7970 Mitchell Court Sebastopol, CA 95472
Phone: 707-479-2946
Email: Hollandpsyd@gmail.com

Practice Policies & General Information Agreement for Psychotherapy Services or Informed Consent for Psychotherapy

Welcome

I look forward to our work together. To ensure that it goes smoothly, it is important that you are aware of my policies and the limits to confidentiality. Please fill out these forms as completely as possible before our next session. I will be happy to go over any questions or concerns you may have.

CONFIDENTIALITY:

All information disclosed within sessions and the written records pertaining to those sessions are confidential and may not be revealed to anyone without your written permission except where disclosure is required by law.

WHEN DISCLOSURE IS REQUIRED OR MAY BE REQUIRED BY LAW:

Some of the circumstances where disclosure is required or may be required by law are: where there is a reasonable suspicion of child, dependent, or elder abuse or neglect; where a client presents a danger to self, to others, to property, or is gravely disabled; or when a client's family members communicate to Dr. Holland) that the client presents a danger to others. Disclosure may also be required pursuant to a legal proceeding by or against you. 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 Dr. Jenny Holland. 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. Dr Holland will use her clinical judgment when revealing such information. Dr. Holland will not release records to any outside party unless s/he is 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 client.

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EMERGENCY:

If there is an emergency during therapy, or in the future after termination, where Dr. Holland becomes concerned about your personal safety, the possibility of you injuring someone else, or about you receiving proper psychiatric care, she will do whatever she 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, she may also contact the person whose name you have provided on the biographical sheet.

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, Dr. Holland only the minimum necessary information will be communicated to the carrier. Dr. Holland has no control over, or knowledge of, what insurance companies do with the information s/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.

LITIGATION:

Sometimes patients become involved in litigation while they are in therapy or after therapy has been completed. Sometimes patients (or the opposing attorney, in a legal case) want the records disclosed to the legal system. Due to the nature of the psychotherapeutic process and the fact that it often involves making a full disclosure with regard to many matters, clients' records are generally confidential and private in nature.

Patients should know that very serious consequences can result from disclosing therapy records to the legal system. Such disclosures may negatively affect the outcome of custody disputes or other legal matters and may negatively affect the therapeutic relationship. If you or the opposing attorney are considering requesting Dr Hollands's disclosure of the records, Dr. Holland will do her best to discuss with you the risks and benefits of doing so. As noted in this document, you have the right to review your own psychotherapy records anytime. (See also relevant section above: "WHEN DISCLOSURE IS REQUIRED OR MAY BE REQUIRED BY LAW")

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CONSULTATION:

Dr. Holland consults regularly with other professionals regarding her clients, to ensure that you are receiving the highest standard of care. However, each client's identity remains completely anonymous and confidentiality is fully maintained.

E–MAILS, CELL PHONES, COMPUTERS, AND FAXES:

It's very important to be aware that computers and unencrypted email, texts, and e-faxes communication (which are part of the clinical records) can be relatively easily accessed by unauthorized people and hence can compromise the privacy and confidentiality of such communication. Emails, texts, and e-faxes are vulnerable to such unauthorized access due to the fact that servers or communication companies may have unlimited and direct access to all emails, texts and e-faxes that go through them. While data on Dr. Holland's laptop is encrypted, emails, texts and e-fax are not. It is always a possibility that e-faxes, texts, and email can be sent erroneously to the wrong address and computers. Dr. Holland's laptop is equipped with a firewall, a virus protection and a password, and he backs up all confidential information from his computer on a regular basis onto an encrypted hard drive. Also, be aware that phone messages are transcribed and sent to via unencrypted emails. Please notify Dr. Holland if you decide to avoid or limit, in any way, the use of email, texts, cell phones calls, phone messages, or e-faxes. If you communicate confidential or private information via unencrypted email, texts or e- fax or via phone messages, will assume that you have made an informed decision, will view it as your agreement to take the risk that such communication may be intercepted, and he will honor your desire to communicate on such matters. Please do not use texts, email, voice mail, or faxes for emergencies.

