Vorpahl Psychology Associates, LLC
258 Main Street, Suite 7
Medfield, MA 02052
Tel:508-242-9666
Fax:815-572-8941
vpa-psychologist.com

PSYCHOTHERAPY AGREEMENT

Welcome to Vorpahl Psychology Associates (VPA). This document (the Agreement) contains important information about our professional services and business policies. It also contains summary information about the Health Insurance Portability and Accountability Act (HIPAA), a federal law that provides new privacy protections and new 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 VPA provides 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, and our practice is in general accordance with HIPAA policies. The law requires that VPA obtains your signature acknowledging that we have provided you with this information prior to commencement of treatment.

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. When you sign this document, it will also represent an agreement between us. You may revoke this Agreement in writing at any time. That revocation will be binding unless VPA has taken action in reliance on it or if you have not satisfied any financial obligations you have incurred.

PSYCHOLOGICAL SERVICES

Therapy is a relationship between people that works in part because of the clearly defined rights and responsibilities held by each person. This frame helps to create the safety to take risks and the support to become empowered to create change. As a client in psychotherapy, you have certain rights and responsibilities that are important for you to know about. There are also legal limitations to those rights that you should be aware of. VPA, as your therapist, has corresponding responsibilities to you. These respective rights are described in the following section.

Psychotherapy has both benefits and risks. Risks sometimes include experiencing uncomfortable feelings, such as sadness, guilt, anxiety, anger, frustration, loneliness and helplessness. Psychotherapy often requires discussing unpleasant aspects of your life. However, psychotherapy has been shown to have benefits for individuals who undertake it. Therapy 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. Psychotherapy requires a very active effort on

your part. In order to be most successful, you will have to work on things that we discuss outside of sessions.

The first few sessions will involve a comprehensive evaluation of your needs. By the end of the evaluation, VPA will be able to offer you some initial impressions of what our work may include. At that point, we will discuss your treatment goals and create a personalized, initial treatment plan, if you decide to continue. You should evaluate this information as well as your own assessment about whether you feel comfortable working with us. 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 our procedures, we should discuss them whenever they arise.

APPOINTMENTS

VPA normally conduct an evaluation that will last from 2 to 4 sessions. During this time, we can both decide if VPA can provide the services you need in order to meet your treatment goals. Once psychotherapy begins, VPA will usually schedule one 45-minute session (one appointment hour of 45 minutes duration) per week at a time we agree on, although some sessions may be longer or more frequent.

CANCELLATION

Psychological services are most effective when meeting times are regular and consistent. The time scheduled for your appointment is assigned to you and you alone. **If you need to cancel or reschedule a session, it is required that you provide more than 24 hours notice. If you miss a session without canceling, or cancel with less than 24 hours notice, you must pay $165 for the missed session.** It is important to note that insurance companies do not provide reimbursement for canceled sessions. In addition, you are responsible for coming to your session on time and at the time scheduled. If you are late, your appointment will still need to end on time.

FEES, BILLING, AND PAYMENT

Psychotherapy sessions are 45 minutes and billed at $200 per session (initial sessions are $250). Session fees or insurance co-pays are payable at time of service unless alternative arrangements have been made. Fees may be reevaluated periodically. **You will be responsible for paying the entire fee if your insurance fails to authorize units of service or if no units of service are available to you. Moreover, legal fees ($250 per hour of service provided) are not billable to insurance companies and will be charged to the patient directly (eg. court evaluations, court appearances).** Should a balance accrue and no payment is received, VPA reserves the right to seek remuneration by any means legally possible including, but not limited to, the retention of a collection agency.

INSURANCE

VPA accepts payments directly from insurance companies for whom we are participating providers (check with provider in regards to your insurance plan).

