



Ellen N. Emerson, Ph.D.

Licensed Psychologist Georgia #2041

112 N. College Street
Statesboro, GA 30458
Phone/Fax: 912.764.3595
ellenemerson@nctv.com
www.ellenemersonphd.com

INFORMED CONSENT

Welcome to my practice. This document contains important information about my professional services and business policies. It also contains summary information about the Health Insurance Portability and Accountability Act (HIPAA), a federal law that provides privacy protections and patient rights with regard to the use and disclosure of your Protected Health Information (PHI) used for the purpose of treatment, payment, and health care operations. HIPAA requires that I provide you with a Notice of Privacy Practices (the Notice) for use and disclosure of PHI for treatment, payment and health care operations. The Notice, which is attached to this Agreement, explains HIPAA and its application to your personal health information in greater detail. The law requires that I obtain your signature acknowledging that I have provided you with this information at the end of this session. Although these documents are long and sometimes complex, it is very important that you read them carefully before our next session. We can discuss any questions you have about the procedures at that time.

PSYCHOLOGICAL SERVICES

Psychotherapy is not easily described in general statements. It varies depending on the personalities of the psychologist and patient, and the particular problems you are experiencing. There are many different methods I may use to deal with the problems that you hope to address, and I will be glad to answer any questions you may have about my treatment approach(s) as those questions arise.

Our first few sessions will involve us jointly evaluating your needs. By the end of the evaluation, I will be able to offer you some first impressions of what our work will include if you decide to continue in therapy 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 or concerns about our work together, it is important that we discuss them whenever they arise.

MEETINGS

Our sessions will run 50 minutes. I have a reciprocal 24-hour cancellation policy, which means that I will charge you for a session if you do not give 24 hours notice of cancellation, or if you do not keep the appointment. If I cancel a session with you with less than 24 hours notice, I will give you a free session to offset the inconvenience to you.

CONTACTING ME

You may leave a confidential message for me at any time by calling (912) 764-3595. I generally return calls within a few hours during business hours (10:00 a.m. – 6:00 p.m., Mon. – Fri.) and the following business day for calls received after hours. Should you have an emergency after hours, please let me know this in your message, as that will let me know to return the call immediately.

PROFESSIONAL RECORDS

You should be aware that, pursuant to HIPAA, I may keep Protected Health Information about you in two sets of professional records. One set constitutes your Clinical Record. It includes information about your reasons for seeking therapy, a description of the ways in which your problem impacts your life, your diagnosis, the goals that we set for treatment, your progress towards those goals, your medical and social history, your treatment history, any past treatment records that I receive from other providers, reports of any professional consultations, your billing records, and any reports that have been sent to anyone, including reports to your insurance carrier. Except in unusual circumstances that

INFORMED CONSENT, Page 2

involve danger to yourself or others or makes reference to another person (unless such other person is a health care provider) and I believe that access is reasonably likely to cause substantial harm to such other person, you or your legal representative may examine and/or receive a copy of your Clinical Record, if you request it in writing. Because these are professional records, they can be misinterpreted and/or upsetting to untrained readers. For this reason, I recommend that you initially review them in my presence, or have them forwarded to another mental health professional so you can discuss the contents. In most situations, I am allowed to charge a reasonable fee for copying and for certain other expenses. The exceptions to this policy are contained in the attached Notice Form. If I refuse your request for access to your records, you have a right of review (except for information provided to me confidentially by others) which I will discuss with you upon request.

In addition, I may also keep a set of Psychotherapy Notes. These Notes are for my own use and are designed to assist me in providing you with the best treatment. My Psychotherapy Notes may include notes about our sessions, as well as sensitive information you or others may give to me, that is not legally required to be included in your medical record. These Psychotherapy Notes are kept separate from your medical record. Your Psychotherapy Notes are not available to you and cannot be sent to anyone else, including insurance companies without your written, signed Authorization. Insurance companies cannot require your authorization as a condition of coverage nor penalize you in any way for your refusal to provide it.

PATIENT RIGHTS

HIPAA provides you with several new or expanded rights with regard to your Clinical Record and disclosures of protected health information. These rights include requesting that I amend your record; requesting restrictions on what information from your Clinical Record is disclosed to others; requesting an accounting of most disclosures of protected health information that you have neither consented to nor authorized; determining the location to which protected information disclosures are sent; having any complaints you make about my policies and procedures recorded in your records; and the right to a paper copy of this Agreement, the attached Notice form, and my privacy policies and procedures. I am happy to discuss any of these rights with you.

MINORS & PARENTS

Patients under 18 years of age who are not emancipated and their parents should be aware that the law allows parents to examine their child's treatment records unless I believe that doing so would endanger the child or we agree otherwise. Because privacy in psychotherapy is often crucial to successful progress, particularly with teenagers, it is my policy to request an agreement from parents that they consent to give up their access to their child's records. If they agree, during treatment, I will provide them only with general information about the progress of the child's treatment, and his/her attendance at scheduled sessions. I will also provide parents with a summary of their child's treatment when it is complete. Any other communication will require the child's Authorization, unless I feel that the child is in danger or is a danger to someone else, in which case, I will notify the parents of my concern. Before giving parents any information, I will discuss the matter with the child, if possible, and do my best to handle any objections he/she may have.

INSURANCE REIMBURSEMENT

I participate in several insurance plans, and will be glad to file insurance claims for you. If you have a PPO or fee for service health insurance plan with which I am not affiliated and it provides mental health coverage for you, it

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INFORMED CONSENT, Page 3

will generally pay a portion of my fee. **However, please understand that you, not your insurance company, are ultimately responsible for the payment of my fees.** It is very important that you find out exactly what mental health services your insurance policy covers. You should carefully read the section in your insurance coverage booklet that describes mental health services. If you have questions about the coverage, call your plan administrator.

You should be aware that your contract with your health insurance company requires that I provide it with information relevant to the services that I provide to you. I am required to provide a clinical diagnosis. Sometimes I am required to provide additional clinical information such as treatment plans or summaries, or copies of your entire Clinical Record. In such situations, I will make every effort to release only the minimum information about you that is necessary for the purpose requested. 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 databank. I will provide you with a copy of any report I submit, if you request it.

By signing this Agreement, you agree that I can provide requested information to your carrier.

Your signature below indicates that you have read, understand, and agree to the terms of this document, and that you have been given a copy of the Notice of Psychologist's Policies & Practices to Protect the Privacy of Your Health Information.

Signature of Client(s) or Legal Representative

Date

Relationship to Client

Witness

Date