RECORDS AND YOUR RIGHT TO REVIEW THEM:

Both the law and the standards of Dr. Holland's profession require that she keep treatment records for at least _7_ years. Please note that clinically relevant information from emails, texts, and axes are part of the clinical records. Unless otherwise agreed to be necessary, Dr. Holland retains clinical records only as long as is mandated by (California law. If you have concerns regarding the treatment records, please discuss them with Dr. Holland. As a client, 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 Dr. Holland assesses that releasing such information might be harmful in any way. In such a case, Dr. Holland 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, Dr. Holland will release information to any agency/ person you specify unless Dr. Holland assesses that releasing such information might be harmful in any way.

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When more than one client is involved in treatment, such as in cases of couple and family therapy, Dr. Holland will release records only with signed authorizations from all the adults (or all those who legally can authorize such a release) involved in the treatment.

TELEPHONE & EMERGENCY PROCEDURES:

If you need to contact Dr. Holland between sessions, please leave a message on my confidential voicemail. (707) 479-2946 and text me stating that your needs are urgent. I will respond as soon as possible. Dr. Holland checks her messages a few times during the daytime unless she is out of town. If an emergency situation arises and you need to talk to someone right away, call Psychiatric Emergency Services. Santa Rosa: (707) 576-8181 to access a 24-hour crisis line or call 911. Please do not use email for emergencies. Dr. Holland does not always check her email.

PAYMENTS & INSURANCE REIMBURSEMENT:

Clients are expected to pay the standard fee of $165.00 per 45-minute individual session or $185.00 per couples' session at the Beginning of the session unless other arrangements have been made. 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 same rate, unless indicated and agreed upon otherwise.

Please notify Dr. Holland if any problems arise during the course of therapy regarding your ability to make timely payments. Clients who carry insurance should remember that professional services are rendered and charged to the clients and not to the insurance companies. Unless agreed upon differently, Dr. Holland will provide you with a copy of your receipt on a monthly basis, which you can then submit to your insurance company for reimbursement, if you so choose. As was indicated in the section, Health Insurance & Confidentiality of Records, you must be aware that submitting a mental health invoice for reimbursement carries a certain amount of risk. Not all issues/ conditions/problems, which are dealt with in psychotherapy, are reimbursed 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, Dr. Holland can use legal or other means (courts, collection agencies, etc.) to obtain payment.

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THE PROCESS OF THERAPY

EVALUATION AND SCOPE OF PRACTICE:

Participation in therapy 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. Psychotherapy requires your very active involvement, honesty, and openness in order to change your thoughts, feelings, and/or behavior. Dr. Holland 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 therapy, 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.

Dr. Holland 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. Psychotherapy 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 psychotherapy will yield positive or intended results. During the course of therapy, Dr. Holland is likely to draw on various psychological approaches according, in part, to the problem that is being treated and her assessment of what will best benefit you. These approaches include, but are not limited to, behavioral, cognitive-behavioral, cognitive, psychodynamic, existential, system/ family, developmental (adult, child, family), humanistic or psycho-educational. Art Therapy and Clinical Hypnosis. Dr. Holland provides neither custody evaluation recommendation nor medication or prescription recommendation nor legal advice, as these activities do not fall within his/her scope of practice.

TREATMENT PLANS:

Within a reasonable period of time after the initiation of treatment, Dr. Holland will discuss with you her working understanding of the problem, treatment plan, therapeutic objectives, and 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 therapy, the possible risks, Dr. Holland'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.

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TERMINATION:

As set forth above, after the first couple of meetings, Dr. Holland will assess if she can be of benefit to you. Dr. Holland does not work with clients who, in her opinion, she cannot help. In such a case, if appropriate, she will give you referrals that you can contact. If at any point during psychotherapy Dr. Holland either assesses that she is not effective in helping you reach the therapeutic goals or perceived you as non-compliant or non- responsive, and if you are available and/or it is possible and appropriate to do, she will discuss with you the termination of treatment and conduct pre-termination counseling. In such a case, if appropriate and/or necessary, she would give you a couple of referrals that may be of help to you. If you request it and authorize it in writing, Dr. Holland will talk to the psychotherapist 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 therapist, Dr. Holland will give you a couple of referrals that you may want to contact, and if she has your written consent, she will provide her or him with the essential information needed. You have the right to terminate therapy and communication at any time. If you choose to do so, upon your request and if appropriate and possible, Dr. Holland will provide you with names of other qualified professionals whose services you might prefer.

