KairosCounseling

Agreement for Adolescent Individual Psychotherapy Services with Phillip J. Atkinson, PhD, ABPP

By signing below, the client & his/her parent or legal guardian(s) indicate that they have read, understood, and agree to comply with the "Informed Consent for Individual Psychotherapy" and "HIPAA Notice of Privacy Practices" in accepting services from Dr. Phillip Atkinson, a Licensed Psychologist (#PSY21927) at Kairos Counseling Center.

Confidentiality

Dr. Atkinson will keep information disclosed in the session confidential. However, Dr. Atkinson is legally required to report the following exceptions to the appropriate authorities:

1. The client indicates that he/she intends to commit suicide.
2. The client indicates that he/she intends to harm another person.
3. The client provides information that indicates that child abuse has occurred.
4. The client indicates that elder or dependent adult abuse has occurred.

Confidentiality for Minors

While parents and/or guardians have a legal right to medical information pertaining to a minor under their care, the effectiveness and success of therapy depends on a confidential therapeutic relationship. In order to facilitate an effective and healing therapeutic environment, parents and/or guardians are asked to respect the confidential nature of the communications between their minor and his/her therapist. Parents and/or guardians will be informed of any of the legally mandated exceptions to confidentiality listed above, and the therapist will inform parents and/or guardians of other information the therapist deems to be in the best interest and safety of the minor client. Additionally, the therapist will speak privately with parents and/or guardians regularly (typically monthly) to provide an update on treatment progress, but will refrain from disclosing confidential communications during these meetings unless the minor client has assented to such disclosures.

Fees

Clients are expected to pay Dr. Atkinson's standard fee is $140 per 50-minute session at the beginning of each appointment, and understand that additional charges may apply for extended sessions or other services.

For clients with insurance coverage through TRICARE, Dr. Atkinson will bill for appointments, and the client will pay all deductibles and copays at the time of service. By using insurance to pay for services, the client consents to allow Kairos Counseling Center to submit Private Health Information (PHI) to the client's insurance company as required for billing. Kairos Counseling Center will take every appropriate measure to protect client confidentiality and will provide only the information required for billing. The client may request a copy of the information submitted to their insurance. The client agrees to check with his or her insurance plan in advance to ensure that services will be covered, and the client is responsible to pay all fees that are not covered by his or her insurance company in the event that a claim is denied. For insurance plans other than TRICARE, Dr. Atkinson will provide clients, at their request, with a monthly statement, which can be submitted to their insurance for reimbursement if the services are covered by their plan.

Cancellation Policy

Appointments must be cancelled at least 24 hours prior to the scheduled session. The client is responsible to pay the full session fee for any appointments that are not cancelled 24 hours prior.

HIPAA Acknowledgement and Consent

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

1. Conduct, plan and direct my treatment and follow-up care among the multiple service providers who may be involved in that treatment directly or indirectly.
2. Obtain payment from designated third-party payers.
3. Conduct normal care procedures such as quality assessments or evaluations.

I have been informed by Kairos Counseling Center of their Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such Notice of Privacy Practices prior to signing this consent.

I understand that I may request in writing that this organization restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand that Kairos Counseling Center is not required to agree to my requested restrictions, but if the organization does agree, then it is bound to abide by such restrictions.

I understand and consent to all of the above. I understand that I may revoke this consent in writing at any time, except to the extent that Kairos Counseling Center has taken action relying on this consent.

Client Printed Name	Client Signature and Date
Parent/Guardian Printed Name	Parent/Guardian Signature and Date
Parent/Guardian Printed Name	Parent/Guardian Signature and Date
Client Date of Birth	Insurance ID (if applicable)

Therapist Signature and Date

Outcome Questionnaire (OQ®-45.2)

Instructions: Looking back over the last week, including today, help us understand how you have been feeling. Read each item carefully and mark the box under the category which best describes your current situation. For this questionnaire, work is defined as employment, school, housework, volunteer work, and so forth.

