

LIMITS OF CONFIDENTIALITY

Contents of all therapy sessions are considered to be confidential. Both verbal information and written records about a client cannot be shared with another party without the written consent of the client or the client's legal guardian. Noted exceptions are as follows:

Duty to Warn and Protect

When a client discloses intentions or a plan to harm another person, the mental health professional is required to warn the intended victim and report this information to legal authorities. In cases in which the client discloses or implies a plan for suicide, the health care professional is required to notify legal authorities and make reasonable attempts to notify the family of the client.

Abuse of Children and Vulnerable Adults

If a client states or suggests that he or she is abusing a child (or vulnerable adult) or has recently abused a child (or vulnerable adult), or a child (or vulnerable adult) discloses abuse that has not been previously reported, the mental health professional is required to report this information to the appropriate social service and/or legal authorities.

By signing below, I agree to the above limits of confidentiality and understand their meanings and ramifications:

(Client signature) (Date)

(Parent/Guardian signature) (Date)

PAYMENT POLICIES

(Revised and in effect as of 1/09/2021)

Payments are due the same day as your session, unless other arrangements have been made. You have the option to pay with ONLINE through secure Wix payment services. If I am not able to collect the fee, such as if your card is declined, or you resumed chargeback after the session, you must pay your account in full before I can see you for another session. **Unpaid bills over 30 days will be subject to 15% interest until paid in full. I reserve the right to place your account with a collection agency after all internal efforts to obtain payment have been exhausted. You are then responsible for any collection costs in addition to your outstanding bill.**

If you are paying out of pocket (full fee or sliding scale): WIX PAYMENT SYSTEM Credit and debit card payments will have a small fee added on to cover credit card processing fees.

I charge the following fees for services:

If on a sliding scale 50-minute individual couple session - \$50 with proof of income.

Regular session price is \$90 and subject to change.

Letters for current clients (have seen me within the past 30 days) \$40 MUST BE PAID BEFORE LETTER IS WRITTEN

Letters for former or inactive clients \$50 MUST BE PAID BEFORE LETTER IS WRITTEN

Court appearances \$150/hr

Records request fee (sometimes may be charged to company requesting records) \$50, \$0.25 per page.

(Client signature) (Date)

(Parent/Guardian signature) (Date)

LATE CANCELLATION/ NO-SHOW POLICY

If you fail to cancel or reschedule a scheduled appointment within 24 hours or less of your appointment time, you would be charged a \$50 fee. The fee will also be charged if you fail to show up for your appointment. **This fee is required to be paid before your next session.** The payment on file will be charged for the fee the same day as the missed appointment unless other arrangements have been made. **Frequent or habitual cancellations, even with enough advance notice, may result in termination of sessions.**

As your therapist, I am dedicated to helping you, but I also must provide for my family and cover my business expenses. Without a 24-hour notice, I have difficulty filling this time slot for another client, which results in loss of income and waste of time to help someone else. It is your responsibility to plan ahead and contact me as soon as you are aware of a schedule conflict. **Please be aware that the fee will be charged for any cancelation with less than 24-hour notice regardless of the reason, even for illnesses. ONLY EMERGENCY CASES WITH PROOF WILL BE CONSIDERED FOR FEE WAIVER.**

(Client signature) (Date)

(Parent/Guardian signature) (Date)

Notice of Privacy Practices Receipt and Acknowledgment of Notice

Client Name: _____ DOB: _____ I hereby acknowledge that I have received and have been given an opportunity to read a copy of Luba Olm NPD Notice of Privacy Practices which is available at www.naturopathpsychologist.com on the Services Page. I understand that if I have any questions regarding the Notice or my privacy rights, I can contact Cari Morphet, CMHC at (202) 619-0257

Client Signature and Date

Signature or Parent, Guardian or Personal Representative and Date

_____ * If you are signing as a personal representative of an individual, please describe your legal authority to act for this individual (power of attorney, healthcare surrogate, etc.).

HIPAA Privacy Practices Notice Effective 1/1/2018

AS REQUIRED BY THE PRIVACY REGULATIONS CREATED AS A RESULT OF THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 (HIPAA), THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW THIS NOTICE CAREFULLY.