DUAL RELATIONSHIPS:

Despite a popular perception, not all dual or multiple relationships are unethical or avoidable. Therapy never involves sexual or any other dual relationship that impairs Dr. Holland's objectivity, clinical judgment or can be exploitative in nature. Dr. Holland will assess carefully before entering into non-sexual and non-exploitative dual relationships with clients. It is important to realize that in some communities, particularly small towns, small communities, military bases, university campuses, spiritual and rehabilitation communities, etc., multiple relationships are either unavoidable or expected. Dr. Holland will never acknowledge working with anyone without his/her written permission. Many clients have chosen Dr. Holland as their therapist because they knew her before they entered therapy with her, and/or are personally aware of her professional work and achievements. Nevertheless, Dr. Holland 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 therapeutic effectiveness but can also detract from it and often it is impossible to know which ahead of time. It is your responsibility to advise Dr. Holland if the dual or multiple relationship becomes uncomfortable for you in any way. Dr. Holland will always listen carefully and respond to your feedback and will discontinue the dual relationship if she finds it interfering with the effectiveness of the therapy or your welfare and, of course, you can do the same at any time.

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AUDIO OR VIDEO RECORDING:

Unless otherwise agreed to by all parties beforehand, there shall be no audio or video recording of therapy sessions, phone calls, or any other services provided by Dr. Holland.

SOCIAL NETWORKING AND THE INTERNET:

In order to protect your confidentiality and privacy, as well as the importance of our work together, I do not accept friend requests from current or former clients on social networking sites, such as Facebook. I believe that adding clients as friends on these sites and/or communicating via such sites can compromise their privacy and confidentiality. For this same reason, I request that clients not communicate with me via any interactive or social networking web sites. I do have a few public pages: Dr. Jenny Holland on Facebook, is a great place to post insights or experiences. I also have a Google business page, as well as a profile on Psychology Today. Dr. Holland appreciates your reviews and feedback on her public pages as well as on her website: www.drjennyholland.com

PUBLIC APPEARANCES:

Dr. Holland has expertise in many cutting-edge areas of Psychology and uses only empirically validated approaches to treatment. As such, Dr. Holland frequently participates in public speaking engagements, newspaper and other articles, essays and clinical conferences. Whenever these engagements are open to the public, you are welcome to attend.

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Psychotherapy

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CANCELLATION AND MISSED APPOINTMENTS:

IMPORTANT: PLEASE READ MY CANCELLATION and MISSED APPOINTMENT POLICY CAREFULLY.

Since the scheduling of an appointment involves the reservation of time specifically for you, a minimum of **48 hours (2 days)** notice is required for re-scheduling or canceling an appointment. Unless we reach a different agreement, the full fee will be charged for sessions missed without such notification. Most insurance companies do not reimburse for missed sessions. Because life happens, and Dr. Holland knows that flat tires occur as well as viruses, Dr. Holland will not charge for one missed appointment or last-minute cancel 1x per year. I call this your Get Out of Jail Free Card. If you do need to cancel last minute, Dr. Holland will inform you if she has a cancellation within the week, allowing you to make up the session. Dr. Holland believes that continuity and consistency of care are important factors for successful treatment. If you miss more than 3 appointments in a six-month period, Dr. Holland may refer you out, unless we have a different arrangement in place ahead of time.

Dr. Holland appreciates your understanding in the event that she becomes ill and does not want to expose you to anything. When appropriate, Dr. Holland may offer you a video session in lieu of an in-person session if you or she is ill, out of town, or if physically unable to come into the office. Dr. Holland appreciates your letting her know if you believe you might be contagious, and she will do the same.

Dr. Holland takes your trust in her very seriously and will make efforts to accommodate your needs and requests.

I have read the above Office Policies and General Information, Agreement for Psychotherapy Services or Informed Consent for Psychotherapy carefully. I understand them and agree to comply with them:

Client's Name(s) (print) ____

____

Signature(s) ____

____

Date ___________________

Psychotherapist's Name (print) ____

Signature ____Date ___________________

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Biographical Information – Intake Form

Please fill out this biographical background form as completely as possible. It will help me in our work together. Information is confidential as outlined in the Office Policy form and the HIPAA Notice of Privacy Practices. If you do not desire to answer any question, merely write, "Do not care to answer." Please print or write clearly and bring it with you to the first session.