Name:_____ Age:_____Yrs

Sex

ID#_____ **M** ☐ **F** ☐

Session #_____ Date_____/_____/____

		Never	Rarely	Sometimes	Frequently	Almost Always	SD	IR	SR
1.	I get along well with others.	☐ 4	☐ 3	☐ 2	☐ 1	☐ 0		☐	
2.	I tire quickly.	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐		
3.	I feel no interest in things.	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐		
4.	I feel stressed at work / school	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4			☐
5.	I blame myself for things.	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐		
6.	I feel irritated.	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐		
7.	I feel unhappy in my marriage / significant relationship.	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4		☐	
8.	I have thoughts of ending my life.	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐		
9.	I feel weak.	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐		
10.	I feel fearful.	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐		
11.	After heavy drinking, I need a drink the next morning to get going. (If you do not drink, mark "never")	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐		
12.	I find my work / school satisfying.	☐ 4	☐ 3	☐ 2	☐ 1	☐ 0			☐
13.	I am a happy person.	☐ 4	☐ 3	☐ 2	☐ 1	☐ 0	☐		
14.	I work / study too much.	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4			☐
15.	I feel worthless.	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐		
16.	I am concerned about family troubles.	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4		☐	
17.	I have an unfulfilling sex life.	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4		☐	
18.	I feel lonely.	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4		☐	
19.	I have frequent arguments.	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4		☐	
20.	I feel loved and wanted.	☐ 4	☐ 3	☐ 2	☐ 1	☐ 0		☐	
21.	I enjoy my spare time.	☐ 4	☐ 3	☐ 2	☐ 1	☐ 0			☐
22.	I have difficulty concentrating.	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐		
23.	I feel hopeless about the future.	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐		
24.	I like myself.	☐ 4	☐ 3	☐ 2	☐ 1	☐ 0	☐		
25.	Disturbing thoughts come into my mind that I cannot get rid of.	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐		
26.	I feel annoyed by people who criticize my drinking (or drug use) (If not applicable, mark "never")	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4		☐	
27.	I have an upset stomach.	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐		
28.	I am not working /studying as well as I used to.	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4			☐
29.	My heart pounds too much.	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐		
30.	I have trouble getting along with friends and close acquaintances.	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4		☐	
31.	I am satisfied with my life.	☐ 4	☐ 3	☐ 2	☐ 1	☐ 0	☐		
32.	I have trouble at work / school because of drinking or drug use. (If not applicable, mark "never")	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4			☐
33.	I feel that something bad is going to happen.	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐		
34.	I have sore muscles.	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐		
35.	I feel afraid of open spaces, of driving, or being on buses, subways, and so forth.	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐		
36.	I feel nervous.	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐		
37.	I feel my love relationships are full and complete.	☐ 4	☐ 3	☐ 2	☐ 1	☐ 0		☐	
38.	I feel that I am not doing well at work / school	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4			☐
39.	I have too many disagreements at work / school.	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4			☐
40.	I feel something is wrong with my mind.	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐		
41.	I have trouble falling asleep or staying asleep.	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐		
42.	I feel blue.	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐		
43.	I am satisfied with my relationships with others.	☐ 4	☐ 3	☐ 2	☐ 1	☐ 0		☐	
44.	I feel angry enough at work / school to do something I might regret.	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4			☐
45.	I have headaches.	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐		
							+	+	
							Total=		

For More Information:

American Professional Credentialing Services LLC
E-mail: APCS@EROLS.COM
Web: WWW.OQFAMILY.COM
Toll-Free: 1-888-MH SCORE (1-888-647-2673)
Fax/Voice: 1-973-366-8665

KairosCounseling

Adolescent Intake Form

Today's Date _____ Referred By _____

Identifying Information

Name _____ Date of Birth _____

Address _____ City:_____ Zip:_____

Phones (home) _____ (cell) _____ (work) _____

Email _____ Preferred Contact Method _____

Current Grade & School _____ Ethnicity _____

Emergency Contact _____ Relationship to Client _____

Phone (Home) _____ Alt Phone (Cell) _____

Reason for Treatment

What issues/concerns cause you to seek treatment? _____

_____

_____

_____

_____

How long has this issue/concern been a problem? _____

How does this interfere with your life? (Family? Friends? School? etc.) _____

_____

What are your specific goals for your treatment? _____

_____

_____

Do you have any particular concerns/fears with regard to treatment? _____

_____

_____

Psychological History

Have you ever received counseling or mental health treatment before? _____

When and for how long? _____

What was the focus of treatment? _____

Please list any psychiatric diagnoses: _____

What did you find helpful/not helpful about treatment? _____

_____

Name of Therapist _____ Phone number: _____

Address _____

May we contact him/her? (circle) YES / NO – Why not? _____

Have you ever participated in psychological testing / assessment? _____

If so, by whom? _____ Phone number: _____

Address _____

May we contact him/her? (circle) YES / NO – Why not? _____

Have you ever been hospitalized for mental or emotional problems? _____

When and for how long? _____

Why were you hospitalized? _____

Name of Hospital _____ Phone number: _____

May we contact this hospital? (circle) YES / NO – Why not? _____

Have you ever experienced any traumatic events? Please describe: _____

_____

_____

Family Psychiatric History

Has anyone in your family been diagnosed or treated for mental/emotional problems? Please list:

Relationship to you _____ Treated for: _____

Relationship to you _____ Treated for: _____

Relationship to you _____ Treated for: _____

Relationship to you _____ Treated for: _____

Relationship to you _____ Treated for: _____

Medical Conditions & History

Do you have any medical conditions? Please list below (past and present): _____

_____

_____

_____

List any medical conditions that may affect your mental health treatment: _____

_____

List any medical / surgical hospitalizations (include dates): _____

_____

List any serious accidents / injuries (include dates & outcome): _____

_____

Are you experiencing any medical/physical symptoms you attribute to a mental, emotional, or stress-related condition? Please describe. _____

_____

What are your current and past exercise habits? _____

_____

Please describe your overall health today. _____

Date of last physical exam: _____ Name of physician _____

List any relevant family medical history: _____

_____

_____

Have you ever attempted suicide? (circle) YES / NO When? _____

Describe the circumstances that led to that attempt. _____

_____

_____

Have you had suicidal thoughts in the last year? (circle) YES / NO When? _____

Are you currently having any suicidal thoughts? Please describe: _____

_____

_____

Are you currently having any thoughts about hurting someone else? Please describe: _____

