psychological test scores Legal matters
- Billing and insurance information

(*Not a complete list- there may be other kinds of information that go into your health care record.)*

I use this information for many purposes. For example:

- To plan your care and treatment
- To decide how well treatment is working for you
- When talking to other health care professionals who are treating you, such as your family doctor or the professional who referred you to me
- To document that you actually received the services for which you or your insurance company was billed.
- To improve the way we do our job by measuring the results of our work.

When you understand what is in your record and what it is used for, you can make better decisions about whom, when and why others should have this information.

Although your health care record is the physical property of the doctor who collects the information, the information belongs to you. You can inspect it, read it or review it. If you want a copy, I can make one for you, but there will be a charge for copying and mailing (if you want it to be mailed). In some unusual situations, you cannot see all of what is in your records. If you find anything in your record that you think is incorrect, or something important is missing, you can ask me to amend (add or remove information) although in some rare situations, I do not have to agree to do that.

I will use the information that I get from you mainly to provide you with treatment, to arrange payment, or for some other business activities that are called health care operations. After you read this information, I will ask you to sign a **Consent Form** to let me use and share your information for very specific purposes described in the notice of privacy practices. If you do not consent and sign this form, I cannot treat you. If you or I want to disclose (send, share, release) your information for any other purposes, I will discuss this with you and ask you to sign an **Authorization** to allow this.

Although I am committed to keeping your health information private, there are times when the law requires me to use or share it with or without your consent. For example,

- When there is a serious threat to your health and safety or the health and safety of another individual or the public: I will only share information with a person or organization able to help prevent or reduce the threat.
- Some lawsuits and legal or court proceedings: If your treatment or evaluation is court ordered, information will be shared with the court and the other parties.
- For Workers Compensation, Social Security Disability Assessment and similar benefit programs

Your Rights Regarding Your Health Information

- You can ask me to communicate with your health-related issues in specified ways. For example, you can ask me to call you at home and not at work to schedule or cancel an appointment. I will try my best to do as you ask.

- Other than the circumstance outlined in the NPP, I will not discuss your PHI unless I have an authorization. When I have an authorization to disclose information, you have the right to ask me to limit what I tell certain individuals involved in your care. While I do not have to agree to your request, if I do agree, I will keep the agreement except if it is against the law, or in an emergency or when the information is necessary to treat you.

- You have the right to look at the health information I have about you, such as your medical and billing records. Psychotherapy notes may not be included. You can even have a copy of these records, but there may be a charge. Talk to me to arrange to see your records.

- If you believe the information in your records is incorrect or incomplete, you can ask me to make some kinds of changes (called amending) to your health care information. You must include the reasons why you want to make the changes. You have to make this request in writing.

- You have a right to have a copy of this notice. If the policy is changed, a notice will be posted in the waiting room and you can get a copy of these changes.

- You have the right to file a complaint if you believe your privacy rights have been violated. You can file a complaint with the US Secretary of the Department of Health and Human Services. All complaints must be filed in writing. If you have any questions regarding this notice or these health information privacy policies, please contact me at (404) 246-1257.

The effective date of this notice is January 1, 2018