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Welcome.

The three documents within this contract contain important information about my professional service, business policies and expectations for office place conduct. They also contain summary information about the Health Insurance Portability and Accountability Act (HIPAA), a federal law that provides privacy protections and patient rights about the use and disclosure of your Protected Health Information (PHI) for the purposes of treatment, payment, and health care operations. Although these documents are long and sometimes complex, it is very important that you understand them. When you sign this document, it will represent an agreement between us. We can discuss any questions you have when you sign them or at any time in the future.

DOCUMENT 1

INFORMED CONSENT FOR TREATMENT / PSYCHOTHERAPY SERVICES

PSYCHOLOGICAL SERVICES

Therapy is a relationship between people that works in part because of clearly defined rights and responsibilities held by each person. As a patient in psychotherapy, you have certain rights and responsibilities that are important for you to understand. There are also legal limitations to those rights that you should be aware of. As your therapist, I have corresponding responsibilities to you. These rights and responsibilities are described in the following sections.

To begin, it should be clearly stated that psychotherapy has both benefits and risks. Risks may include experiencing uncomfortable feelings (e.g. sadness, guilt, anxiety, anger, helplessness, etc.) because the process of psychotherapy often requires discussing the unpleasant aspects of your life. However, psychotherapy has consistently been shown to have benefits for individuals who undertake it. For example, psychotherapy often leads to a significant reduction in feelings of distress, increased satisfaction in interpersonal relationships, greater personal awareness and insight, increased skills for managing stress and resolutions to specific problems. But, there are no guarantees about what will happen.

APPOINTMENTS

Ordinarily, appointments will be 45 to 55 minutes in duration, occurring at a once weekly duration. However, I may suggest changing the frequency of our meetings depending on the goals of the treatment or, for example, during a time of crisis. The time scheduled for your appointment is assigned to you and you alone. If you need to cancel or reschedule a session, I ask that you provide me with 24 hours notice. You may call and leave me a VM 24/7. If you miss a session without canceling, or cancel with less than 24 hour notice, my policy is to collect the full cost of the session. It is important to note that insurance companies do not provide reimbursement for canceled sessions; thus, you will be responsible for the fee as described above. If it is possible, I will try to find another time to reschedule the appointment so that we can maintain the consistency in the therapy. In addition, you are responsible for coming to your session on time; if you are late, your appointment will still need to end on time.

PROFESSIONAL FEES

The standard fee for the initial intake is $275.00 and each subsequent session is $165.00. You are responsible for paying at the time of your session unless prior arrangements have been made. Payment must be made by check, cash, or credit card. Due to the fee's associated with credit card transactions, I prefer payment in other forms. Any checks returned to my office are subject to an additional fee of up to $25.00 to cover the bank fee that I incur. If you refuse to pay your debt, I reserve the right to use an attorney or collection agency to secure payment. In

addition to weekly appointments, it is my practice to charge this amount on a prorated basis (I will break down the hourly cost) for other professional services that you may require such as report writing, telephone conversations that last longer than 15 minutes, attendance at meetings or consultations which you have requested, or the time required to perform any other service which you may request of me. If you anticipate becoming involved in a court case, I recommend that we discuss this fully before you waive your right to confidentiality. If your case requires my participation, you will be expected to pay for the professional time required even if another party compels me to testify.

INSURANCE

In order for us to set realistic treatment goals and priorities, it is important to evaluate what resources you have available to pay for your treatment. If you have a health insurance policy, it will usually provide some coverage for mental health treatment. With your permission, my billing service and I will assist you to the extent possible in filing claims and ascertaining information about your coverage, but you are responsible for knowing your coverage and for letting me know if/when your coverage changes.

