Child and Adolescent Psychology Professionals

Registration Form

Date: _____

Name: _____ Sex: _____ Age: _____ DOB: _____

Address: _____

Primary Phone: _____ 2nd Phone: _____

Email: _____

(Please indicate if phone numbers are Home, Work, and/or Cell)

Okay to leave a message? _____ Yes _____ No

EMERGENCY CONTACT: _____ Relationship: _____

Phone number(s): _____

Financial Agreement

Payment/Financial Responsibility: Payment is collected at the time of your appointment. If you are paying privately, payment is collected at the time of your appointment. If your insurance is being billed, your co-pay/co-insurance (if required) will be collected at the time of your appointment. We bill only insurance we are contracted with. Furthermore, it is your responsibility to follow up with the insurance company regarding your insurance benefits, including what your insurance will and will not pay for. We assume no responsibility for lack of knowledge regarding your insurance benefits. You are responsible for any unpaid charge(s) as determined by your insurance company regardless of cause. You are responsible for 100% of fees not paid by your insurance within 90 days of nonpayment. We reserve the right to change fees with 30 days written notice. Refunds are not made after the services have been rendered. It is your responsibility to provide notification if problems arise during the course of treatment regarding your ability to make timely payments. In circumstances of unusual financial hardship, fees adjustments or a payment installation plan can be negotiated.

☐ Private Pay (see Fee Schedule)

☐ Contracted Insurance:

By completing the information below, you assign your insurance benefits to be paid directly to Lisa Elder Outhier, Psy.D. PLLC. You also authorize Dr. Outhier to release any information which may be needed for processing all of claims; certification/case management/quality improvement; and/or information related to the benefits of your health plan and in accordance with HIPPA regulations. Furthermore, it is your responsibility to ensure that proper referrals or authorizations are obtained for each visit.

Insurance Company: _____ Phone: _____

Employer: _____ Employee SS#: _____

ID#: _____ Group#: _____

Employee/Insured's name: _____ DOB: _____

Insurance Mailing Address: _____

<u>Cancelled/Missed Appointments</u>: Cancellations must be made at least 24 hours in advance. You will be billed according to the Fee Schedule. Waiver of the late cancellation fee will be made on a case by case basis.

Fee Schedule

<u>Psychotherapy</u>	
Diagnostic Intake	$200
Individual Psychotherapy	$82.50
Individual Psychotherapy	$137.50
Individual Psychotherapy	$175
Conjoint/Family Psychotherapy	$175
Telephone consultation (> 15 min) (e. g. client, parent, school, teacher, or other professional)	$175/hour
Missed appointment (full)/late cancellation: 2nd occurrence	$82.50 per
Missed appointment (full)/late cancellation: 3rd occurrence+	$175 per
Letter (brief)	$25
Letter/documentation (extensive: >15 min)	$175/hour
Records Review	$175/hour
Personality testing	$50

PLEASE NOTE: Fees associated with phone consultations, missed/late cancelled appointments, letters/documentation, records requests, or any service beyond scheduled psychotherapy sessions are billed according to the above schedule of fees and are not necessarily covered by insurance. You are 100% responsible for fees incurred for services rendered that are not covered by your insurance and have not been paid in 90 days. Thank you.

I understand and agree to <u>all</u> of the terms and conditions above:

_____

Signature Date

Child and Adolescent Psychology Professionals

Adult Background Questionnaire

Name _____ DOB _____ Age _____

Current Occupation _____Employer _____

Relationship Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Significant Other/Partner

Spouse/Partner's Name _____ Age____ Occupation _____

Children: Name/Gender/Age

_____ _____

_____ _____

List all people living in the household(s):

Name	Gender	Relationship to You	Age

Presenting Problem

Briefly describe your current difficulties: _____

_____

_____

_____

_____

When was the problem first noticed? _____

What seems to help the problem? _____

What seems to make the problem worse? _____

Have you received evaluation or treatment for the current problem or past problems? ☐ Yes ☐ No

If yes, when and with whom? _____

_____

Any established diagnoses? _____

_____

Educational History

Highest grade level/degree completed: _____ Grades earned: _____

History of Learning Difficulties/Academic Problems: _____

_____

Were you ever truant from school, expelled, or suspended? ☐ Yes ☐ No If Yes, please explain:

_____

Vocational school or training: _____

If **currently** attending school:

Name of School _____ Area of Study _____

Projected graduation date _____ Degree _____

Any current academic difficulties _____

_____

_____

Occupational/Employment History

Employer	Occupation/Position	Dates	Reason for leaving

Medical History

Place a check next to any illness or condition that you have had. When you check an item, also note the approximate age when you had the illness or condition.