PROFESSIONAL RECORDS

VPA is required to keep appropriate records of the psychological services provided to you. Although psychotherapy often includes discussions of sensitive and private information, normally very brief records are kept noting that you have been here, what was done in session, and a mention of the topics discussed. You have the right to a copy of your file at any time. You have the right to request that a copy of your file be made available to any other health care provider at your written request. Your records are maintained in a secure location in the office.

CONTACTING VPA

VPA clinicians are often not immediately available by telephone. While VPA clinicians are usually in the office during normal business hours, they do not answer the phone when they are with a client. If you need to reach any of us between sessions, or in an emergency, you have the right to a timely response. You may leave a message on VPA confidential voicemail. Each VPA clinician indicates days and times they are in the office on their voicemail. An emergency number will be provided on the voicemail. VPA clinicians check their voicemail for messages for the last time at 5:00 PM.

OTHER RIGHTS

If you are unhappy with what is happening in therapy, VPA hopes you'll talk with us so that we can respond to your concerns. Such criticism will be taken seriously and with care and respect. You may also request that VPA refers you to another therapist and you are free to end therapy at any time.

You have the right to considerate, safe, and respectful care, without discrimination as to race, ethnicity, color, gender, sexual orientation, age, religion, national origin, or source of payment. You have the right to ask questions about any aspect of the therapy and about your VPA clinician's specific training and experience.

CONSENT TO PSYCHOTHERAPY

Your signature below indicates that you have read this Psychotherapy Agreement and agree to its terms.

Name (print)_____________________________________ Date__________________

Signature_______________________________________ Date of Birth___________

When patient is a minor, or is unable to give consent, the signature of a parent, guardian, or other representative is required.

Signature of Representative_________________________ Date___________________

Name (print) __________________________Relationship to Patient________________

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NOTICE OF PRIVACY POLICIES TO PROTECT THE PRIVACY OF YOUR HEALTH INFORMATION

REVISED 9/16/2013

This notice describes how psychological and medical information about you may be used and disclosed and how you can get access to this information.

Please read it carefully!

I. Uses and Disclosures for Treatment, Payment and Health Care Operations

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

- "PHI" refers to information in your chart that could identify you.
- *"Treatment, Payment and Health Care Operations"*

  Treatment is when we provide, coordinate or manage your health care and other services related to your health care. An example of treatment would be when we consult with another health care provider, such as your PCP or another therapist.

  Payment is when we obtain reimbursement for your healthcare. Examples of payment are when we disclose your PHI to your health insurer to obtain reimbursement for your health care or to determine eligibility or coverage.

  Health Care Operations are activities that relate to the performance and operation of our practice. Examples of health care operations are quality assessment and improvement activities, business-related matters, such as audits and administrative services, and case management and case coordination.

  Use applies to activities within our practice, such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.

  Disclosure applies to activities outside of our practice, such as releasing, transferring, or providing access to information about you to other parties.

II. Uses and Disclosures Requiring Authorization

We may use or disclose 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 we are asked for information for purposes outside of treatment, payment and health care operations, we will obtain an authorization from you before releasing this information. We will also need to obtain an authorization before releasing your psychotherapy notes. "*Psychotherapy notes*" are notes we have made about our conversation during a private, group, joint, or family counseling session, which we have kept separate from the rest of your chart. These notes are given a greater degree of protection than PHI. It is VPA's policy not to keep separate psychotherapy notes. All documentation we keep is a part of your clinical chart.

We will also obtain an authorization from you before using or disclosing PHI in a way that has not been described in this notice.

We will not use your PHI for marketing or sales purposes under any conditions.

III. Uses and Disclosures with Neither Consent nor Authorization

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

- **Child Abuse:** If any of the clinicians at VPA, in their professional capacity, have reasonable cause to believe that a minor child is suffering physical or emotional injury resulting from abuse inflicted upon him or her which causes harm or substantial risk or harm to the child's health or welfare (including sexual abuse), or from neglect, including malnutrition, they must immediately report such a condition to the Massachusetts Department of Children and Families.