Due to the rising costs of health care, insurance benefits have increasingly become more complex. It is sometimes difficult to determine exactly how much mental health coverage is available. Managed Health Care plans such as HMOs and PPOs often require advance authorization, without which they may refuse to provide reimbursement for mental health services. These plans are sometimes limited to short-term treatment approaches designed to work out specific problems that interfere with a person's usual level of functioning. It may be necessary to seek approval for more therapy after a certain number of sessions.
You should also be aware that most insurance companies require you to authorize me to provide them with a clinical diagnosis. (Diagnoses are technical terms that describe the nature of your problems and whether they are short- term or long-term problems. All diagnoses come from a book entitled the DSM-V. There is a copy in my office and I will be glad to let you see it to learn more about your diagnosis, if applicable). Sometimes I have to provide additional clinical information such as treatment plans or summaries, or copies of the entire record (in rare cases). This information will become part of the insurance company files and will probably be stored in a computer. 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 hands. In some cases, they may share the information with a national medical information data bank. By signing this Agreement, you agree that I can provide requested information to your carrier if you plan to pay with insurance.

In addition, if you plan to use your insurance many policies leave a percentage of the fee (which is called co-insurance) or a flat dollar amount (referred to as a co- payment) to be covered by the patient. Either amount is to be paid at the time of the visit by check or cash. In

addition, some insurance companies also have a deductible, which is an out-of-pocket amount, that must be paid by the patient before the insurance companies are willing to begin paying any amount for services. This will typically mean that you will be responsible to pay for initial sessions with me until your deductible has been met; the deductible amount may also need to be met at the start of each calendar year. It is important to remember that you always have the right to pay for my services yourself to avoid the problems described above.

If I am not a participating provider for your insurance plan, I may still be able to provide billing services for you. If needed I will supply you with a receipt of payment for services, which you can submit to your insurance company for reimbursement. Please note that not all insurance companies reimburse for out- of-network providers.

INSURANCE BILLING

The billing specialist I use to assist me in submitting claims to insurers is Holly Kelly. Here is her contact information:

Holly Kelly - Billing Specialist
PO BOX 174
Lake Oswergo, OR 97034

If you choose to use your insurance, I will provide my billing specialist your full name, DOB, insurance carrier ID #, diagnosis and home address, as these are typically the data needed to bill for services rendered. All of this information is provided through secure FAX, thus ensuring the protection of your personal health information (PHI).

PROFESSIONAL RECORDS

I am required to keep appropriate records of the psychological services that I provide. Your records are maintained securely. I keep brief records noting that you were here, your reasons for seeking therapy, the goals and progress we set for treatment, your diagnosis, topics we discussed, your medical, social, and treatment history, records I receive from other providers, copies of records I send to others, and your billing records.

CONFIDENTIALITY

My policies about confidentiality, as well as other information about your privacy rights, are fully described in a separate document entitled Notice of Privacy Practices. You have been provided with a copy of that document and we have discussed those issues. Please remember that you may reopen the conversation at any time during our work together.

PARENTS & MINORS

While privacy in therapy is crucial to successful progress, parental involvement can also be

essential. It is my policy not to provide treatment to a child under age 14 unless s/he agrees that I can share whatever information I consider necessary with a parent. For minors 14 and older, I would recommend that together we come to an agreement about the best approach to what communication, if any, is shared with a parent. All other communication will require the child's agreement, unless I feel there is a safety concern (see also above section on Confidentiality for exceptions), in which case I will make every effort to notify the child of my intention to disclose information ahead of time and make every effort to handle any objections that are raised.

CONTACTING ME

I am often not immediately available by telephone nor do not answer my phone when I am with clients or otherwise unavailable. At these times, you may leave a message on my confidential voicemail and your call will be returned as soon as possible, but it may take a day or two (24-48 hours) for non-urgent matters. If, for any number of unseen reasons, you do not hear from me or I am unable to reach you, and you feel you cannot wait for a return call or if you feel unable to keep yourself safe, by signing this contract you agree to adhere to the following protocol unless another plan is discussed during the course of treatment:

1) Contact either the Multnomah County Crisis Line (503-988-4888), Washington County Crisis Line (503-291-9111) or the Clackamas County Crisis Line (503-655-8585) each are available 24 hours a day;

2) go to the nearest emergency department; or

3) call 911 and ask to speak to the mental health worker on call.