NAME: ____ PREFERRED PRONOUN ______

DATE: ___________ DATE OF BIRTH _________________________ AGE: _____________

ADDRESS: ____

TELEPHONES: Home: ____________ Cell: ______________ Work/Off: ________________

FOR ROUTINE MESSAGES:

Phone #___________________ Email: ____

TEXT: ____

FOR CONFIDENTIAL/PRIVATE MESSAGES: Phone #_________ Email: ______ Text: _______

HIGHEST GRADE/DEGREE: ___________ TYPE OF DEGREE: _________________________

PERSON & PHONE NO. TO CONTACT IN EMERGENCY: _______________________________

REFERRAL SOURCE: ____

OCCUPATIONS (former, if retired): ____

PRESENTING PROBLEM (be as specific as you can: when did it start, how does it affect you):

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Estimate the severity of above problem: Mild ____ Moderate ____ Severe ___Very severe ____

CURRENT: Relationship status: ________________ Partner's Name: ______________Years: ____

PAST & PRESENT SIGNIFICANT PARTNERS/MARRIAGE/S (names, years together, and statement about the nature of the relationship(s), i.e., friendly, distant, physically/emotionally abusive, loving, hostile):

PRESENT SPOUSE/PARTNER:

Occupation: ____

CHILDREN/STEP/GRAND (names/ages & brief statement on your relationship with the person.)

1. ____
2. ____
3. ____

PARENTS/STEPPARENTS (Name/age or year of death/cause of death, occupation, personality, how did s/he treat you, brief statement about the relationship.):

Father: ____

____

____

Mother:

____

____

____

Stepparents: ____

____

____

SIBLINGS (name/age, if deceased: age and cause of death and brief statement about the relationship.):

1. ____
2. ____
3. ____

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MEDICAL DOCTOR (S) (name/phone): ____

____

____

PAST/PRESENT MEDICAL CARE (major medical problems, surgeries, accidents, falls, illness, etc.):

____

____

____

SPECIFY MEDICATION you are presently taking and for what. PRINT clearly:

____

____

PAST/PRESENT DRUG/ALCOHOL USE/ABUSE (AA, NA, treatments):

____

____

SUICIDE ATTEMPT/S or VIOLENT BEHAVIOR (describe ages, reasons, circumstances, how, etc.)

____

____

FAMILY MEDICAL HISTORY (Describe any illness that runs in the family: e.g., cancer, epilepsy, etc.):

____

____

FRIENDSHIPS, COMMUNITY, & SPIRITUALITY:

____

____

PAST/PRESENT PSYCHOTHERAPY (specify: month year(s) (beginning—end), estimated no. of sessions, name, degree, phone & address, initial reason for therapy, Individual/Couple/Family, medication, brief description of the relationship and how helpful it was, and how/why it ended): Was your treatment helpful and effective?

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DESCRIBE YOUR CHILDHOOD, IN GENERAL (Relationships with parents, siblings, others, school, neighborhood, relocations, any school/behavioral/problems, abusive/ alcoholic parent):

IF PARENTS DIVORCED: Your age at the time: Describe how it affected you at the time.

ESTIMATE HOW MANY HOURS/DAYS YOU SPEND ONLINE (Facebook, YouTube, internet gaming, texting, browsing, etc.):

Facebook: ______ YouTube: ______ Gaming: ______ Texting: ______ Browsing: ______

Work/School: ______ Other: ______

DO YOU FEEL YOUR TECHNOLOGY USE IS BALANCED AND HEALTHY OR COULD IT USE IMPROVEMENT? Please explain:

FAMILY HISTORY OF ALCOHOLISM, MENTAL ILLNESS, OR VIOLENCE (including suicide, depression, hospitalizations in mental institutions, abuse, etc.):

ARE YOU INVOLVED IN ANY CURRENT OR PENDING CIVIL OR CRIMINAL LITIGATION/S, LAWSUIT/S OR DIVORCE OR CUSTODY DISPUTE/S? (if you answer Yes, please explain):

What gives you the most joy or pleasure in your life?

What are your main worries and fears?

What are your most important hopes or dreams?

If you could change one thing about your life instantly, what would you change?

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Please add, any other information you would like me to know about you and your situation.