_____

_____

Current Medications

Name of medication _____Dose _____ Start Date _____

Prescribed by _____ Phone # _____

Name of medication _____Dose _____ Start Date _____

Prescribed by _____ Phone # _____

Name of medication _____Dose _____ Start Date _____

Prescribed by _____ Phone # _____

Name of medication _____Dose _____ Start Date _____

Prescribed by _____ Phone # _____

Have you ever taken any medications for a mental or emotional condition in the past? YES / NO

What medication(s)? _____

When and for how long? _____

Alcohol & Substance Use

Alcohol Use: (circle) YES / NO – If yes, how much do you drink in a typical week? _____

Are you currently able to abstain for 72 hours? YES / NO

Nicotine Use: (circle) YES / NO – If yes, how much do you smoke in a typical day? _____

Are you currently able to abstain for 72 hours? YES / NO

Marijuana Use: (circle) YES / NO – If yes, how do you use and how much? _____

_____

Are you currently able to abstain for 72 hours? YES / NO

Caffeine Use: (circle) YES / NO – If yes, how much do you drink in a typical day? _____

Do you use any illegal drugs? Please describe any current or past use: _____

_____

Please describe any substance-related blackouts, seizures or medical complications: _____

_____

Have you ever had an addiction? Please describe: _____

_____

Have you ever been in a 12-Step or other recovery program? Please describe: _____

_____

Family History

Mother's name, age, living/deceased, patient's age at the time of mother's death, description of relationship with mother. _____

_____

_____

Father's name, age, living/deceased, patient's age at the time of father's death, description of relationship with father. _____

_____

_____

Names and ages of siblings: _____

_____

Briefly describe your childhood: _____

_____

_____

Were you ever subjected to verbal, physical, emotional, sexual abuse? Please describe:

_____

_____

Have you ever been a victim of a violent crime? Please describe: _____

_____

Current Living Situation & Social Support

Which of the following best describes your current living situation (Please circle):

Rent Apartment	Rent House	Own House
Rent Condominium	Own Condominium	Staying with Friends / Family
Foster Care	Group Home	Residential Treatment
Shelter	Homeless	Other: _____

Primary language(s) spoken at home: _____

What do you like most about your current living situation? What do you like least?

_____

_____

_____

_____

List all individuals living in your home at this time:

Name _____ Age _____ Relationship to you_____

Name _____ Age _____ Relationship to you_____

Name _____ Age _____ Relationship to you_____

Name _____ Age _____ Relationship to you_____

Name _____ Age _____ Relationship to you_____

Name _____ Age _____ Relationship to you_____

List important friends, family members or relatives living outside the home:

Name _____ Age _____ Relationship to you_____

Name _____ Age _____ Relationship to you_____

Name _____ Age _____ Relationship to you_____

Name _____ Age _____ Relationship to you_____

Name _____ Age _____ Relationship to you_____

Name _____ Age _____ Relationship to you_____

Please describe your religious or spiritual identity/orientation: _____

List any groups, religious affiliations or other organizations that are important to you:

_____

_____

Education & Work

How are you currently doing in school? _____

What is your favorite subject? _____ Least favorite? _____

Current Grades: _____ GPA: _____

Have you received Special Education services? Describe: _____

Do you currently have a job? YES / NO Job/Employer: _____

How satisfied are you with your current job? _____

_____

Behavioral & Legal History

Have you ever been suspended or expelled from school? Describe: _____

_____

Do you have any current or past legal problems? Please describe: _____

_____

Personal Strengths:

Please circle all of the characteristics below that apply to you:

helpful	employed	attend school/work	independent
humorous	positive outlook	spiritual	usually cope with well problems
stay active	easy going	intelligent	share with others
caring	hard-working	playful	maintain friends
a leader	artistic	good-looking	structure time well
athletic	have a hobby	liked by others	positive view of the world
responsible	honest	good health	*Others:* _____

Other Concerns or Comments:

Please share any other information that would be helpful to know about you:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Informed Consent for Individual Psychotherapy
Phillip J. Atkinson, PhD, ABPP
Licensed Psychologist (PSY21927)

This form provides you, the client, with information that is additional to that detailed in the HIPAA Notice of Privacy Practices and it is subject to HIPAA preemptive analysis.

CONFIDENTIALITY: All information disclosed within sessions and the written records pertaining to those sessions are confidential and may not be revealed to anyone without your written permission except where disclosure is required by law.

MINORS IN THERAPY: If you are under eighteen years of age, please be aware that the law may give your parents or guardians the right to obtain information about your treatment and/or examine your treatment records. It is my policy to request a written agreement from your parents or guardians indicating that they consent to respect the confidentiality of the information we discuss in therapy and your records. If they agree, I will provide them only with general information about our work together subject to your approval, or, if I feel it is important for them to know in order to make sure that you and people around you are safe. If I think it is appropriate, I will involve them if I feel that there is a high risk that you will seriously harm yourself or another/others. Before giving them any verbal or written information, I will discuss the matter with you, if possible. I will do the best I can to resolve any differences that you and I may have about what I am prepared to discuss.