I will make every attempt to inform you in advance of planned absences, and provide you with the name and phone number of the mental health professional covering my practice in the event that I am unavailable/away.

For some matters, such as scheduling and confirming appointment times, I may be available to be contacted via email (ryan@doctorryank.com) or via text (SMS). I take measures to keep these communications private, however neither text nor email are confidential methods of communication. Email is stored on servers outside of my control and, while unlikely, they could potentially be intercepted by someone other than myself. Clinical information should not be sent by email. In addition, my access to email is inconsistent and my responses may take several days. For that reason, any time sensitive matters (particularly that which pertains to your safety) should be address over the phone or by leaving me a voice message.

By signing the end of this document, you are stating that you have been informed of the risks (including the possibility of confidentiality being compromised) associated with transmitting

your protected health information by unsecured means (e.g. via email or text). Furthermore, you are in understanding that by no means are you required to communicate via email or text to receive treatment.

TELEMEDICINE INFORMED CONSENT

1. Using this platform (telelmedicine), I will no longer be able to control the privacy of the physical environment you are in, being that we will be in different locations. Thus, you will be required to make sure the room you are in is private and free of interruptions (e.g. other people, etc). We need to make this mode of communication confidential, which will require efforts on both parties to do so.

2. I may not be able to legally provide this service should you be physically outside the state of Oregon (where my license is issued). Thus, I ask that you remain in the state of Oregon should you desire to meet in this format unless I have a license in the state you are in or are granted one due to emergency declarations (such as in the case of COVID19 for many states).

3. While I will bill your insurance for the session cost, I cannot be certain your insurer will reimburse given that I will be using a different billing code (i.e. a telemedicine code). As such, I ask that you check with your insurer to verify that they cover the costs of telemedicine in an attempt to prevent any surprising billing costs utilizing this format may entail.

4. You agree to have/use a webcam or smartphone during the session. Moreover, it is important to be in a quiet, private space that is free of distractions during the session.

5. You agree to use a secure internet connection rather than public/free Wi-Fi.

6. It is important to be on time. If you need to cancel or change your tele-appointment, I ask that you notify me 24 hours in advance by phone or email.

7. I may determine that due to certain circumstances, telepsychology is no longer appropriate and that we should resume our sessions in-person.

OTHER RIGHTS

If you are unhappy with what is happening in therapy, I hope you will will talk with me so that I can respond to your concerns. Such comments will be taken seriously and handled with care and respect. You may also request that I refer you to another therapist and are free to end therapy at any time.

DOCUMENT 2

OREGON HIPAA NOTICE & LIMITS OF CONFIDENTIALITY

Notice of Policies and Practices to Protect the Privacy of Your Health Information

This describes how psychological and medical information about you may be used, disclosed, and how youcan access this information. This disclosure is, in part, required for compliance with the Health Insurance Portability and Accountability Act (HIPAA) Please review it carefully.

USES & DISCLOSURES FOR TREATMENT, PAYMENT, HEALTH CARE OPERATIONS

I may use or disclose your protected health information (PHI) for treatment, payment and healthcare operations purposes with your consent. To help clarify these terms, here are some definitions:

"PHI" refers to information in your health record that could identify you.

"Treatment," "Payment" and "Health Care Operations" are defined as:

"Treatment" is when I provide, coordinate, or manage your health care and other services related to your health care. One example of treatment would be when I consult with another health care provider, such as your family physician or another mental health provider.

"Payment" is when I obtain reimbursement of my fees for your healthcare. Examples of payment are when I disclose your PHI to your health insurer to obtain reimbursement for your healthcare or to determine your eligibility or coverage.