☐ Measles
☐ Mumps
☐ Chicken Pox
☐ Whooping cough
☐ High Fever
☐ Convulsions
☐ Hay fever
☐ Head injury
☐ Seizures
☐ Broken bones
☐ Hearing problems
☐ Vision problems
☐ Ear infections
☐ Loss of consciousness
☐ Dizziness
☐ Frequent headaches
☐ Difficulty concentrating
☐ Memory problems
☐ Epilepsy
☐ Bone or joint disease
☐ Anemia
☐ Hepatitis
☐ Thyroid problems
☐ Liver disease
☐ Diabetes
☐ Cancer
☐ High blood pressure
☐ Heart problems
☐ Asthma
☐ Bleeding problems
☐ Eczema or hives
☐ Suicide attempt(s)
☐ HIV/AIDS
☐ Allergies
☐ Eating problems
☐ Other: _____

Please explain all those checked above: _____

_____

_____

_____

_____

Did anyone in your biological family (including parents, grandparents, aunts, uncles, siblings, etc.) ever have the aforementioned medical conditions?_☐ Yes ☐ No If Yes, please explain: _____

_____

Do you have any problems with your sleep? ☐ Yes ☐ No If Yes, please describe: _____

_____

Do you have any problems with your weight? ☐ Yes ☐ No If Yes, please describe: _____

_____

Are you currently being treated for a medical illness? ☐ Yes ☐ No

If yes, for what condition: _____

Are you on any medications at this time? ☐ Yes ☐ No

If yes, please list names of medications and dates started: _____

_____

Name, address, and phone number(s) of prescriber(s):

_____

_____

_____

Vitamin's/Supplements taken: _____

_____

_____

Alternative/naturopathic/homeopathic intervention(s): _____

_____

Physical, cognitive, or developmental disabilities? ☐ Yes ☐ No

Please describe: _____

_____

Serious illnesses? ☐ Yes ☐ No Please describe: _____

_____

Have you ever been hospitalized? ☐ Yes ☐ No Please describe: _____

_____

Have you had any operations? ☐ Yes ☐ No Please describe: _____

_____

Have you had any accidents? ☐ Yes ☐ No Please describe: _____

_____

Any family history of:

☐ Alcoholism
☐ Anxiety
☐ Depression
☐ Bipolar Disorder
☐ Schizophrenia
☐ Autism/Asperger's
☐ Substance abuse
☐ ADHD
☐ Suicide (attempt or completed)
☐ Learning disability
☐ Behavioral problems
☐ Sleep problems
☐ Eating problems

Social and Behavioral Checklist

Please check any behavior or problem that you **currently** exhibit:

☐ Lack of social relationships
☐ Lack of intimate relationships
☐ Prefer to be alone
☐ Do not get along well with others
☐ Verbally aggressive
☐ Physically Aggressive
☐ Mood swings
☐ Withdrawn
☐ Shy or timid
☐ Tire easily
☐ Frequently lie
☐ Steal
☐ Self injure: _____
_____
☐ Low self-esteem
☐ Feel suicidal
☐ Blame others for own troubles
☐ Argumentative
☐ Trouble showing feelings
☐ Frequent crying episodes
☐ Unusual or special fears, habits, or mannerisms
☐ Pull/pick hair
☐ Trouble sleeping
☐ Eat poorly
☐ Overactive/restless
☐ Fidgety
☐ Easily distracted
☐ Disorganized
☐ Unusually talkative
☐ Forgetful/poor memory
☐ Blank spells
☐ Daydream frequently
☐ Worry a lot
☐ Act without thinking
☐ Excessive guilt
☐ Slow to learn
☐ Do not understand other people's feelings
☐ Have difficulty following directions
☐ Give up easily
☐ Aches & pains
☐ Legal problems
☐ Constantly seeking attention
☐ Have periods of confusion or disorientation
☐ Extremely jealous
☐ Feel hopeless
☐ Nervous or anxious
☐ Easily frustrated
☐ Difficulty learning
☐ Suspicious of others
☐ Excessive shame
☐ Difficulty resisting peer pressure
☐ Anger easily
☐ Difficulty accepting criticism
☐ Often sad/unhappy
☐ Poor attention span
☐ Fearful of new situations
☐ Eat inedible objects
☐ Use drugs/alcohol
☐ Sexually provocative/risky behavior
☐ Extreme anxiety

☐ Overeat
☐ Very eager to please others
☐ Compulsive about cleanliness; wanting to wash or feeling dirty all the time
☐ Sexual dysfunction
☐ Binge/purge

☐ Calorie restricting
☐ Compulsive exercising
☐ Lonely
☐ Isolate from others
☐ Lack empathy
☐ Nightmares
☐ Addiction: _____
_____

☐ Spirituality/faith concerns
☐ Other: _____
_____
_____
_____
_____
_____

Did anyone in your biological family (including parents, grandparents, aunts, uncles, siblings, etc.) ever have a history of emotional, behavioral, psychiatric, or mental health concerns? ☐ Yes ☐ No