WHEN DISCLOSURE IS REQUIRED OR MAY BE REQUIRED BY LAW: Some of the circumstances where disclosure is required or may be required by law are: where there is a reasonable suspicion of child, dependent, or elder abuse or neglect; where a client presents a danger to self, to others, to property, or is gravely disabled; or when a client's family members communicate to Dr. Atkinson that the client presents a danger to others. Disclosure may also be required pursuant to a legal proceeding by or against you. If you place your mental status at issue in litigation initiated by you, the defendant may have the right to obtain the psychotherapy records and/or testimony by Dr. Atkinson. In couple and family therapy, or when different family members are seen individually, even over a period of time, confidentiality and privilege do not apply between the couple or among family members, unless otherwise agreed upon. Dr. Atkinson will use his clinical judgment when revealing such information. Dr. Atkinson will not release records to any outside party unless he is authorized to do so by all adult parties who were part of the family therapy, couple therapy or other treatment that involved more than one adult client.

EMERGENCY: If there is an emergency during therapy, or in the future after termination, where Dr. Atkinson becomes concerned about your personal safety, the possibility of you injuring someone else, or about you receiving proper psychiatric care, he will do whatever he can within the limits of the law, to prevent you from injuring yourself or others and to ensure that you receive the proper medical care. For this purpose, he may also contact the emergency contact you have named above.

HEALTH INSURANCE & CONFIDENTIALITY OF RECORDS: Disclosure of confidential information may be required by your health insurance carrier or HMO/PPO/MCO/EAP in order to process the claims. If you so instruct Dr. Atkinson, only the minimum necessary information will be communicated to the carrier. Dr. Atkinson has no control over, or knowledge of, what insurance companies do with the information he submits or who has access to this information. You must be aware that submitting a mental health invoice for reimbursement carries a certain amount of risk to confidentiality, privacy or to future capacity to obtain health or life insurance or even a job. The risk stems from the fact that

mental health information is likely to be entered into big insurance companies' computers and is likely to be reported to the National Medical Data Bank. Accessibility to companies' computers or to the National Medical Data Bank database is always in question as computers are inherently vulnerable to hacking and unauthorized access. Medical data has also been reported to have been legally accessed by law enforcement and other agencies, which also puts you in a vulnerable position.

LITIGATION LIMITATION: Due to the nature of the therapeutic process and the fact that it often involves making a full disclosure with regard to many matters which may be of a confidential nature, it is agreed that, should there be legal proceedings (such as, but not limited to divorce and custody disputes, injuries, lawsuits, etc.), neither you nor your attorney(s), nor anyone else acting on your behalf will call on Dr. Atkinson to testify in court or at any other proceeding, nor will a disclosure of the psychotherapy records be requested unless otherwise agreed upon.

CONSULTATION: Dr. Atkinson consults regularly with other professionals regarding his clients; however, each client's identity remains completely anonymous and confidentiality is fully maintained.

E–MAILS, CELL PHONES, COMPUTERS, AND FAXES: It is very important to be aware that computers and e-mail communication can be relatively easily accessed by unauthorized people and hence can compromise the privacy and confidentiality of such communication. Faxes can easily be sent erroneously to the wrong address. E-mails, in particular, are vulnerable to unauthorized access due to the fact that Internet servers have unlimited and direct access to all e-mails that go through them. It is important that you be aware that e-mails, faxes, and important texts are part of the medical records. Additionally, Dr. Atkinson's e-mails are not encrypted. Dr. Atkinson's computers are equipped with a firewall, a virus protection, and a password and he also backs up all confidential information from his computers on a regular basis. Please notify Dr. Atkinson if you decide to avoid or limit in any way the use of any or all communication devices, such as e-mail, cell phone, or faxes. If you communicate confidential or private information via e-mail, Dr. Atkinson will assume that you have made an informed decision, will view it as your agreement to take the risk that such communication may be intercepted, and will honor your desire to communicate on such matters via e-mail. Please do not use e-mail or faxes for emergencies.

RECORDS AND YOUR RIGHT TO REVIEW THEM: Both the law and the standards of Dr. Atkinson's profession require that he keep treatment records for at least 7 years. Unless otherwise agreed to be necessary, Dr. Atkinson retains clinical records only as long as is mandated by California law. If you have concerns regarding the treatment records, please discuss them with Dr. Atkinson. As a client, you have the right to review or receive a summary of your records at any time, except in limited legal or emergency circumstances or when Dr. Atkinson assesses that releasing such information might be harmful in any way. In such a case, Dr. Atkinson will provide the records to an appropriate and legitimate mental health professional of your choice. Considering all of the above exclusions, if it is still appropriate, and upon your request, Dr. Atkinson will release information to any agency/person you specify unless Dr. Atkinson assesses that releasing such information might be harmful in any way. When more than one client is involved in treatment, such as in cases of couple and family therapy, Dr. Atkinson will release records only with signed authorizations from all the adults (or all those who legally can authorize such a release) involved in the treatment.

TELEPHONE & EMERGENCY PROCEDURES: If you need to contact Dr. Atkinson between sessions, please leave a message at the answering service (707) 874-8463 and your call will be returned as soon as possible. Dr. Atkinson checks his messages a few times during the daytime only, Monday through Friday, unless he is out of town. If an emergency situation arises, and if you need to

talk to someone right away call the 24-hour Solano County Mental Health Crisis Line: (707) 428-1131, or the Police: 911, or go to the nearest hospital emergency room. Please do not use e-mail or faxes for emergencies. Dr. Atkinson does not always check his e-mail or faxes daily.