"Health Care Operations" are activities that relate to the performance and operation of my practice. Examples of Health Care Operations are quality assessment and improvement activities, business related matters such as audits and administrative services, and case management.

"Use" applies to activities within my office, clinic, practice group, etc, such as sharing, employing, applying, utilizing, examining and analyzing information that identifies you.

"Disclosure" applies to activities outside my office, clinic, practice group, etc, such as releasing, transferring, or providing access to information about you or to other parties.

USES AND DISCLOSURES REQUIRING AUTHORIZATION

I may use your PHI, or disclose your PHI, for purposes outside of treatment, payment and health care operations when your appropriate authorization is obtained. An "authorization" is written permission above and beyond the general consent that permits only specific disclosures. In those instances when I am asked for written authorization from you before releasing that information. I will also need to obtain a written authorization before releasing your psychotherapy notes. "Psychotherapy Notes" are notes that I may have made about our discussions during a private, group, joint, or couple's counseling session, which I have kept separate from the rest of your medical record. These notes are given a greater degree of protection than PHI.

At any time, you may revoke all such authorizations (PHI and/or psychotherapy notes) provided each revocation is in writing. You may not revoke an authorization to the extent that (1) I have relied on that authorization; or (2) if the authorization was obtained as a condition of obtaining insurance coverage, as the law provides the insurer with the right to contest the claim under the policy.

USES AND DISCLOSURES WITH NEITHER CONSENT NOR AUTHORIZATION (LIMITS TO CONFIDENTIALITY)

I may use or disclose PHI without your consent in the following circumstances:

Child Abuse Should there be a child abuse investigation, I may or may not be compelled to turn over records relevant to the case. Child abuse may be defined as including physical abuse, neglect, mental injury or emotional maltreatment, sexual abuse or sexual exploitation, and threat to harm a child, which may include exposure to domestic violence.

Elder Abuse If there is report of elder abuse, I may or may not be compelled to turn over your relevant records to the case.

Health Oversight — Should the Oregon State Board of Psychologist Examiners subpoena relevant records from me were I the subject of a complaint.

Judicial Proceedings Should you be involved in a court proceeding there is a request made for information about your evaluation, diagnosis and treatment, this information is privileged under state law and I must not release your information without written authorization by you, by your personal or legally appointed representative, or by a

direct court order. Pleas note that this privilege does not apply if/when you are being evaluated for a third party or where the evaluation is court-ordered. Should this be the case, I will inform you in advance and, whenever possible, I will do my all to avoid any legal involvement.

Serious Threat to Health or Safety — In the most rarest of situations, I reserve the right to disclose confidential information if, in my judgment, I believe this disclosure would be necessary to protect against a clear and substantial risk of imminent serious harm being inflicted by you on yourself or another person.

Worker's Compensation — Should you file a worker's compensation claim, this constitutes authorization for me to release your relevant mental health records to involved parties and officials. This would likely include a past history of complaints or treatment of a condition similar to that in the complaint.

Crimes Against Me — I will report to the police any threat and/or crime by a patient towards me.

Access to Records by Non-Custodial Parents — Both parents have rights to have access to a minor child's chart. This applies if you are not married to the child's other parent, and even if you have sole custody. Only the court can limit the right of non-custodial parents.

PATIENT'S RIGHTS AND PSYCHOLOGIST'S DUTIES

<u>Patient's Rights:</u>

Right to request Restrictions You have the right to request restrictions on certain uses and disclosures of your PHI. However, I am not required to agree to your request for a restriction.

Right to Receive Confidential Communications by Alternative Means and at Alternative Locations You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations (For example, you may not want a family member to know that you are seeing me. Upon your request, I will send your correspondence to another address.)

Right to Inspect and Copy You have the right to inspect or obtain a copy (or both) of PHI and psychotherapy notes in my mental health and billing records as long as the PHI is maintained in the record. I may deny your request in some circumstances, but

in some cases, you may have this decision reviewed. On your request, I will discuss with you the details of the request and denial process.