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Minors in Therapy

If you are under eighteen years of age, please be aware that the law may give your parents or guardians the right to obtain information about your treatment and/or examine your treatment records. It is my policy to request a written agreement from your parents or guardians indicating that they consent to give up access to such information and/or, to your records. If they agree, I will provide them only with general information about our work together subject to your approval, or, if I feel it is important for them to know in order to make sure that you and people around you are safe. If I think it is appropriate, I will involve them if I feel that there is a high risk that you will seriously harm yourself or another/others. Before giving them any verbal or written information, I will discuss the matter with you, if possible. I will do the best I can to resolve any differences that you and I may have about what I am prepared to discuss.

Group Therapy

In group therapy, it is of utmost important that all members maintain confidentiality and neither disclose the content of sessions nor the identity of fellow group members. It is highly recommended that any meaningful exchange outside the group also be discussed in the group. In group therapy, the other members of the group are not therapists. They are not regulated by the same ethics and laws that bind your therapist. The limits of confidentiality and the reporting laws have been outlined earlier in this document. While the expectation is that all group members will maintain confidentiality regarding anything said in the group, you cannot be certain that they will. You are ultimately responsible for what you say and what you think, feel, or do with the feedback you receive in the group.

Touch in Therapy

Dr. Holland may also incorporate non-sexual touch as part of psychotherapy. Sexual touch of clients by therapists is unethical and illegal. Dr. Holland will ask your permission before touching you and you have the right to decline or refuse to be touched without any fear or concern of a negative response or reaction from your therapist.

Touch can be very beneficial but can also unexpectedly evoke emotions, thoughts, physical reactions, or memories that may be upsetting, depressing, evoke anger, etc. Sharing and processing such feelings with the therapist, if they arise, may be a helpful part of therapy. You may request not to be touched at any time during therapy without needing to explain it, if you choose not to, and without fear of a negative response or reaction from your therapist.

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Coaching Informed Consent

Life Coaching and Psychotherapy, I understand that life coaching neither treats mental disorders nor conducts mental health evaluations. I understand that if my life coach detects or suggests that I suffer from a mental disorder or determines that I need to be evaluated for mental health concerns he/she should refer me to a licensed mental health practitioner. I fully understand that life coaching is not psychotherapy or counseling and that professional referrals will be given if needed. I certify that if I am currently in therapy or counseling, or otherwise under the care of a mental health professional, that I have consulted with this professional about my working with a life coach. I further certify that this mental health professional is aware of my decision to enter into a life coaching relationship. I understand that life coaching is not a substitute for counseling, psychotherapy, psychoanalysis, mental health care or substance abuse treatment and I will not use it in place of any form of psychotherapy.

The Nature of the Life Coach Relationship I understand that the purpose of my relationship with my life coach is to create, develop, and facilitate my personal, professional or business goals. I understand that the purpose of life coaching is to develop and to implement a strategy, plan, and/or program that is designed to achieve those goals. I understand that life coaching is not to be used in lieu of professional advice. I will seek professional guidance for legal, medical, financial, business, spiritual or other matters. I understand that all decisions in these areas are exclusively mine and I acknowledge that my decisions and my actions regarding them are my responsibility. I am aware that I can choose to discontinue coaching at any time. I understand that although life coaching is a process that may involve several areas of my life, including career and work, finances, health, and personal and professional relationships, deciding how to manage these issues and implement my choices is solely my responsibility. I am aware that I can read more about coaching online or on the web site of the International Coach Federation (ICF) at www.coachfederation.org.

Records & Confidentiality I understand that information transmitted by me in this life coaching relationship will be kept strictly confidential unless I give explicit, specific permission to release it to specifically designated persons. I understand that the only exception to this confidentiality will occur if the release of personal information is required by law.

I have read and agree to the above.

Client Name: ___________________________________ Client Signature: _________ ___________________

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Consent for Treatment of Minor(s) & Others

I _________________________ give my consent that Dr. Holland will be conducting psychotherapy with_________________________.

My relationship to the client (parent, uncle, etc.): ______________________________ I was notified that the holder of the privilege is (parent, guardian, etc.) _______________ I was also notified that all material discussed during the psychotherapy sessions is confidential and can be released only with the permission of the holder of the privilege. I have been informed of the limitation to confidentiality in the Office Policies form, which I have read and signed.