PAYMENTS & INSURANCE REIMBURSEMENT: Clients are expected to pay the standard fee of $130.00 per 50-minute session at the beginning of each session. Extended sessions, telephone conversations, site visits, writing and reading of reports, consultation with other professionals, release of information, reading records, travel time, etc. will be charged at the same rate, unless indicated and agreed upon otherwise. Please notify Dr. Atkinson if any problems arise during the course of therapy regarding your ability to make timely payments. Clients who carry insurance should remember that professional services are rendered and charged to the clients and not to the insurance companies. Dr. Atkinson is a contracted network provider with TRICARE, HealthNet and Managed Health Network (MHN), and Dr. Atkinson will bill for clients with these insurance plans. Clients with TRICARE, HealthNet and MHN are responsible to pay all deductibles and co-payments as required by their insurance plan. For all other insurance plans, Dr. Atkinson will provide you with a copy of your receipt on a monthly basis, which you can then submit to your insurance company for reimbursement, if you so choose. As was indicated in the section, Health Insurance & Confidentiality of Records, you must be aware that submitting a mental health invoice for reimbursement carries a certain amount of risk. Not all issues, conditions or problems that are dealt with in psychotherapy are reimbursed by insurance companies. It is your responsibility to verify the specifics of your coverage. If your account is overdue (unpaid) and there is no written agreement on a payment plan, Dr. Atkinson can use legal or other means (courts, collection agencies, etc.) to obtain payment.

MEDIATION & ARBITRATION: All disputes arising out of, or in relation to, this agreement to provide psychotherapy services shall first be referred to mediation, before, and as a pre-condition of, the initiation of arbitration. The mediator shall be a neutral third party chosen by agreement of Dr. Atkinson and the client(s). The cost of such mediation, if any, shall be split equally, unless otherwise agreed upon. In the event that mediation is unsuccessful, any unresolved controversy related to this agreement should be submitted to and settled by binding arbitration in (your county, state) in accordance with the rules of the American Arbitration Association which are in effect at the time the demand for arbitration is filed. Notwithstanding the foregoing, in the event that your account is overdue (unpaid) and there is no agreement on a payment plan, Dr. Atkinson can use legal means (court, collection agency, etc.) to obtain payment. The prevailing party in arbitration or collection proceedings shall be entitled to recover a reasonable sum as and for attorney's fees. In the case of arbitration, the arbitrator will determine that sum.

THE PROCESS OF THERAPY/EVALUATION AND SCOPE OF PRACTICE: Participation in therapy can result in a number of benefits to you, including improving interpersonal relationships and resolution of the specific concerns that led you to seek therapy. Working toward these benefits, however, requires effort on your part. Psychotherapy requires your very active involvement, honesty, and openness in order to change your thoughts, feelings, and/or behavior. Dr. Atkinson will ask for your feedback and views on your therapy, its progress, and other aspects of the therapy and will expect you to respond openly and honestly. Sometimes more than one approach can be helpful in dealing with a certain situation. During evaluation or therapy, remembering or talking about unpleasant events, feelings, or thoughts can result in you experiencing considerable discomfort or strong feelings of anger, sadness, worry, fear, etc., or experiencing anxiety, depression, insomnia, etc. Dr. Atkinson may challenge some of your assumptions or perceptions or propose different ways of looking at, thinking about, or handling situations, which can cause you to feel very upset, angry, depressed, challenged, or disappointed. Attempting to resolve issues that brought you to therapy in the first place, such as

personal or interpersonal relationships, may result in changes that were not originally intended. Psychotherapy may result in decisions about changing behaviors, employment, substance use, schooling, housing, or relationships. Sometimes a decision that is positive for one family member is viewed quite negatively by another family member. Change will sometimes be easy and swift, but more often it will be slow and even frustrating. There is no guarantee that psychotherapy will yield positive or intended results. During the course of therapy, Dr. Atkinson is likely to draw on various psychological approaches according, in part, to the problem that is being treated and his assessment of what will best benefit you. These approaches include, but are not limited to, behavioral, cognitive-behavioral, cognitive, psychodynamic, existential, system/family, developmental (adult, child, family), humanistic or psycho-educational. Dr. Atkinson DOES NOT provide custody evaluation recommendations, medication or prescription recommendations, or legal advice, as these activities do not fall within his scope of practice.

TREATMENT PLANS: Within a reasonable period of time after the initiation of treatment, Dr. Atkinson will discuss with you his working understanding of the problem, treatment plan, therapeutic objectives, and his view of the possible outcomes of treatment. If you have any unanswered questions about any of the procedures used in the course of your therapy, their possible risks, Dr. Atkinson's expertise in employing them, or about the treatment plan, please ask and you will be answered fully. You also have the right to ask about other treatments for your condition and their risks and benefits.

TERMINATION: As set forth above, after the first couple of meetings, Dr. Atkinson will assess if he can be of benefit to you. Dr. Atkinson does not accept clients who, in his opinion, he cannot help. In such a case, he will give you a number of referrals whom you can contact. If at any point during psychotherapy, Dr. Atkinson assesses that he is not effective in helping you reach the therapeutic goals or that you are non-compliant, he is obligated to discuss it with you and, if appropriate, to terminate treatment. In such a case, he would give you a number of referrals that may be of help to you. If you request it and authorize it in writing, Dr. Atkinson will talk to the psychotherapist of your choice in order to help with the transition. If, at any time, you want another professional's opinion or wish to consult with another therapist, Dr. Atkinson will assist you with referrals, and, if he has your written consent, he will provide her or him with the essential information needed. You have the right to terminate therapy at any time. If you choose to do so, and if appropriate, Dr. Atkinson will offer to provide you with names of other qualified professionals.