- **Adult and Domestic Abuse:** If any of the clinicians at VPA have reasonable cause to believe that an elderly person (age 60 or older) is suffering or has died as a result of abuse, they must immediately make a report to the Massachusetts Department of Elder Affairs.

- **Health Oversight:** The Board of Registration that applies to our particular license to practice has the power, when necessary, to subpoena relevant records should we be the focus of an inquiry.

- **Judicial or Administrative Proceedings:** If you are involved in a court proceeding and a request is made for information about your diagnosis and treatment and the records thereof, such information is privileged under state law and we will not release information without written authorization from you or your legally-appointed representative, or a court order. The privilege does not apply when you are being evaluated for a third party or where the court evaluation is court ordered. You will be informed in this case.

- **Serious Threat to Health or Safety:** If you communicate to any of the clinicians at VPA an explicit threat to kill or inflict serious bodily injury upon an identified person and you have the apparent intent and ability to carry out the threat, they must take reasonable precautions. Reasonable precautions may include warning the potential victim, notifying law enforcement, or arranging for your hospitalization. They must also do so if they know you to have a history of physical violence and they believe there is a clear and present danger that you will attempt to kill or inflict bodily injury upon an identified person.

Furthermore, if you present a clear and present danger to yourself and refuse to accept further appropriate treatment and they have a reasonable basis to believe that you can be committed to a hospital, they must seek said commitment and may contact members of your family or other individuals if it would assist in protecting you.

- **Workers Compensation:** If you file a worker's compensation claim, your records relevant to that claim will not be confidential to entities such as your employer, the insurer and the Division or Worker's Compensation.

When the use and disclosure without your consent or authorization is allowed under sections of Section 164.512 of the Privacy Rule and the state's confidentiality law, this includes certain narrowly defined disclosures to law enforcement agencies, to a health oversight agency (such as HHS or a state department of health), to a coroner or medical examiner, for public health purposes relating to disease or FDA-regulated products, or for specialized government functions such as fitness for military duties, eligibility for VA benefits, and national security and intelligence.

IV. Patient's Rights and Mental Health Clinician's Duties

Patient's Rights:

- **Right to Request Restrictions:** You have the right to request restrictions on certain uses and disclosures of protected health information about you. However, we are not required to agree to a restriction you request.

- **Right to Receive Confidential Communications by Alternative Means and 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 us. Upon your request, we will send your bills to another address). This request must be made in writing.

- **Right to Inspect and Copy:** You have the right to inspect or obtain a copy (or both) of PHI in our mental health and billing records used to make decisions about you for as long as the PHI is maintained in the record. We may deny your access to PHI under certain circumstances, but in some cases, you may have the decision reviewed. On your written request, we will discuss with you the details of the amendment process.

- **Right to Amend:** You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. We may deny your request. On your written request, we 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 written request, we 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 us upon written request, even if you have agreed to receive the notice electronically.

- **Right to Restrict Disclosures When You Have Paid for Your Care Out-of-Pocket:** You have the right to restrict certain disclosures of PHI to a health plan when you pay out-of-pocket or in full for our services.
- **Right to Be Notified if There is a Breach of Your Unsecured PHI:** You have a right to be notified if: (a) there is a breach (a use or disclosure of your PHI in violation of the HIPAA Privacy Rule) involving your PHI; (b) that PHI has not been encrypted to government standards; and (c) my risk assessment fails to determine that there is a low probability that your PHI has been compromised.

Mental Health Clinician's Duties:

- We are required by law to maintain the privacy of PHI and to provide you with a notice of my legal duties and privacy practices with respect to PHI.
- We reserve the right to change the privacy policies and practices described in the notice. Unless we notify you of such changes, however, we are required to abide by the terms currently in effect. If we revise our policies and procedures, we will notify current clients and post the new policies in the waiting area.