LUBA OLM NPD is dedicated to maintaining the privacy of your individually identifiable health information (also called protected health information, or PHI). Your health record contains personal information about you and your health. In conducting business, I will create records regarding you and the treatment and services I provide to you. I am required by law to maintain the confidentiality of health information that identifies you. I also am required by law to provide you with this notice of my legal and ethical duties and the privacy practices that I maintain in my practice concerning your PHI. By federal and state law, I must follow the terms of the Notice of Privacy Practices that I have in effect at the time.

Although these laws are complicated, I must provide you with the following important information:

- How I may use and disclose your PHI,
- Your privacy rights in your PHI,
- Our obligations concerning the use and disclosure of your PHI.

The terms of this notice apply to all records containing your PHI that are created or retained by my practice. I am required to abide by the terms of this Notice of Privacy Practices. I reserve the right to revise or amend this Notice of Privacy Practices at any time. Any revision or amendment to this notice will be effective for all of your records that has been created or maintained in the past, and for any of your records that I may create or maintain in the future.

A copy of my current Notice will be available on my website at all times, and you have a right to request a copy of the most current Notice at any time by mail, at your next appointment, or by printing a copy from my website: www.naturopathypsychologist.com under "Services" page.

HOW I MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU For Treatment.

LUBA OLM NPD may use your PHI to treat you or to assist others to support you in your treatment with your authorization. Your PHI may be used and disclosed by those who are involved in your care for the purpose of providing, coordinating, or managing your health care treatment and related services. Finally, I may also disclose your PHI to other health care providers or consultants for purposes related to your treatment with your permission. For Payment. LUBA OLM NPD may use and disclose your PHI in order to bill and collect payment for the services. THESE ALL will ONLY be done with your authorization.

Examples of payment-related activities are: making a determination of eligibility or coverage for insurance benefits, processing claims with your insurance company, reviewing services provided to you to determine medical necessity, or undertaking utilization review activities. If it becomes necessary to use collection processes due to lack of payment for services, I will only disclose the minimum amount of PHI necessary for purposes of collection. I may also use and disclose your PHI to obtain payment from third parties that may be responsible for such costs, such as family members who are paying for therapy sessions. For Health Care Operations. I may use and disclose your PHI to operate my practice. For

example, LUBA OLM NPD may use your PHI to evaluate the quality of care you received, to send appointment reminder calls or texts, or to conduct licensing, cost-management, or business planning activities. I may share minimal info of your PHI with third parties that perform various business activities (e.g., billing or typing services) provided I have a written contract with the business that requires them to safeguard the privacy of your PHI. For training or teaching purposes PHI will be disclosed only with LUBA OLM NPD HIPAA Privacy Practices Notice Effective 4/1/2015 YOUR authorization. I may also disclose your PHI to other health care providers and entities to assist in their health care operations with your permission. Required by Law. Under the law, I must make disclosures of your PHI to you upon your request. LUBA OLM NPD may disclose your PHI if you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities. In addition, I must make disclosures to the Secretary of the Department of Health and Human Services for the purpose of investigating or determining LUBA OLM NPD compliance with the requirements of the Privacy Rule. Without Authorization. Applicable law and ethical standards permit me to disclose information about you without your authorization only in a limited number of other situations. The types of uses and disclosures that may be made without your authorization are those that are: Required by Law, such as the mandatory reporting of child abuse or neglect or mandatory government agency audits or investigations (such as the licensing board or the health department) Required by Court Order Necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. If information is disclosed to prevent or lessen a serious threat it will be disclosed to a person or persons reasonably able to prevent or lessen the threat, including the target of the threat.

Verbal Permission LUBA OLM NPD may use or disclose your information to family members that are directly involved in your treatment with YOUR permission. For example, I may give a brief overview of how a session went with a parent of a minor. With Authorization. Uses and disclosures not specifically permitted by applicable law will be made only with your written authorization, which may be revoked at any time upon your request.