If Yes, please explain: _____

_____

_____

Substance History

How much caffeine do you drink on a daily basis? _____

Do you drink alcohol? ☐ Yes ☐ No If yes, please indicate type of alcohol, how often, and quantity: _____

_____

At what age did you first try alcohol? _____ At what age did you begin drinking alcohol regularly? _____ Have you ever been told that you needed to cut back or stop drinking? ☐ Yes ☐ No

Have you ever received treating for alcohol abuse or dependency? ☐ Yes ☐ No

Do you smoke cigarettes? ☐ Yes ☐ No If yes, how many packs per day? _____

Do you smoke marijuana? ☐ Yes ☐ No If yes, how much and how often? _____

Have you every misused or abused prescription drugs? ☐ Yes ☐ No If yes, what and how often?_____

_____

Do you use (or ever used) any illicit substances (e.g. amphetamines/stimulants; sedatives; tranquilizers; cocaine/crack; heroin; opiates; psychedelics; spice; bath salts, etc.) ☐ Yes ☐ No

If yes, please list type, amount, frequency, when, and for how long: _____

_____

Have you ever participated in treatment for chemical dependency? ☐ Yes ☐ No If Yes, please describe: _____

Other Information

What are your favorite activities/what do you do for fun? _____

_____

_____

Describe your typical routine (include morning routine, school/work, and evening routine; bedtime; activities before or after school/work; volunteering; employment; faith-based activities; clubs, sports, or social activities; etc.)

_____

_____

_____

_____

What are your strengths? _____

What do you do well? _____

List any current personal, family, or child stressors, changes, losses, or recent adjustments (e.g. move, change of job, divorce/separation, death of family member, loss of friends, finances, etc.)

_____

_____

Legal problems? ☐ Yes ☐ No Please describe: _____

_____

Has you ever been physically or sexually abused, experience emotional abuse or neglect, and/or witnessed or experienced a life-threatening event? ☐ Yes ☐ No

Please describe: _____

_____

Have you, your family, or your child been involved with Child Protective Services? ☐ Yes ☐ No

Please describe: _____

Treatment Planning

What are your goals for treatment? _____

_____

_____

What are your expectations for behavioral, emotional, and/or interpersonal change? _____

_____

_____

Do you anticipate any obstacles to behavior change or participation in therapy? _____

Any there any special considerations or limitations that you would like your therapist to be aware of?

Clinician Notes:

Child and Adolescent Psychology Professionals
Consent For Treatment: Adult

Introduction

Welcome! As a new client, Dr. Lisa Elder Outhier looks forward to working with you. Informed consent is requested as part of psychological treatment, and this document clarifies the agreement of services including definitions, limits of confidentiality, legal consent, financial and procedural terms, and records maintenance. Please read this document carefully and speak with Dr. Outhier should you have any questions. You have a right to revoke informed consent at any time.

Therapy

Psychotherapy typically begins after an initial assessment or what is also referred to as an "intake" session. During this appointment, extensive background information is collected to inform diagnosis and treatment planning, after which therapy can begin. Likewise, you will be asked to complete the Registration form and provide contact and financial information; a copy of your insurance card and photo identification will be requested; and you will be provided with a receipt for services. This initial phase is also a good opportunity to size up the match between your needs and the services, policies, and treatment methodology of the treatment provider.

The relationship between feelings, thoughts, and behavior is crucial to understanding the issues that affect being successful in life. Dr. Outhier may utilize a variety of strategies including psycho-educational, cognitive behavioral, psychodynamic, interpersonal, family, and group approaches, while integrating developmental and biological influences. It is important to understand an individual from his or her own unique biological, social/emotional, familial, cultural, and environmental experience.

Individual therapy can offer you a chance to express ideas and concerns to better understand your situation and to learn new ways to solve problems. However, there are sometimes risks within this process. Success of the therapy process will be influenced by the time, effort, and willingness of all who are involved. As therapy is a collaborative process, communication is imperative to discuss expectations, determine goals, and evaluate progress. At times, you might experience feelings that are uncomfortable and difficult. Dr. Outhier is available to discuss these concerns openly with you and will provide an accurate and fair assessment that will help guide your treatment-planning/goal setting.

Treatment Planning

A treatment plan will be developed collaboratively with you in an effort to identify treatment goals and provide a guide for the treatment process. These goals provide a focus for treatment and will be evaluated throughout the course of treatment with your input to ensure satisfactory progress is being achieved. Your written consent will be obtained for each treatment plan. At the close of treatment, a brief summary will be completed reflecting your overall progress in therapy.