V. Complaints

If you are concerned that we have violated your privacy rights, or you disagree with a decision we made about access to your records, you may contact our Privacy Officer: Kai Vorpahl at 508.333.4300. You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services. The person listed above can provide you with the appropriate address upon request.

VI. Effective Date and Changes to Privacy Policy

This notice will go into effect September 23, 2013. We reserve the right to change the terms of this notice and to make the new notice provisions effective for all PHI that we maintain. we will notify current clients of changes in person or by mail and closed client cases can, if interested, call and ask if our policies have changed and obtain a copy by mail or view one in our waiting area.

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Acknowledgement of Receipt of Privacy Notice and
Vorpahl Psychology Associates Policies and Procedures

Federal law requires that all patients be given a copy of the privacy notice. The Privacy Notice describes in detail how patient health information is used and shared with others. All reasonable efforts will be made to protect the privacy of patient health information, whether it is maintained on paper or electronically, and regardless of how it is communicated, for example by e-mail or facsimile mail.

I have been given a copy of the Privacy Notice.
Name (print)_____________________________________ Date__________________

Signature_______________________________________ Date of Birth___________

When patient is a minor, or is unable to give consent, the signature of a parent, guardian, or other representative is required.

Signature of Representative_________________________ Date___________________

Name (print) ___________________________Relationship to Patient________________

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CONSENT TO USE AND DISCLOSE YOUR HEALTH INFORMATION

SIGNATURE PAGE

This form is an agreement between you ___________________________ and Vorpahl Psychology Associates, LLC. When we use the word "you" below it will mean your child, relative, or other person if you have written his name here.

When we examine, 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 here to decide on what treatment is best for you and to provide treatment to you. We may also share this information with others who provide treatment to you or need it to arrange payment for your treatment or for other business or government functions.

By signing this form you are agreeing that you have read and understand our Notice of Privacy Policies and you are agreeing to let us use your information here and send it to others in accordance with our written policies. Please make sure you have read and understand our Privacy Policies above before signing this Consent form.

If you do not sign this consent form agreeing to what is in our Notice of Privacy Policies, we cannot treat you.

In the future we may change how we use and share your information and so may change our Notice of Privacy Policies. If we do change it, you can get a copy from our website: www.vpa-psychologist.com, or by calling us at 508.498.9667, or from our privacy officer, Kai Vorpahl.

If you are concerned about some of your information, you have the right to ask us not to use or share some of your information 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 agree to these limitations. However, if we do agree, we promise to comply with your wish.

After you have signed this consent, you have the right to revoke it (by writing a letter telling us you no longer consent) and we will comply with your wishes about using or sharing your information from that time on but we may already have used or shared some of your information and cannot change that.

____ ____

Signature of client or personal representative | Printed name of client or personal representative

____ ____

Date of Signature | Date NPP received by client or representative

Jacqueline M Vorpahl, PhD
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drvorpahl@yahoo.com

Request/Authorization for Release of Confidential Records and/or Information

This forms allows your clinician to communicate with other key professionals. I hereby authorize:

Name/Facility: ____

Address: ____

Phone number: ____

Email Address: ____

To **obtain/release** (circle one or both) the records/information about:

If you circle obtain, VPA can receive information about the patient named below. If you circle release, then VPA can release information to the person named above. If you circle both, then both parties can release and discuss information about the patient named below.

Patient Name: ______________________________ **Date of Birth:** _______________

To the provider, ______________________, at Vorpahl Psychology Associates for the purpose(s) of:

_____ Further mental health evaluation, treatment, or care

_____ Treatment Planning and coordination of care

_____ Education planning

_____ Other: ____

Information should be sent to the postal address/fax/email/phone number in the letterhead at the top of this form

I have had it explained to me and fully understand that this request/authorization to release records and information, including the entire nature of the records, their content, and the consequences and implications of their release. This request is entirely voluntary on my part. I understand that I may rescind this consent at any time within 90 days, except to the extent that action based on this consent has already been taken.