In the case of a minor, special sensitivity may be required in releasing information about certain topics such as drugs and sex. I will accept Dr. Holland's judgment in regard to releasing or sharing information obtained during the course of psychotherapy with the minor that may endanger or jeopardize the client's wellbeing.

Name (print) ____

Relationship ____

Signature____

Date____

Name (print) ____

Relationship ____

Signature ____

Date____

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Authorization Consenting to Release of Information

I authorize Dr. Holland to discuss (verbally or in writing) anything that has been brought up during our psychotherapy or evaluation with any person/s or staff of clinic, office, agency, or institution/s named below and receive any relevant information from them.

1. ____

2. ____

3. ____

4. ____

For the following reason(s):

____ Consultation/Psychotherapy,

____ Evaluation,

____ Other: ___________________________________

I may revoke this consent at any time. This consent is in effect for five years from the date of the last session, unless revoked in writing earlier or renewed. This consent is also subject to all conditions outlined in the Office Policies (Form #1).

Name (print)______________________________________

Date ____

Signature ____

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Informed Consent to Assume Responsibility for Payment for Psychotherapy Services

I, _________________________________ agree to pay for psychotherapy services and other clinical services for _________________________ according to the fee agreement between the therapist and the client.

I understand the following terms apply to this agreement:

Payment will be made as follows; (check one):

_______ At the time of service

_______ Within two weeks of receiving an invoice

_______ Other (specify): ______________________________________

The fee for psychotherapy, psychological testing and interpretation, consultation, letter or report writing or other clinical services is $ 165.00 per 45 minute session unless otherwise specified. For more details, see previous informed consent.

Please inform the therapist as soon as you know if there are changes in your ability or willingness to pay.

Services will be terminated if timely payment is not made as agreed to by this consent.

Consent to assume financial responsibility for these services does not entitle the third- party payer access to confidential information unless otherwise agreed in writing by the above-named client.

Upon your request and upon obtaining the client's written permission, if appropriate, you will be provided with a bill, which is suitable for presenting to your insurance carrier for possible reimbursement. Not all conditions are reimbursable.

This agreement supplements previous informed consents.

Signature of Client: _____________________________________ Date: __________________________

Signature of Payee: _____________________________________ Date: __________________________

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Premature Discontinuation of Therapy – Letter To Client

Dear ______________,

I have noticed that it has been more than _____ weeks/months since our last appointment. I hope you (and your family) are doing well. I have contacted you by phone and left messages but I have not heard back from you. I am assuming that you have chosen to discontinue therapy and will consider your case closed if I have not heard from you within two weeks of the date of this letter.

If you do choose to resume therapy, I would be pleased to continue working with you. If you have any questions or concerns about our previous work together or future therapeutic goals please call me - I would be happy to discuss them with you. If you prefer to schedule a final appointment to review the work we did together and envision where you might go from this point, I would also be pleased to arrange this with you.

I do not necessarily believe that this is the appropriate point for you to discontinue therapy but I respect your right to decide otherwise. If you choose to work with another therapist, I am willing to give you a number of referrals and help you with the transition. I am also willing to speak with any future therapist if you ask me to do so and give me your written authorization to release information to the therapist of your choice.

If I may be of any further assistance, please give me a call. I wish you all the best.

Sincerely,

Dr. Jenny Holland

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Treatment Is Being Terminated Due To Lack Of Progress And Lack Of Benefit To Patient

Dear _______________,

As we discussed during the last several sessions, it is clear to me that our ongoing work together has not been beneficial to you. Although I understand your desire for your treatment under my care to continue, I strongly believe it to be in your best interest for us to end our work together. It is my ethical mandate to appropriately discontinue therapy if it is not beneficial to my clients.

As we discussed, I am hereunder providing you with the names, addresses, and telephone numbers of a number of psychotherapists. Each of these professionals is licensed, has training and experience in the areas outlined below, and is located in your local area. I hope you will contact them and make arrangements to begin treatment with one of them. If you would like me to discuss your situation and our treatment with them - and give me written permission to do so - I would be happy to speak to them. If any difficulties are experienced, I will be happy to assist in this transition.

Name/Degree/License/Phone/Area of expertise

Name/Degree/License/Phone/Area of expertise

Name/Degree/License/Phone/Area of expertise

Again, as we agreed, I will meet with you up to four more times to assist you during this time of transition. Please discuss these, or any other issues that concern you, during our upcoming meetings.

