CABOT psychological services

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This document is an inclusive document consenting to various aspects of your treatment at Cabot Psychological Services (Cabot). Please carefully read and initial after each section, if you consent. Your signature at the end indicates that you have read and agree to every section in this document. Please speak to your therapist or staff at Cabot if you have any questions.

Consent to Treatment

I acknowledge that I have received, have read (or have had read to me), and understand the "Information for Clients" brochure and/or other information about the therapy I am considering. I have had all my questions answered fully.

I do hereby seek and consent to take part in the treatment by the therapist named below. I understand that developing a treatment plan with this therapist and regularly reviewing our work toward meeting the treatment goals are in my best interest. I agree to play an active role in this process.
I understand that no promises have been made to me as to the results of treatment or of any procedures provided by this therapist.
I am aware that I may stop my treatment with this therapist at any time. The only thing I will still be responsible for is paying for the services I have already received. I understand that I may lose other services or may have to deal with other problems if I stop treatment. (For example, if my treatment has been court-ordered, I will have to answer to the court.)
I know that I **must cancel an appointment at least 24 hours (1 day) before the time** of the appointment. If I do not cancel and do not show up, I will be charged a fee of $100 for that missed appointment. This fee is not covered by insurance.
I am aware that an agent of my insurance company or other third-party payer may be given information about the type(s), cost(s), date(s), and providers of any services or treatments I receive. I understand that if payment for the services I receive here is not made, the therapist may stop my treatment.

My initials here show that I understand and agree with all of the statements in the preceding section: ____

Consent to Use and Disclose Your Health Information

This form is an agreement between you and your therapist. When we examine, test, diagnose, treat, or refer you, we will be collecting what the law calls "protected health information" (PHI) about you. We need to use this information in our office to decide on what treatment is best for you and to provide treatment to you. We may also share this information with others to arrange payment for your treatment, to help carry out certain business or government functions, or to help provide other treatment to you. By signing this form, you are also agreeing to let us use your PHI and to send it to others for the purposes described above. Your signature below acknowledges that you have read or heard our notice of privacy practices, which explains in more detail what your rights are and how we can use and share your information.

If you do not sign this form agreeing to our privacy practices, we cannot treat you. In the future, we may change how we use and share your information, and so we may change our notice of privacy practices. If we do change it, we will contact you.

If you are concerned about your PHI, you have the right to ask us not to use or share some of it for treatment, payment, or administrative purposes. You will have to tell us what you want in writing. Although we will try to respect your wishes, we are not required to accept these limitations. However, if we do agree, we promise to do as you asked. After you have signed this consent, you have the right to revoke it by writing to us. We will then stop using or sharing your PHI, but we may already have used or shared some of it, and we cannot change that.

My initials here show that I understand and agree with all of the statements in the preceding section: ____

Agreement to Pay for Professional Services

I request that my therapist at Cabot provide professional services to me, and I agree to pay this therapist's fee of $175 per session ($250 for intake interview) for these services, or ensure that my insurance company is providing appropriate reimbursement for services rendered.

I agree that my financial relationship with this therapist will continue as long as the therapist provides services or until I inform them, in person or by writing, that I wish to end it. I agree to meet with this therapist at least once before stopping therapy. I agree to pay for services provided to me up until the time I end the relationship.

I agree that I am responsible for the charges for services provided by this therapist to me, although other persons or insurance companies may make payments on my account.

My initials here show that I understand and agree with all of the statements in the preceding section: ____

Credit Card Payment Consent Form

Cabot Psychological Services, PLLC (CPS) requires all clients to have a valid credit card on file prior to any sessions being held.

We require your credit card information for several reasons:

1. If you miss more than one appointment without calling 24 hours in advance, we charge your card the missed appointment fee of $100.00 (plus fees). This fee cannot be submitted to insurance.
2. In the event that you have an outstanding balance past 90 days, we will notify you via phone call and/or email that your card will be charged for the outstanding balance if you do not call to make partial or full arrangements for payment.
3. If you have co-pays or are paying out-of-pocket, we can keep your credit card information on file and charge it at the time of each session. This is optional.

As part of this service, our credit card providers charge CPS a service fee on each transaction. This additional fee is passed on to you as part of the payment and is covered by this signed consent form. The

2013 Minnesota Statutes related to credit card fees are printed on the back of this document. CPS does not generate any profit from the charging of this fee.

The per-charge fee is as follows:

- **3.15% + 15¢**

No fee is charged for clients who wish to pay off their balance in cash or via standard check.

I authorize CPS to keep my signature on file and to charge my Visa, Mastercard, American Express or Discover account for recurring charges of $100.00 (plus fees) for any missed appointment in which I have not called 24 hours in advance to cancel and for any outstanding balances past 90 days. I realize I will only be charged for outstanding balances past 90 days if I have not made any payment arrangements with the billing department.

I understand this form is valid unless I cancel the authorization in writing. I promise not to dispute charges ("charge back") for sessions I have received or that I have not cancelled 24 hours prior to a scheduled session. I further authorize CPS to disclose information about my attendance/cancellation to my credit card issuer if I dispute the charge.

If you have any questions, please consult with your clinician prior to signing this document.

