INFORMED CONSENT, TREATMENT AGREEMENT FOR PSYCHOLOGICAL SERVICES AND OFFICE POLICY

Welcome to the psychotherapy practice of Zane Dodd, Ph.D. This document contains important information about my professional services and business practices. Please read it carefully and note any questions you might have so I can answer them.

Purpose and Nature of Services Provided:
Psychologists help patients with mental, emotional, cognitive, and behavioral difficulties. Psychological consultation and psychotherapy is intended to help you reach a better understanding of specific problems or increased self-awareness. It is also intended to work toward improvement of the identified problems, offer support in problem solving, provide some symptom relief, and improvement in coping with daily life activities. Your progress in psychotherapy and its outcome depends upon many factors including but not limited to your level of motivation and desire to change, the effort that you put forth in following through with agreed upon therapeutic tasks outside of session, keeping your appointments, and your willingness to be open with me as we work together.

Methods and Procedures and Risks and Benefits of Psychotherapy: Initially, I will conduct a clinical interview to assess the nature of the presenting problem(s). You might be asked to complete psychological inventories to gather additional information. Outside records from previous mental health providers or discussion with important family members may be requested for which a signed release of information is necessary.

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. These feelings or memories may bother you at school, home or at work. Some of the changes you make as a result of psychotherapy may not be welcomed by other people in your life. This may result in some strain in your relationships with family and others. Therapy may disrupt a romantic relationship. Sometimes, too, it is possible for a patient’s problems to worsen immediately after beginning therapy. Most of these risks are to be expected when people are making important changes in their lives. On the other hand, psychotherapy has also been shown to have benefits leading to better relationships, solutions to specific problems and reductions in feelings of distress. But there are no guarantees of what you will experience. The outcome is based upon our joint effort in working collaboratively toward specific goals.

Together we will typically agree on specific goals for therapy, such as symptom reduction, behavioral change, improved communication and/or interpersonal skills, the ability to return to work or school, etc. Goals will in all likelihood change as the therapy progresses and should be renegotiated accordingly. The therapeutic approach used will vary and should be discussed with me whenever you have questions or when you believe therapy is not helpful.

Typically, our first few sessions will involve an evaluation of your needs. By the end of the evaluation, I will be able to offer you some first impressions of what our work will include and a treatment plan to follow, if you decide to continue with therapy. You should evaluate this information along with your own opinions of whether you feel comfortable working with me. Therapy involves a large commitment of time, money, and energy, so you should be very careful about the therapist you select. If you have questions about my treatment procedures, we should discuss them whenever they
arise. If your doubts persist, I will be happy to help you set up a meeting with another therapist for a second opinion or referral.

How long you remain in therapy and the frequency of sessions is a matter best discussed while we work together to achieve your goals. While it is your right to end therapy at any time, when you decide to end treatment it is in your best interest to discuss this with me beforehand.

Types of psychological services. Change will sometimes be easy and swift, but more often it will be slow and potentially frustrating. There is no guarantee that therapy will yield positive or intended results. During the course of therapy, I may draw on various psychological approaches including but not limited to behavioral, cognitive behavioral, emotion focused, psychodynamic, family systems, mindfulness, positive psychology, health psychology, and (multi)cultural modalities.

If you are a parent your participation in your child’s counseling is important for long-term gains. You may need to learn a different way of dealing with your child to facilitate and maintain gains. I will ask for your feedback and views on your (your child’s) therapy, progress and other aspects of the therapy and will expect you to respond openly and honestly.

Minors: When working with minor patients I will initially meet with all involved caregivers before meeting with the adolescent. From that point forward all discussions about clinical matters and concerns about the adolescent will be done in the presence of the minor. Meetings without the patient present tend to undermine the trust and therapeutic relationship. How frequently caregivers attend is something that can be negotiated at the outset of treatment and can be adjusted as needed. If one caregiver has custody of the minor then documentation identifying the managing conservator will be required before treatment begins.

Couples: When working with a couple, I consider the relationship between the members to be my patient. As such, sessions will only be conducted with both parties present. If one member of the couple is unable to attend the session it will need to be rescheduled. The only exception to this is a brief (1 hour) individual intake interview conducted in the process of the initial assessment of the appropriateness for treatment. Each member will receive equal time during the initial individual interview. It should be noted that confidentiality applies to the couple and statements made in the individual assessment may be shared with the partner (or you may be asked to share the information) based on my clinical judgment. I do not see individual members of the couple while conducting couples therapy.