Sincerely,

Dr. Jenny Holland

Jenny Holland, Psy. D.
Psychotherapy

7970 Mitchell Court Sebastopol, CA 95472
Phone: 707-479-2946
Email: Hollandpsyd@gmail.com

INVOICE

To:

Address:

Invoice Date:

CPT CODESERVICEDIAGNOSISDATE OF SERVICEFEEBALANCE90834

Therapy Session

Enter ICD-10-CM Code

$165.00/Session

$165.00

90836 Therapy Session

Enter ICD-10- CM Code

$165.00/ Session

$165.00

90836 Therapy Session

Enter ICD-10- CM Code

$165.00/ Session

$165.00

Balance

Amount Paid

.... Paid

Balance Due

....

....

$0.00

7970 Mitchell Court Sebastopol, CA 95472
Phone: 707-479-2946
Email: Hollandpsyd@gmail.com

SUPER BILL

THERAPIST'S INFORMATION

Name of therapist/Degree ____

Address ____

Office phone number ________________ State license number _________________

Tax ID number ______________________NPI number ________________________

CLIENT'S INFORMATION

Client Name _________________________________ Address
_____________________________________ DOB____

Name of Policy Holder _________________________________

Insurance ID #_____________________ Group # __________________

PAYMENT & TREATMENT INFORMATION

Previous Balance _________________________________

Balance Due _____________________________________

Payment ____

Remaining Balance _______________________________

Place of Service ( ) Office ( ) Hospital ___________( ) Other __________

DATE OF SERVICE ____________________

CPT CODE SERVICE FEE 90832 Individual Psychotherapy (30 mins.) 90834 Individual Psychotherapy (45 mins.) 90837 Individual Psychotherapy (53 mins.)

Total for Period $ DIAGNOSIS, ICD-10-CM: ____

THERAPIST'S SIGNATURE ___________________________________

AUTHORIZATION TO PAY BENEFITS TO CLINICAL PSYCHOLOGIST: I hereby authorize that the Medical Benefits, if any, which would otherwise be payable to me, be paid directly to the undersigned psychotherapist, but are not to exceed the reasonable and customary charge for these services.

Signed (Insured Person) ______________________________ Date ______________

7970 Mitchell Court Sebastopol, CA 95472
Phone: 707-479-2946
Email: Hollandpsyd@gmail.com

Phone Consultation Agreement

Please fill-out and email to: ______________________________________

DATE: _________________ NAME: ____

ADDRESS: ____

EMAIL: ____________________________ PHONE: _____________________________

FAX: ____

Please check the appropriate box on left:

❒ 30 minutes phone consultation for $150.00

❒ 45 minutes phone consultation for $165.00

❒ 1.0-hour phone consultation for $180.00

❒ Reading and research at rate of $150.00/hour

Please charge my card for the amount checked above:

CREDIT CARD INFORMATION

Please check the appropriate box:

❒ Visa

❒ MasterCard

C/C # _____________________________Expiration Date: ___________________

Signature: ____

Jenny Holland, Psy. D.
Psychotherapy

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Email: Hollandpsyd@gmail.com

Fax Cover Sheet

C O N F I D E N T I A L

This fax transmission may contain confidential information, may be protected by Federal statute, and may be legally and clinically privileged. It is intended only for the use of the individual or entity named in this facsimile transmission. If the reader of this transmission is not the intended recipient, you are hereby notified that any use, dissemination, distribution, or copying of this transmission is strictly prohibited. If you received this transmission in error, please notify me immediately by phone and mail the original transmission to me. Thank you.

Date: ____

To: ____

From: ____

Reference: ____

Total number of pages including cover sheet: ____________ C O N F I D E N T I A L

Jenny Holland, Psy. D.
Psychotherapy

7970 Mitchell Court Sebastopol, CA 95472
Phone: 707-479-2946
Email: Hollandpsyd@gmail.com

Email Signature Re: Email Confidentiality

Notice of Confidentiality: This email, and any attachments, is intended only for use by the addressee(s) and may contain privileged private or confidential information. Any distribution, reading, copying, or use of this communication and any attachments, by anyone other than the addressee is strictly prohibited and may be unlawful. If you have received this email in error, please immediately notify me by email (by replying to this message) or telephone (707) 479-2946 and permanently destroy or delete the original and any copy or printout of this email and any attachments.