DUAL RELATIONSHIPS: Despite a popular perception, not all dual or multiple relationships are unethical or avoidable. Therapy never involves sexual or any other dual relationship that impairs Dr. Atkinson's objectivity, clinical judgment or can be exploitative in nature. Dr. Atkinson will assess carefully before entering into non-sexual and non-exploitative dual relationships with clients. It is important to realize that in some communities, particularly small towns, military bases, university campus, etc., multiple relationships are either unavoidable or expected. Dr. Atkinson will never acknowledge working with anyone without his written permission. Many clients have chosen Dr. Atkinson as their therapist because they knew him/her before they entered therapy with him/her, and/or are personally aware of his professional work and achievements. Nevertheless, Dr. Atkinson will discuss with you the often-existing complexities, potential benefits and difficulties that may be involved in dual or multiple relationships. Dual or multiple relationships can enhance trust and therapeutic effectiveness but can also detract from it and often it is impossible to know which ahead of time. It is your responsibility to advise Dr. Atkinson if the dual or multiple relationship becomes uncomfortable for you in any way. Dr. Atkinson will always listen carefully and respond to your

feedback and will discontinue the dual relationship if he finds it interfering with the effectiveness of the therapy or your welfare and, of course, you can do the same at any time.

SOCIAL NETWORKING AND INTERNET SEARCHES: At times, I may conduct a web search on my clients before the beginning of therapy or during therapy. If you have concerns or questions regarding this practice, please discuss them with me. I do not accept friend requests from current or former clients on social networking sites, such as Facebook. I believe that adding clients as friends on these sites and/or communicating via such sites is likely to compromise their privacy and confidentiality. For this same reason, I request that clients not communicate with me via any interactive or social networking web sites.

CANCELLATION: Since the scheduling of an appointment involves the reservation of time specifically for you, a minimum of 24 hours notice is required for re-scheduling or canceling an appointment. Unless we reach a different agreement, the full fee will be charged for sessions missed without such notification. Most insurance companies do not reimburse for missed sessions.

HIPAA NOTICE OF PRIVACY PRACTICES

I. THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

II. IT IS MY LEGAL DUTY TO SAFEGUARD YOUR PROTECTED HEALTH INFORMATION (PHI).

By law I am required to insure that your PHI is kept private. The PHI constitutes information created or noted by me that can be used to identify you. It contains data about your past, present, or future health or condition, the provision of health care services to you, or the payment for such health care. I am required to provide you with this Notice about my privacy procedures. This Notice must explain when, why, and how I would use and/or disclose your PHI. Use of PHI means when I share, apply, utilize, examine, or analyze information within my practice; PHI is disclosed when I release, transfer, give, or otherwise reveal it to a third party outside my practice. With some exceptions, I may not use or disclose more of your PHI than is necessary to accomplish the purpose for which the use or disclosure is made; however, I am always legally required to follow the privacy practices described in this Notice.

Please note that I reserve the right to change the terms of this Notice and my privacy policies at any time as permitted by law. Any changes will apply to PHI already on file with me. Before I make any important changes to my policies, I will immediately change this Notice and post a new copy of it in my office and on my website. You may also request a copy of this Notice from me, or you can view a copy of it in my office or on my website, which is located at:

www.KairosCounselingCenter.com

III. HOW I WILL USE AND DISCLOSE YOUR PHI.

I will use and disclose your PHI for many different reasons. Some of the uses or disclosures will require your prior written authorization; others, however, will not. Below you will find the different categories of my uses and disclosures, with some examples.

A. Uses and Disclosures Related to Treatment, Payment, or Health Care Operations Do Not Require Your Prior Written Consent.

I may use and disclose your PHI without your consent for the following reasons:

1. For treatment. I can use your PHI within my practice to provide you with mental health treatment, including discussing or sharing your PHI with my trainees and interns. I may disclose your PHI to physicians, psychiatrists, psychologists, and other licensed health care providers who provide you with health care services or are otherwise involved in your care. Example: If a psychiatrist is treating you, I may disclose your PHI to her/him in order to coordinate your care.

2. For health care operations. I may disclose your PHI to facilitate the efficient and correct operation of my practice. Examples: Quality control - I might use your PHI in the evaluation of the quality of health care services that you have received or to evaluate the performance of the health care professionals who provided you with these services. I may also provide your PHI to my

attorneys, accountants, consultants, and others to make sure that I am in compliance with applicable laws.

3. To obtain payment for treatment. I may use and disclose your PHI to bill and collect payment for the treatment and services I provided you. Example: I might send your PHI to your insurance company or health plan in order to get payment for the health care services that I have provided to you. I could also provide your PHI to business associates, such as billing companies, claims processing companies, and others that process health care claims for my office.

4. Other disclosures. Examples: Your consent isn't required if you need emergency treatment provided that I attempt to get your consent after treatment is rendered. In the event that I try to get your consent but you are unable to communicate with me (for example, if you are unconscious or in severe pain) but I think that you would consent to such treatment if you could, I may disclose your PHI.