Length of Session and Meetings: The frequency of our sessions will be discussed and determined by mutual agreement. Your sessions will last for 50 minutes. Once an appointment is scheduled, you will be expected to pay for it if you do not cancel 24 hours in advance.

Termination of Treatment: If I determine that I cannot provide appropriate services to you for any reason, I will terminate our treatment and refer you to other professionals. If you request it and authorize it in writing, I will talk to the new therapist in order to help with the transition. If at any time you want another professional’s opinion or wish to consult with another therapist, I will assist you with referrals. Upon termination of therapy for any reason, the termination will be confirmed in writing.
**Professional Fees:** Your fee is set at $170 per 50 minute session. You are expected to pay for each session at the time it is held. In addition to psychotherapy sessions, I charge this amount for other professional services you may need or request, such as report writing, telephone conversations of ten minutes or more, consultation with other professionals with your written permission, and preparation of records or treatment summaries. The time spent performing any other service you may request of me will incur additional charges. I will pro-rate the cost if I work for periods of less than one hour.

**Litigation Policy:** Due to the nature of the therapeutic process and the fact that it often involves making a full disclosure with regard to many matters which may be of a confidential nature, it is agreed that should there be legal proceedings (including but not limited to divorce and custody disputes, injuries, lawsuits, depositions etc.), neither you, your attorneys or anyone acting on your behalf will subpoena records from my office, or subpoena me to testify in court or in any legal proceeding. By your signature below, you agree to abide by this agreement. If I am subpoenaed to provide records or testimony in violation of this agreement, you acknowledge and agree you will pay for all of my professional time, including preparation and transportation costs, even if I am called to testify by another party. If you become involved in any legal matter that requires my services, there is a fee of **$350 per hour** and this includes preparation time, travel time and attendance at any legal proceeding. I also reserve the right to terminate our professional, therapeutic relationship immediately and refer you to other mental health providers.

I will NOT provide custody evaluations or recommendations. I will NOT provide medication or prescription recommendations. None of these activities are within scope of my practice.

**Insurance Reimbursement:** I do not participate in network with any insurance programs. I am licensed in Texas as a Psychologist. Your insurance company may reimburse you according to guidelines they have established for out of network providers. Your health insurance policy will usually provide some coverage for mental health treatment. I will give you a receipt after each session so you can file with your insurance company. However, you (not your insurance company) are responsible for full payment of my fees. You are responsible for knowing what mental health services your insurance policy covers. If you have questions about the coverage, call your plan administration.

**Charge for Missed Appointments:** There is a full session fee charge for missed appointments or cancellations made without 24 hours notice. The charge may be waived in the case of a reasonable emergency. I reserve the right to request that you provide a credit card number to be kept on file so that it may be charged for any missed appointments.

**Charge for Phone Consultations:** There is a charge at the agreed upon session fee for all phone conversations that exceed ten minutes. The charge is pro-rated.

**Availability, Office Hours and Contacting Me:** My office hours vary and I am often not immediately available by telephone. Messages may be left for me at (817) 416-8970. I routinely return calls within 12-24 hours during regular business hours (that is between 8:00 AM and 5:00 PM) Monday through Friday. Please set your phone to accept private calls, otherwise I may be unable to reach you. If you are difficult to reach, please let me know of some times when you will be available.

If you experience a life-threatening emergency, go to the nearest hospital emergency room and request to see a mental health professional. Another option is to call 911. If you are suicidal you can call the Dallas Suicide and Crisis Center (214) 828-1000 or the Suicide Prevention Lifeline 1-800-273-TALK (8255). If you have...
insurance you can call the number listed on the back of your card and get a referral to an in-network psychiatric hospital for consultation with an intake specialist.

If you are taking any psychotropic medications, it is important to coordinate a crisis response plan with your physician to determine what steps you should take in a crisis. If at any time you experience suicidal thoughts during our work together we will develop a detailed Crisis Response Plan specific to keeping you safe. When a Crisis Response Plan is developed it is important you have it readily available to use should the need arise. It will detail steps for you to follow.