It is important to be aware that email communication can be relatively easily accessed by unauthorized people and hence can compromise the privacy and confidentiality of such communication. Emails, in particular are vulnerable to such unauthorized access due to the fact that servers have unlimited and direct access to all emails that go through them. It is important that you be aware that emails are part of the medical records. Un-encrypted emails, such as this are even more vulnerable to unauthorized access. Please notify Dr. Holland if you decide to avoid or limit in any way the use of email. Please do not use email for emergencies. Phone messages and emails are checked frequently but may not be checked daily, particularly if I am out of town.

Name: ____

Address: ______________________________________

Letter Announcing Therapist's Resignation from Managed Care Panels

Make sure that all the following reasons that led you to resign are covered in the letter.

7970 Mitchell Court Sebastopol, CA 95472
Phone: 707-479-2946
Email: Hollandpsyd@gmail.com

Confidentiality and privacy

Control of treatment

Continuity/interruption of treatment

Availability for follow-ups

Your conflict of interests when you are put in a situation in which you must choose between care for your clients and economic or employment security.

The moral, ethical, and clinical problems with a capitation contract, if appropriate. Include a short explanation of capitation.

Ensure that your letter clearly states your moral, ethical, and clinical stance.

People appreciate it when they see that you are prepared to fight and take risks for your convictions.

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Email: Hollandpsyd@gmail.com

Telehealth Disclosure - Telemedicine Informed Consent

I ______________________________ hereby consent to engage in telemedicine (e.g., internet, email or telephone-based therapy) with Dr as the main mode of my psychotherapy treatment. I understand that telemedicine includes the practice of health care delivery, including mental health care delivery, diagnosis, consultation, treatment, transfer of medical data, and education using interactive audio, video, and/or data communications. I understand that telemedicine also involves the communication of my medical/mental health information, both orally and visually, to other health care practitioners.

I understand that I have the following rights with respect to telemedicine:

(1) I have the right to withhold or withdraw consent at any time without affecting my right to future care or treatment or risking the loss or withdrawal of any program benefits to which I would otherwise be entitled.

(2) The laws that protect the confidentiality of my medical information also apply to telemedicine. As such, I understand that the information disclosed by me during the course of my therapy is generally confidential. However, there are both mandatory and permissive exceptions to confidentiality including, but not limited to: reporting child, elder, and dependent adult abuse; expressed threats of violence towards an ascertainable victim; and where I make my mental or emotional state an issue in a legal proceeding. (See also Office Policies and HIPAA Notice of Privacy Practices forms, provided to me, for more details of confidentiality and other issues.)

I also understand that the dissemination to researchers or other entities, of any personally identifiable images or information from the telemedicine interaction shall not occur without my written consent.

(3) I understand that there are risks and consequences from telemedicine. These may include, but are not limited to, the possibility, despite reasonable efforts on the part of my psychotherapist, that: the transmission of my medical information could be disrupted or distorted by technical failures; the transmission of my medical information could be interrupted by unauthorized persons; the electronic storage of my medical information could be accessed by unauthorized persons; and/or misunderstandings can more easily occur, especially when care is delivered in an asynchronous manner.

In addition, I understand that telemedicine-based services and care may not yield the same results nor be as complete as face-to-face service. I also understand that if my psychotherapist believes I would be better served by another form of psychotherapeutic service (e.g. face-to-face service), I will be referred to a psychotherapist in my area who can provide such service. Finally, I understand that there are potential risks and benefits associated with any form of psychotherapy and that, despite my efforts and the efforts of my psychotherapist, my condition may not improve and in some cases may even get worse.

(4) I understand that I may benefit from telemedicine, but results cannot be guaranteed or assured. The benefits of telemedicine may include but are not limited to: finding a greater ability to express thoughts and emotions; transportation and travel difficulties are avoided; time constraints are minimized; and there may be a greater opportunity to prepare in advance for therapy sessions.

(5) I understand that I have the right to access my medical information and copies of medical records in accordance with California law, that these services may not be covered by insurance, and that, if there is intentional misrepresentation, therapy will be terminated.

I have read and understand the information provided above, which has also been explained to me verbally. I have discussed it with my psychotherapist and all of my questions have been answered to my satisfaction.

Name ____ Date ______________________

Signature:____