____ ____________________________
Signature of patient/parent/guardian/representative Date

____
Printed name of signatory above/Relationship to patient

Vorpahl Psychology Associates, LLC
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Initial Child Evaluation Questionnaire

Today's Date:

Name of Patient:
Age of Patient:

Parents Names:
Parents Home & Cellular phone:
Parents Email:
Parents Marital Status:

Emergency Contact Person (and responsible person for child):
Name:

Relationship to child:
Address:

Their home phone number:
Their work phone number:
Their cell phone number

Primary Care Physician's Name, Address, and Phone :

Do you wish to have your child's primary care physician contacted or involved in your child's mental health treatment? See Release Form and Complete.

How did you learn about or get referred to VPA?

I. Presenting Problem

Please describe the key problems for which you are currently seeking treatment for your child, and when they began. Please feel free to note situations that are difficult for your child, as well as problematic stressors, moods, thoughts, and behaviors.

II. Environment

With whom does the child currently live with?

Who are the most emotionally supportive people in his/her life?

How would you describe his/her friendship network? Does he/she have friends they feel close to?

What are typical things your child does for pleasure or enjoyment, and how often? What is child most interested in?

Are there any other environmental factors that contribute to your child's difficulties (e.g., divorce, recent move, financial difficulties, illness)?

Name of child's school:
Child's Grade/Teacher:
Does your child like school?

Is your child content with his/her academic performance? Are you?

Does your child have an IEP or 504?
Has your child repeated a grade or had academic difficulty? Please explain.

Does your child have any social problems at school? Please explain.

Please describe your child's strengths:

Please note immediate family members (parents, stepparents, guardians, children, siblings, parents, in laws, etc.) using the categories below:

Name:	*Relationship to child:*	*Age:*	*Where do they live?*

III. Medical History

Please describe your child's current physical health:

Please describe any significant past medical problems and treatments (e.g., surgeries, head injury, recent strep):

Does your child exercise? How often and what kind of exercise?

Describe your child's eating habits and diet.

Please list any psychiatric and nonpsychiatric medications your child is currently taking using the categories below:

Psychiatric:

Medication	*Dosage*	*Reason for taking the medication (e.g., antidepressant)*

Nonpsychiatric:

Medication	*Dosage*	*Reason for taking the medication (e.g., blood pressure)*

Who currently prescribes your child's psychiatric medications?

Your prescriber's office address and phone number:

Please let me know if you would like me to consult with your child's medication prescriber at any point in treatment. See Release Form and Complete.

IV. Mental Health Treatment History

Please describe your child's past experiences in outpatient treatment using the categories below:

Therapist or counselor	*Dates of treatment (start – end dates)*	*Approx. # of sessions*	*Type of treatment (individual, etc.)*	*Reasons for seeking treatment*

Please describe your child's past experiences in inpatient or day hospital programs:

Facility/program	*Dates of treatment (start – end dates)*	*Type of program*	*Reasons for seeking treatment*

Does anyone in your family struggle with mental illness? If so, please describe.

V. History of Suicidal Feelings

Many people think about suicide on occasion. Has your child had times in his/her life when they were thinking a lot about suicide? If so, please briefly describe when, what seemed to be triggering the thoughts, and whether a suicide attempt or a suicidal gesture was made.

VI. Other Symptoms

Below is a list behaviors and issues that are cause for concern to some children. Please place an "×" or a "✓" next to any and all items that you think might apply to your child. At the end of the list there is space to enter any additional issues or concerns that you might have.