B. Certain Other Uses and Disclosures Do Not Require Your Consent. I may use and/or disclose your PHI without your consent or authorization for the following reasons:

1. **When disclosure is required by federal, state, or local law; judicial, board, or administrative proceedings; or, law enforcement.** Example: I may make a disclosure to the appropriate officials when a law requires me to report information to government agencies, law enforcement personnel and/or in an administrative proceeding.
2. **If disclosure is compelled by a party to a proceeding before a court of an administrative agency pursuant to its lawful authority.**
3. **If disclosure is required by a search warrant lawfully issued to a governmental law enforcement agency.**
4. **If disclosure is compelled by the patient or the patient's representative pursuant to California Health and Safety Codes or to corresponding federal statutes of regulations**, such as the Privacy Rule that requires this Notice.
5. **To avoid harm.** I may provide PHI to law enforcement personnel or persons able to prevent or mitigate a serious threat to the health or safety of a person or the public (i.e., adverse reaction to meds).
6. **If disclosure is compelled or permitted by the fact that you are in such mental or emotional condition as to be dangerous to yourself or the person or property of others, and if I determine that disclosure is necessary to prevent the threatened danger.**
7. **If disclosure is mandated by the California Child Abuse and Neglect Reporting law.** For example, if I have a reasonable suspicion of child abuse or neglect.
8. **If disclosure is mandated by the California Elder/Dependent Adult Abuse Reporting law.** For example, if I have a reasonable suspicion of elder abuse or dependent adult abuse.
9. **If disclosure is compelled or permitted by the fact that you tell me of a serious/imminent threat of physical violence by you against a reasonably identifiable victim or victims.**
10. **For public health activities.** Example: In the event of your death, if a disclosure is permitted or compelled, I may need to give the county coroner information about you.
11. **For health oversight activities.** Example: I may be required to provide information to assist the government in the course of an investigation or inspection of a health care organization or provider.
12. **For specific government functions.** Examples: I may disclose PHI of military personnel and veterans under certain circumstances. Also, I may disclose PHI in the interests of national

security, such as protecting the President of the United States or assisting with intelligence operations.

13. **For research purposes.** In certain circumstances, I may provide PHI in order to conduct medical research.
14. **For Workers' Compensation purposes.** I may provide PHI in order to comply with Workers' Compensation laws.
15. **Appointment reminders and health related benefits or services.** Examples: I may use PHI to provide appointment reminders. I may use PHI to give you information about alternative treatment options, or other health care services or benefits I offer**.**
16. **If an arbitrator or arbitration panel compels disclosure,** when arbitration is lawfully requested by either party, pursuant to subpoena *duces tectum* (e.g., a subpoena for mental health records) or any other provision authorizing disclosure in a proceeding before an arbitrator or arbitration panel.
17. **If disclosure is required or permitted to a health oversight agency for oversight activities authorized by law.** Example: When compelled by U.S. Secretary of Health and Human Services to investigate or assess my compliance with HIPAA regulations.
18. **If disclosure is otherwise specifically required by law.**

C. Certain Uses and Disclosures Require You Have the Opportunity to Object.

1. Disclosures to family, friends, or others. I may provide your PHI to a family member, friend, or other individual who you indicate is involved in your care or responsible for the payment for your health care, unless you object in whole or in part. Retroactive consent may be obtained in emergency situations.

D. Other Uses and Disclosures Require Your Prior Written Authorization. In any other situation not described in Sections IIIA, IIIB, and IIIC above, I will request your written authorization before using or disclosing any of your PHI. Even if you have signed an authorization to disclose your PHI, you may later revoke that authorization, in writing, to stop any future uses and disclosures (assuming that I haven't taken any action subsequent to the original authorization) of your PHI by me.

IV. WHAT RIGHTS YOU HAVE REGARDING YOUR PHI

These are your rights with respect to your PHI:

A. The Right to See and Get Copies of Your PHI. In general, you have the right to see your PHI that is in my possession, or to get copies of it; however, you must request it in writing. If I do not have your PHI, but I know who does, I will advise you how you can get it. You will receive a response from me within 30 days of my receiving your written request. Under certain circumstances, I may feel I must deny your request, but if I do, I will give you, in writing, the reasons for the denial. I will also explain your right to have my denial reviewed.

If you ask for copies of your PHI, I will charge you not more than $.25 per page. I may see fit to provide you with a summary or explanation of the PHI, but only if you agree to it, as well as to the cost, in advance.

B. The Right to Request Limits on Uses and Disclosures of Your PHI. You have the right to ask that I limit how I use and disclose your PHI. While I will consider your request, I am not legally bound to agree. If I do agree to your request, I will put those limits in writing and abide by them

except in emergency situations. You do not have the right to limit the uses and disclosures that I am legally required or permitted to make.

C. The Right to Choose How I Send Your PHI to You. It is your right to ask that your PHI be sent to you at an alternate address (for example, sending information to your work address rather than your home address) or by an alternate method (for example, via email instead of by regular mail). I am obliged to agree to your request providing that I can give you the PHI, in the format you requested, without undue inconvenience. I may not require an explanation from you as to the basis of your request as a condition of providing communications on a confidential basis.