Right to Amend You may request an amendment to PHI for as long as the PHI is maintained in the record. I may deny your request. On your request, I will discuss with you the details of the amendment process.

Right to an Accounting You generally have the right to receive an accounting of disclosures of PHI for which you have neither provided consent nor authorization (as described in Section III of this Notice). On your request, I will discuss with you the details of the accounting process.

Right to a Paper Copy - You have the right to obtain a paper copy of the notice from me upon request, even if you have agreed to receive the notice electronically.

Psychologist's Duties:

I am required by law to maintain the privacy of PHI and to provide you with this notice of my legal duties and privacy practices with respect to PHI.

I reserve the right to change the privacy policies and practices described in this notice. Unless I notify you of such changes, however, I am required to abide by the terms currently in effect.

If I revise my policies and procedures, I will provide you with a revised notice by mail or at our first meeting following these revisions.

I maintain records for at least 7 years. In the event of serious incapacity or death, I have a designated colleague on file with the Oregon Board of Psychologist Examiners (OBPE) who will maintain and dispose of records as needed.

QUESTIONS AND COMPLAINTS

If you have questions about this notice, disagree with a decision I make about access to your records, or have other concerns about your privacy rights, you may contact me. If you believe that your privacy rights have been violated and wish to file a complaint with my office, you may send your written complaint to me. You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services. I can provide you with the appropriate address upon request. You have specific rights under the Privacy Rule. I will not retaliate against you for exercising your right to file a complaint.

DOCUMENT 3

HAMILTON HOUSE CODE OF CONDUCT

In an effort to provide a safe environment for our patients, the psychotherapists at *Hamilton House*[1] have created a code of conduct requiring visitors, patients and therapists alike to abstain from behaviors deemed disruptive or that may pose a threat to the safety of those on the premises. Most importantly, we strongly desire that every patient have the right to be safe and not threatened while on site, a shared desire that informs the following guidelines:

1. The practitioners at *Hamilton House* adopt a zero tolerance approach to violence and aggression. These kinds of behaviors include threatening and/or abusive language (e.g. cursing or swearing), gestures (including sexual), physical contact and derogatory remarks. Therefore, any behavior that results in hurt, alarm, damage or distress will be addressed immediately and those who are violent or aggressive towards any person will be prohibited from the premises.

2. While conversations in the waiting room are not prohibited, those entering this space are entitled to their privacy and thus we ask that both therapists and patients refrain from inquiries regarding the nature of one's visit.

3. The sale, distribution, solicitation, purchase or consumption of alcoholic beverages, tobacco, marijuana or illegal drugs -- as well as the misuse or abuse of otherwise legally prescribed drugs -- is prohibited on the premises.

4. If you have a companion or service animal, you assume the responsibility for, and any liability of, the behavior of that animal while on the premises.

If you are subjected to any of these behaviors or witness inappropriate behavior, please report to any therapist on site. In an effort to keep *Hamilton House* safe, those who cannot agree and adhere to this policy would be subject to discharge from the practice.

Thank you for your participation in helping to make *Hamilton House* a safe and therapeutic space.

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[1] *Hamilton House refers to the property of 04 SW Hamilton St, Portland, OR 97239, a space leased exclusively to independent mental health practitioners.*

CONSENT TO PSYCHOTHERAPY

Your signature below indicates that you have read, understand and agree to the terms of the three documents listed below:

1) the INFORMED CONSENT FOR TREATMENT / PSYCHOTHERAPY SERVICES;

2) the OREGON HIPAA NOTICE & LIMITS OF CONFIDENTIALITY; and

3) the HAMILTON HOUSE CODE OF CONDUCT

_____

Signature of Patient or Personal Representative

_____

Printed Name of Patient or Personal Representative

_____

Date