My initials here show that I understand and agree with all of the statements in the preceding section: ____

Electronic Records Disclosure

"Policymakers in Minnesota have recognized that more effective use of health information technology, including timely exchange of information, is needed to improve quality and safety of care as well as to help control costs. In 2007, Minnesota enacted legislation that requires all health care providers in the state to implement an interoperable electronic EHR system by January 1, 2015 (Minn. Stat. §62J.495)." From the Minnesota State website

In keeping with the above mandate, Cabot Psychological Services (CABOT) keeps and stores records for each client in a record-keeping system produced and maintained by SimplePractice. This system is "cloud-based," meaning the records are stored on servers which are connected to the Internet. Here are the ways in which the security of these records is maintained:

- CABOT has entered into a HIPAA Business Associate Agreement with SimplePractice. Because of this agreement, SimplePractice is obligated by federal law to protect these records from unauthorized use or disclosure.
- The computers on which these records are stored are kept in secure data centers, where various physical security measures are used to maintain the protection of the computers from physical access by unauthorized persons.
- SimplePractice employs various technical security measures to maintain the protection of these records from unauthorized use or disclosure.
    - With data security and fill HIPAA compliance as top priorities, the team at SimplePractice partnered with cloud services provider, 7 Medical Systems, to host SimplePractice on HIPAA compliant, SSAE16 audited servers.
- CABOT has its own security measures for protecting the devices that we use to access these records:

- On computers, we employ firewalls, antivirus software, passwords, and disk encryption to protect the computer from unauthorized access and thus to protect the records from unauthorized access.

Here are things to keep in mind about CABOT's record-keeping system:

- While CABOT's record-keeping company and CABOT both use security measures to protect these records, their security cannot be guaranteed.
- Some workforce members at SimplePractice, such as engineers or administrators, may have the ability to access these records for the purpose of maintaining the system itself. As a HIPAA Business Associate, SimplePractice is obligated by law to train their staff on the proper maintenance of confidential records and to prevent misuse or unauthorized disclosure of these records. This protection cannot be guaranteed, however.
- CABOT's record-keeping company keeps a log of our transactions with the system for various purposes, including maintaining the integrity of the records and allowing for security audits. These transactions are kept for six years.

I understand that CABOT will be storing some of my personal health information (PHI) on a cloud-based system, maintained by SimplePractice EHR. I understand the advantages and potential risks associated with this system, and I have been given an opportunity to ask any questions about the process and system. I authorize CABOT to use this system to keep and store my health record.

My initials here show that I understand and agree with all of the statements in the preceding section: ____

Authorization to Electronically Communicate Protected Health Information

By filling out the below form, you are authorizing Cabot Psychological Services, PLLC (CPS) to send you future correspondence regarding your treatment via email or text. Your authorization does not obligate CPS to communicate by email/text or cease non-electronic communication.

Authorize email/text communication:

- ☐ I authorize the CPS staff to email/text me regarding the course of my treatment, billing, scheduling and any other related issues.

Patient's email address (please print): _____

Patient's text number (please print): _____

Discontinue email or text communication

- ☐ I no longer wish to communicate via email.
- ☐ I no longer with to communicate via text.

By signing this document, agree to the following:

- I understand that any email/text transmission between my provider and me/the patient will become part of my medical record. These email/text transmissions may be disclosed in accordance with future authorizations.
- I understand that I have the right to revoke this authorization at any time by indicating so above. If I want to revoke this authorization, I must do so in writing and address it to the entity that I had previously authorized to disclose my information. I understand that if I

revoke this authorization, it will not apply to any information already released as a result of this authorization.

- I understand that this authorization is voluntary and that I may refuse to sign it. I also understand that the institutions or individuals named above cannot deny or refuse to provide treatment if I refuse to sign this authorization.
- I understand that, once information is disclosed pursuant to this authorization, it is possible that it could be disclosed by the entity that receives it for authorized purposes under the HIPAA privacy rule.

Alert for Electronic Communication
Patients and/or personal representatives who want to communicate with their health care providers by email/text should consider all of the following issues before signing an authorization to Electronically Communicate Protected Health Information:

1. Email/text at CPS can be forwarded, intercepted, printed and stored by others.
2. Email/text communication is a convenience and is not appropriate for emergencies or time-sensitive issues**.**
3. Highly sensitive or personal information should only be communicated by email/text at the patient's discretion (i.e., HIV status, mental illness, chemical dependency, and workers compensation claims).
4. Employers generally have the right to access any email received or sent by a person at work.
5. Staff other than the health care provider may read and process email/text.
6. Clinically relevant messages and responses will be documented in the medical record at the provider's discretion.
7. Communication guidelines must be defined between the clinician and the patient, including (1) how often email/text will be checked, (2) instructions for when and how to escalate to phone calls and office visits, and (3) types of transactions that are appropriate for email/text.
8. Email message content must include (1) the subject of the message in the subject line (i.e., prescription refill, appointment request, etc.) and (2) clear patient identification such as patient name in the body of the message.
9. CPS will not be liable for information lost or misdirected due to technical errors or failures.

I have read and understand that email/text messages may include protected health information about me/the patient, whenever necessary.

My initials here show that I understand and agree with all of the statements in the preceding section: ____

My signature below shows that I understand and agree with all of the statements in this document.

_____
Signature of client (or person acting for client) Date

_____
Printed name Relationship to client (if necessary)