D. The Right to Get a List of the Disclosures I Have Made. You are entitled to a list of disclosures of your PHI that I have made. The list will not include uses or disclosures to which you have already consented, i.e., those for treatment, payment, or health care operations, sent directly to you, or to your family; neither will the list include disclosures made for national security purposes, to corrections or law enforcement personnel, or disclosures made before April 15, 2003. After April 15, 2003, disclosure records will be held for six years. I will respond to your request for an accounting of disclosures within 60 days of receiving your request. The list I give you will include disclosures made in the previous six years unless you indicate a shorter period. The list will include the date of the disclosure, to whom PHI was disclosed (including their address, if known), a description of the information disclosed, and the reason for the disclosure. I will provide the list to you at no cost, unless you make more than one request in the same year, in which case I will charge you a reasonable sum based on a set fee for each additional request.

E. The Right to Amend Your PHI. If you believe that there is some error in your PHI or that important information has been omitted, it is your right to request that I correct the existing information or add the missing information. Your request and the reason for the request must be made in writing. You will receive a response within 60 days of my receipt of your request. I may deny your request, in writing, if I find that: the PHI is (a) correct and complete, (b) forbidden to be disclosed, (c) not part of my records, or (d) written by someone other than me. My denial must be in writing and must state the reasons for the denial. It must also explain your right to file a written statement objecting to the denial. If you do not file a written objection, you still have the right to ask that your request and my denial be attached to any future disclosures of your PHI. If I approve your request, I will make the change(s) to your PHI. Additionally, I will tell you that the changes have been made, and I will advise all others who need to know about the change(s) to your PHI.

F. The Right to Get This Notice by Email. You have the right to get this notice by email. You have the right to request a paper copy of it, as well.

V. HOW TO COMPLAIN ABOUT MY PRIVACY PRACTICES

If, in your opinion, I may have violated your privacy rights, or if you object to a decision I made about access to your PHI, you are entitled to file a complaint with the person listed in Section VI below. You may also send a written complaint to the Secretary of the Department of Health and Human Services at 200 Independence Avenue S.W. Washington, D.C. 20201. If you file a complaint about my privacy practices, I will take no retaliatory action against you**.**

VI. PERSON TO CONTACT FOR INFORMATION ABOUT THIS NOTICE OR TO COMPLAIN ABOUT MY PRIVACY PRACTICES

If you have any questions about this notice or any complaints about my privacy practices, or would like to know how to file a complaint with the Secretary of the Department of Health and Human Services, please contact me at: Kairos Counseling Center, 5063 Maple Rd. Suite 100, Vacaville, CA 95687. Phone: (707) 874-8463

VII. NOTIFICATIONS OF BREACHES

In the case of a breach, Dr. Atkinson is required to notify each affected individual whose unsecured PHI has been compromised. Even if such a breach was caused by a business associate, Dr. Atkinson is ultimately responsible for providing the notification directly or via the business associate. If the breach involves more than 500 persons, OCR must be notified in accordance with instructions posted on its website. Dr. Atkinson bears the ultimate burden of proof to demonstrate that all notifications were given or that the impermissible use or disclosure of PHI did not constitute a breach and must maintain supporting documentation, including documentation pertaining to the risk assessment.

VIII. PHI AFTER DEATH

Generally, PHI excludes any health information of a person who has been deceased for more than 50 years after the date of death. Dr. Atkinson may disclose deceased individuals' PHI to non-family members, as well as family members, who were involved in the care or payment for healthcare of the decedent prior to death; however, the disclosure must be limited to PHI relevant to such care or payment and cannot be inconsistent with any prior expressed preference of the deceased individual.

IX. Individuals' Right to Restrict Disclosures; Right of Access

To implement the 2013 HITECH Act, the Privacy Rule is amended Dr. Atkinson is required to restrict the disclosure of PHI about you, the patient, to a health plan, upon request, if the disclosure is for the purpose of carrying out payment or healthcare operations and is not otherwise required by law. The PHI must pertain solely to a healthcare item or service for which you have paid the covered entity in full. (OCR clarifies that the adopted provisions do not require that covered healthcare providers create separate medical records or otherwise segregate PHI subject to a restrict healthcare item or service; rather, providers need to employ a method to flag or note restrictions of PHI to ensure that such PHI is not inadvertently sent or made accessible to a health plan.)

The 2013 Amendments also adopt the proposal in the interim rule requiring Dr. Atkinson, to provide you, the patient, a copy of PHI to any individual patient requesting it in electronic form. The electronic format must be provided to you if it is readily producible. OCR clarifies that Dr. Atkinson must provide you only with an electronic copy of their PHI, not direct access to their electronic health record systems. The 2013 Amendments also give you the right to direct Dr. Atkinson to transmit an electronic copy of PHI to an entity or person designated by you. Furthermore, the amendments restrict the fees that Dr. Atkinson may charge you for handling and reproduction of PHI, which must be reasonable, cost-based and identify separately the labor for copying PHI (if any). Finally, the 2013 Amendments modify the timeliness requirement for right of access, from up to 90 days currently permitted to 30 days, with a one-time extension of 30 additional days.

X. Notice of Privacy Practices (NPP)

Kairos Counseling Center Notice of Privacy Practices (NPP) must contain a statement indicating that most uses and disclosures of psychotherapy notes, marketing disclosures and sale of PHI do require prior authorization by you, and you have the right to be notified in case of a breach of unsecured PHI.

XI. EFFECTIVE DATE OF THIS NOTICE

This notice went into effect on Jan. 30, 2013