YOUR RIGHTS REGARDING YOUR PHI You have the following rights regarding PHI we maintain about you. To exercise any of these rights, please submit your request in writing to Cari Morphet at 151 E. 6100 S., Ste. 315, Murray, Utah, 84107: Right of Access to Inspect and Copy. You have the right, which may be restricted only in exceptional circumstances, to inspect and copy PHI that may be used to make decisions about your care including patient medical records and billing records, but not including psychotherapy notes. Your right to inspect and copy PHI will be restricted only in those situations where there is compelling evidence that access would cause serious harm to you. I may charge a reasonable, cost-based fee for copies. Right to Amend. If you feel that the PHI we have about you is incorrect or incomplete, you may ask me to amend the information although I am not required to agree to the amendment. To request an amendment, your request must be made in writing and submitted to Cari Morphet at 151 E. 6100 S., Ste. 315, Murray, Utah, 84107. You must provide a reason that supports your request for amendment. LUBA OLM NPD will deny your request if you fail to submit your request (and the reason supporting your request) in writing. Also, I may deny your request if you ask me to amend information that is in my opinion: (a) accurate and complete; (b) not part of the PHI kept by or for the practice; (c) not part of the PHI which you would be permitted to inspect and copy; or (d) not created by LUBA OLM NPD, unless the individual or entity that created the information is not available to amend the information. LUBA OLM NPD - HIPAA Privacy Practices Notice Effective 4/1/2015 Right to an Accounting of Disclosures. You have the right to request an accounting of certain of the disclosures that we make of your PHI. An "accounting of disclosures" is a list of certain non-routine disclosures my practice has made of your PHI for purposes not related to treatment, payment or operations. Use of your PHI as part of the routine client care in my practice is not required to be documented – for example, a doctor sharing

information with a nurse; or the billing department using your information to file your insurance claim. In order to obtain an accounting of disclosures, you must submit your request in writing to Cari Morphet at 151 E. 6100 S., Ste. 315, Murray, Utah, 84107.

All requests for an "accounting of disclosures" must state a time period, which may not be longer than six (6) years from the date of disclosure. I may charge you a reasonable fee if you request more than one accounting in any 12-month period. Right to Request Restrictions. You have the right to request a restriction or limitation on the use or disclosure of your PHI for treatment, payment, or health care operations. I am not required to agree to your request; however, if I do agree, I am bound by our agreement except when otherwise required by law, in emergencies or when the information is necessary to treat you. Right to Request Confidential Communication. You have the right to request that I communicate with you about medical matters in a certain way or at a certain location. For instance, you may ask that we contact you at home, rather than work. Right to a Copy of this Notice. You have the right to a copy of this notice. This notice is available on my website: www.naturopathpsychologist.com under "Services" section.

COMPLAINTS - If you believe I have violated your privacy rights, you have the right to file a complaint in writing with our Privacy Officer, Cari Morphet at 151 E. 6100 S., Ste. 315, Murray, Utah, 84107 or with the Secretary of Health and Human Services at 200 Independence Avenue, S.W. Washington, D.C. 20201 or by calling (202) 619-0257. I will not retaliate against you for filing a complaint.

Client Signature and Date

Signature or Parent, Guardian or Personal Representative and Date

*** If you are signing as a personal representative of an individual, please describe your legal authority to act for this individual (power of attorney, healthcare surrogate, etc.).**

INFORMED CONSENT FOR TELETHERAPY

This Informed Consent for Teletherapy contains important information concerning engaging in electronic psychotherapy or teletherapy. Please read this consent carefully. **Benefits and Risks of Teletherapy**
Teletherapy refers to the remote provision of psychotherapy services using telecommunications technologies such as video conferencing or telephone therapy. One of the benefits of teletherapy is that the client and therapist can engage in services without being in the same physical location. This can be helpful in ensuring continuity of care if the client or therapist are in a situation where they are unable to continue to meet in person due to extenuating circumstances. It can also increase the convenience and time efficiency of both parties. There are benefits of teletherapy, as well as some inherent risks of teletherapy. There are some differences between in-person psychotherapy and teletherapy. **Risks to confidentiality:** Because teletherapy sessions take place outside of the typical office setting, there is potential for third parties to overhear sessions if they are not conducted in a secure, private environment. I will take reasonable steps to ensure the privacy and security of your information, and it is important for you to review your own security measures and ensure that they are adequate to protect information on your end. You should participate in therapy only while in a room or area where other people are not present and cannot overhear the conversation. **Issues related to technology:** There are risks inherent in the use of technology for therapy that are important to understand, such as: potential for technology to fail during a session, potential that transmission of confidential information could be interrupted by unauthorized parties, or potential for electronically stored information to be accessed by unauthorized parties. **Crisis management and intervention:** As a general rule I will not engage in teletherapy with patients who are in a crisis situation. Before engaging in teletherapy, we will develop an emergency response plan or safety plan to address potential crisis situations that may arise during the course of our teletherapy work. It is urgent that you share with me any thought that you may have of harming yourself; and any history that you may have of suicide attempts or hospital treatment which you received for suicidal thoughts.