- ☐ Aggression/violence
- ☐ Physical abuse
- ☐ Sexual abuse
- ☐ Argues, talks back
- ☐ Anxiety/panic
- ☐ Bullies, intimidates others
- ☐ Inflicts pain on others
- ☐ Suicidal thoughts/gestures
- ☐ Bossy, provokes others
- ☐ Relationship problems
- ☐ Difficulty at school
- ☐ Cheats
- ☐ Fire Setting
- ☐ Homicidal thoughts/gestures
- ☐ Sadness/depression
- ☐ Loss of appetite
- ☐ Sleep difficulty
- ☐ Attention/concentration
- ☐ Overeating
- ☐ Weight gain/loss
- ☐ Eating disorder
- ☐ Excessive worry
- ☐ Difficulty trusting others
- ☐ Low self-esteem
- ☐ Physical pain/discomfort
- ☐ Medical issues
- ☐ Complains
- ☐ Lack of joy/satisfaction in life
- ☐ Social withdrawal/isolation
- ☐ Stress
- ☐ Loneliness
- ☐ Feeling disorganized
- ☐ Problems with teachers
- ☐ Parent's New Relationship Difficulties
- ☐ Conflict with Parents
- ☐ Persistent Rule Breaking
- ☐ Prescription drugs
- ☐ Substance Use Alcohol/Drugs
- ☐ Restlessness/fidgety
- ☐ Negativity
- ☐ Difficulty forgiving
- ☐ Nightmares
- ☐ Homework Issues
- ☐ Feeling tired/fatigued
- ☐ Hopelessness
- ☐ Easily distracted
- ☐ Anger
- ☐ Self-injury (cutting, burning, scratching, pulling out hair)
- ☐ Hyperactivity
- ☐ Guilt
- ☐ Obsessive thoughts/fears
- ☐ Chronic headache
- ☐ Difficulty making decisions
- ☐ Poor judgment
- ☐ Overly concerned about what other people think
- ☐ Irritability
- ☐ Trouble with authority
- ☐ Developmental Delays
- ☐ Disrupts Family activities
- ☐ Mood swings
- ☐ Overly sensitive, cries easily
- ☐ Frequent conflicts with others
- ☐ Difficulty accepting/making changes
- ☐ Risky/dangerous behavior

- ☐ Few friends
- ☐ Smoking
- ☐ Inappropriate/uncomfortable sexual thoughts/urges
- ☐ Cruelty/neglect of pets
- ☐ Immature
- ☐ Codependency (parent's substance abuse)
- ☐ Confusion with Sexual Identity
- ☐ Feeling spacey/detached from one's surroundings
- ☐ Crying spells
- ☐ Rocking/Repetitive movements
- ☐ Feeling empty/dissatisfied
- ☐ Feeling like a failure
- ☐ Body image
- ☐ Low frustration tolerance
- ☐ Phobias (germs, heights, confined places, etc.)
- ☐ Loss/grief due to death
- ☐ Impulsiveness
- ☐ Compulsive behaviors (hand-washing, checking, etc.)
- ☐ Need for high degree of supervision
- ☐ Feelings of inferiority
- ☐ Trouble taking responsibility
- ☐ Menstrual problems, PMS, menopause
- ☐ Lack of motivation
- ☐ Wetting/Soiling
- ☐ Perfectionism
- ☐ Religion/spirituality
- ☐ Bad temper/tantrums
- ☐ Self-control
- ☐ Procrastination
- ☐ Hallucinations

Please take a moment and review the issues or problems you have noted on this questionnaire. Which three items are you most concerned about. In other words, which three concerns would you most like to have addressed in your treatment?

1.

2.

3.

VIII. Psychosocial and Developmental History

Was the birth typical? Any distress? Premature?

Where was your child born and raised? Have you moved?

Did your child have any developmental delays (language, motor skills, social/emotional attachment)?

How does your child separate from you (at school, for a play date, etc)?

Was your child sexually, physically, or emotionally abused at any point in his/her life?

Has your child or family had any other significant life changing events or traumas that affected your child either negatively or positively?

IX. Other Things I Should Know

Please describe anything else that is important for us to know about your child or your family.

Thank you for completing this Questionnaire. It will be very helpful in developing an organized and effective treatment plan.