**Use of Electronic Communications:** I will use e-mail communication only for administrative purposes, such as scheduling and billing. While I do use a HIPAA compliant email server, e-mail is an inherently unsecure form of communication, so please do not e-mail me about clinical matters. If you need to discuss a clinical matter between sessions please call me. Any e-mails you send to me can be printed and will become part of your clinical record. However, if you choose not to respect my policy regarding e-mail communications, I will take steps to block further e-mail communications. I also reserve the right to terminate therapy and refer you to other providers.

**Use of Fax:** I use an electronic fax service which, like other fax methods, cannot provide a secure form of transmission. The only protected method to deliver information is by hand.

I do not text with patients. My phone number does not receive texts so if they are sent to this number they will not be received.

**Information about Phone/Video Therapy Services**

**Your Responsibilities for Confidentiality & TeleMental Health:**
Please communicate only through devices that you know are secure. 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.). It is strongly recommended to only use a secure network and not a public network. 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 unless arranged with me beforehand.

**Emergency Procedures Specific to Long Distance TeleMental Health Services:**
There are additional procedures for your safety that I need to have in place specific to long distance TeleMental Health services: • 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. • You agree to tell me the address where you are at the beginning of every TeleMental Health session. • You agree to inform me of the hospital nearest to your primary location that you prefer to go to in the event of a mental health emergency.

**In Case of Technology Failure:**
During a TeleMental Health session, we could encounter a technological failure. If you and I get disconnected from a video conferencing or chat session, end and restart the session. If you are unable to reconnect within 5 minutes, please call me. If you and I are on a phone session and you get disconnected, please call me back or contact me to schedule
another session. If the issue is due to my phone/internet 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 but may provide phone or video conferencing if TeleMental Health services are appropriate for you. The structure and cost of TeleMental Health sessions are exactly the same as face-to-face sessions described in my general “Psychotherapist-Patient Services Agreement” form. Insurance companies have many rules and requirements specific to certain benefit plans. It is your responsibility to find out your insurance company’s policies and to file for insurance reimbursement for TeleMental Health services. I will be glad to provide you with a statement for your insurance company. 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.

**Video Conferencing (VC):**
Video Conferencing is an option for us to have remote sessions over the internet where we may speak to one another as well as see one another on a screen. I utilize https://vsee.com. This VC platform is encrypted to the federal standard, HIPAA compatible, and has signed a HIPAA Business Associate Agreement (BAA). The BAA means that Vsee.com is willing to attest to HIPAA compliance and assumes responsibility for keeping your VC interaction secure and confidential. If you choose to utilize this technology, I will give you detailed directions regarding how to access and use it securely. I also ask that you please sign on to the platform at least five minutes prior to your session time to ensure we are able to get started promptly. Additionally, you are responsible for initiating the connection with me at the time of your appointment. For video conferencing, it is recommend that your internet service provide a minimum of 1.5 mb download and 1 mb upload speed. If you have other users on your network who are using excessive data then it might also impact the speed of your connection.

**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, with 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. With these limitations in mind, I strongly encourage you to let me know if something I’ve done (or not done) has upset you.

**I do not engage in communication or relationships via social media with patients.** This is for the protection of your privacy as well as the therapy relationship. If you happen to encounter me by accident through social media or the internet please feel free to discuss this with me in session. I do not accept “friend” requests from current or former clients on my psychotherapy related profiles on social networking sites due to the fact that these sites can compromise clients’ confidentiality and privacy. For the same reason, I request that clients do not communicate with me via any interactive or social networking websites.

If we happen to encounter each other outside of the professional setting I will not address you unless you address me first. This is also for the protection of your privacy from those either of us may be with. I’m happy to return a friendly greeting but will allow you to take the initiative if you would prefer to do so.
**Limits on Confidentiality:** Texas law and the federal HIPAA privacy rules are designed to protect the privacy of all communications between you and a mental health professional and records of your treatment. In most situations, I can only release information about your treatment to others if you sign a written authorization. The authorization will remain in effect for a length of time you determine. You may revoke the authorization at any time, unless I have taken action in reliance on it.