Efficacy: Most research has shown that teletherapy is just as effective as in person psychotherapy. However, some experienced mental health professionals, myself included, believe that something is lost by not being in the same room. For example, there is debate about one's ability when doing remote work to fully process non-verbal information. If you ever have concerns about misunderstandings between you and I related to the use of technology, please bring up such concerns immediately and we will address the potential misunderstanding together.

Electronic Communications We will discuss which is the most appropriate platform to use for teletherapy services. You may be required to have certain system requirements to access electronic psychotherapy via the method chosen. You are solely responsible for any cost to you to obtain any additional/necessary system requirements, accessories, or software to use electronic psychotherapy. For communication between sessions, email exchanges and text messages should be limited to matters such as setting and changing appointments, and other related issues. You should be aware that there is a small risk that a third party could gain access to your information sent by email. So please protect your email communication with passwords or other methods. I am open to use any methods you find the best secured so please discuss the platform you like to use with me. Currently I utilize secure platforms: ZOOM, Google Sheets, GMAIL, Adobe suite.

Treatment is most effective when clinical discussions occur at your regularly scheduled sessions, however if an urgent issue arises, you can reach me by phone or text. If you are unable to reach me and feel that you cannot wait for me to return your call or text, please call 911 or the UNI crisis line at (801) 587-3000 in the case of an emergency.

Confidentiality Counselors have a legal and ethical responsibility to make our best efforts to protect all communications, electric and otherwise, that are a part of our teletherapy. However, the nature of electronic communications technologies is such that I cannot guarantee that our communications will be kept confidential and/or that a third party may not gain access to our communications. Even though we may utilize state of the art encryption methods, firewalls, and back-up systems to help secure our communication, there is a risk that our electronic communications may be compromised, unsecured, and/or accessed by a third party. Emergencies and Technology Assessing and evaluating threats and other emergencies can be more difficult when conducting teletherapy than in traditional in-person therapy. In order to address some of these difficulties, in the event of a crisis or emergency I will ask you to disclose where you are, ask you to contact 911, and I will contact your emergency contact on file to assist in addressing the situation. If the session cuts out, meaning the technological connection fails, and you are having an emergency do not call me back, but call 911, the UNI Crisis Line at (801) 587-3000, or go to your nearest emergency room. Call me after you have called or obtained emergency services. If the session cuts out and you are not having an emergency, disconnect from the session and I will reconnect you via the teletherapy platform on which we agreed to conduct therapy. If you do not reconnect within five (5) minutes, then call me on my cell. If there is a technological failure and we are unable to resume the connection, you will only be charged the prorated amount of actual session time. Fees Different rates shall apply for in-person psychotherapy.

Consent This agreement is intended as a supplement to the general informed consent that we may have agreed to at the outset of treatment. Your signature below indicates agreement with its terms and conditions. I, _____, the client, having been fully informed of the risks and benefits of teletherapy; the security measures in place, which include procedures for emergency situations; the fees associated with teletherapy; the technological requirements needed to engage in teletherapy; and all other information provided in this informed consent, agree to and understand the procedures and policies set forth in this consent.

Client Signature and Date

Signature or Parent, Guardian or Personal Representative and Date

_____ * If you are signing as a personal representative of an individual, please describe your legal authority to act for this individual (power of attorney, healthcare surrogate, etc.).