**Exceptions and limitations of your confidentiality include the following:**

1. If you are involved in a court proceeding and a request is made for information concerning your diagnosis and treatment, such information is protected by the therapist-patient privilege law. I cannot provide any information without your (or your legal representative’s) written authorization. However, if your records are subpoenaed or if a judge issues a court order for your records, I am legally obligated to comply. In the case of a subpoena, I will contact you so you and your attorney can take steps to contest the subpoena, but if you do nothing, I will obey the subpoena.
2. If I believe that you are a danger to yourself or to others, I will contact medical or law enforcement personnel.
3. If you are a minor, elderly, or disabled and I suspect you are a victim of abuse, or if you divulge information about such abuse, I am required by law to notify authorities.
4. If you file suit against me for any reason related to your therapy.
5. If a court order or other legal proceeding or statute requires disclosure of your information.
6. If you waive the rights to privilege or give written consent to disclose information.
7. If third party payers (i.e., insurance companies) or those involved in collecting fees for services require additional information.
8. Information contained in communications via computers with limited security/control, such as e-mail and telephone conversations via cell phone is not secure and can compromise your privacy.
9. If I learn of previous sexual exploitation by a mental health provider I am required to report it to the district attorney in the county of the alleged exploitation and the appropriate licensing board of the provider. The patient has the right to remain anonymous when the report is filed.

**Consultation:**
I maintain consistent consultation with a group of colleagues. This provides improved treatment for my patients as well as continued professional develop. Patients are discussed in de-identified terms that protects confidentiality and all participants are also bound to maintain confidentiality as well.

**Emergency Contact:**
I require an emergency contact for your file. This individual will only be contacted in emergency situations that require assistance. This is not a release to speak with this individual about your file other than what would be immediately necessary information regarding the emergency at hand.

Most insurance companies require a clinical diagnosis to reimburse for treatment. Some may require additional clinical information to support payment. Information collected by an insurance company will become part of the company's files. Though all insurance companies claim to keep such information confidential, I have no control over what they do with it once it is in their possession. Medical data has been also reported to be legally accessed by enforcement and other
agencies, which may place you in a vulnerable position. The safest way to protect confidentiality is to pay cash for treatment. By your signature below, you acknowledge that you have been advised of these potential risks. If you elect to use your insurance coverage to pay for treatment, I will assume that you have evaluated the stated risks and elected to proceed.

RECORDS AND YOUR RIGHT TO REVIEW THEM: Documentation of sessions consists of a summary of each meeting and may include general issues addressed, possible symptom presentation or change, level of functioning, mental status, diagnosis and treatment plans. Texas law requires that I maintain appropriate treatment records for at least 10 years from the last date of service. If the client is a minor child at the time services are provided, the records are kept for 10 years after the client’s 18th birthday. As a client, you have the right to review your records or receive a summary of your records. Texas law requires that all requests to review or obtain copies of your records must be made in writing. The records can be misinterpreted and/or can be upsetting to lay readers. If you request a copy of your records, I will provide them to you within 15 days of receiving the request unless I believe that to do so would endanger your life or the life of another person. I have determined that a reasonable, cost-based charge for providing you with a copy of your records will be $25.00. By law, I am not required to provide copies of requested records until the fee is paid.

COMPLAINTS: You have a right to have your complaints heard and resolved in a timely manner. If we cannot work things out to your satisfaction you may inform your insurance carrier and file a complaint with them or with your counselor’s licensing board: The Texas State Board of Examiners of Psychologists (800-821-3205).
Please Initial

__________ I understand the nature of the proposed therapeutic treatment and I give my informed consent for psychological treatment by Zane Dodd, Ph.D.

__________ I understand that the fee for service is $170 for the clinical hour.

__________ I understand that the clinical hour is **50 minutes** in length.

__________ I agree to pay in full for any missed appointments. To avoid a fee, please give 24 hours advanced notice if you must cancel or reschedule an appointment.

__________ I understand that if I am experiencing a medical or psychiatric emergency, I have been advised to dial 911 or go to nearest emergency room, and I agree to abide by these instructions.

I have read the above Agreement carefully, I understand the terms of this Agreement and I agree to comply with them. I agree that this Agreement will stay in effect until I revoke it in writing. I understand that any written revocation must be dated AFTER the date of this Agreement and must be provided to Dr. Zane Dodd. A copy of this Agreement has the same force and effect as a copy. I have received and read the HI PPA Notice of Privacy Practices.

__________________________________________________  __________________________
Signature of Patient or Authorized Representative   Date Signed

__________________________________________________
Printed Name of Patient or Authorized Representative

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