Psychological Assessment

Dr. Outhier may ask you to complete psychological and/or psychoeducational measures (e.g. questionnaires, behavior rating scales, personality measures, etc.) in order to inform diagnosis and treatment planning, and/or evaluate the outcome or efficacy of treatment. While outcomes from these measures will be discussed with you and integrated into the overall treatment plan, any assessment protocol can only be released to professionals/ clinicians who are trained to interpret such information and will only be released to such an individual with your written consent. **Additional personality testing is billed at $50.00.**

Limits of Confidentiality

Information that is discussed with Dr. Outhier is confidential and can only be released to others outside of this facility with your written consent, or as required by law (e.g. Court Order). There are some exceptions to confidentiality. Confidentiality is limited in matters pertaining to: (1) threat of harm to self or to another person; (2) physical/sexual abuse or neglect of minors, persons with disabilities, and the elderly-current or past; (3) legal activity resulting in a Court order; or (4) in accordance with the law. Lisa Elder Outhier, Psy.D. is a legally mandated reporter of abuse to a minor or elderly person (see Arizona Revised Statute 46-454).

Dr. Outhier provides ongoing training to graduate students as part of their practicum training and in fulfillment of a doctoral degree in Clinical Psychology. You may be asked to consent to having a student present during the appointment for educational purposes, and you may consent or decline as you wish. Likewise, Dr. Outhier participates in peer consultation to facilitate professional growth and provide the best possible treatment to you and your child. While no identifying information is released, the dynamics of the problem and the people are discussed along with best possible treatment approaches and methods.

The use and disclosure without your consent or authorization is allowed under other sections of Section 164.512 of the Privacy Rule and state's confidentiality law. This includes certain narrowly-defined disclosures to law enforcement agencies, to a health oversight agency (such as the U.S. Department of Health and Human Services [HHS] or a state department of health), to a coroner or medical examiner, for public health purposes related 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.

There are also numerous circumstances when information may be released including when disclosure is required by the Board of Psychologist Examiner's such is the case with a board complaint; when a lawsuit is filed against the psychologist; and to comply with other federal, state, or local laws.

HIPPA

The rules regarding confidentiality, privacy, and records are complex. The HIPPA Notice of Privacy Practices details the considerations regarding confidentiality, privacy, and your records. This notice also contains information about your right to access your record and the details of the procedures to obtain them, should you choose to do so. Periodically, the HIPPA Notice of Privacy Practices may be revised. It is imperative that you read and understand the limits of privacy and confidentiality before you start treatment.

Pursuant to HIPPA, Protected Health Information (PHI) is retained in two separate professional records. One set constitutes your "Clinical Record." It includes information about your reason for seeking therapy, a description of ways in which the problem impacts you/your child's life, the diagnosis, the goals that we set for treatment, progress toward these goals, medical and social history, treatment history, and any past treatment records received from other providers, reports of any professional consultations, billing records, and any prepared reports or letters, including reports/updates sent to your insurance provider. Except in unusual circumstances that involve danger to self or others, or where information has been supplied confidentially, you may examine and/or receive a copy of your Clinical Record, as requested in writing. Because these are professional records, they can be misinterpreted and/or upsetting to untrained readers. For this reason, it is recommended that you initially review them with Dr. Outhier present, or have them forwarded to another mental health professional so you can discuss the contents. In most situations, consultation fees apply and a fee of $.25 per page is charged for copies of records over 25 pages.

In addition, "Psychotherapy notes" are also kept as a separate professional record. "Psychotherapy notes" means notes recorded (in any medium) by a health care provider who is a mental health professional documenting or analyzing the contents of conversations during a private counseling session or a group, joint, or family counseling session and that are separated from the rest of the individual's medical record. They may also contain particularly sensitive information that may be revealed that is not required to be included in your Clinical Record. Psychotherapy notes excludes medication prescription and monitoring, counseling session start and stop times, the modalities and frequencies of treatment furnished, results of clinical tests, and any summary of the following items: diagnosis, functional status, the treatment plan, symptoms, prognosis, and progress to date (See Federal Confidentiality Rules 42 CFR Part 2 and 45 CFR Parts 160, 162, & 164; U.S. Department of Health and Human Services, Office for Civil Rights). While insurance companies can request and receive a copy of your Clinical Record, they cannot receive a copy of your Psychotherapy Notes without your written consent and signed authorization. Insurance companies cannot require your authorization as a condition of coverage nor penalize you in any way for your refusal. You may examine and/or receive a copy of your Psychotherapy Notes unless Dr. Outhier determines that such access is clinically contraindicated.

I consent to the use or disclosure of my protected health information (PHI) by Dr. Outhier for the purpose of diagnosing or providing treatment to myself, my child, my family; obtaining payment for my health care bills; or to conduct health care operations. "The Privacy Rule protects 'all *individually identifiable health information'* (PHI) held or transmitted by a covered entity or its business associate, in any for or media, whether electronic, paper, or oral." The Privacy Rule calls this information '*protected health information*.' '*Individually identifiable health information'* is information including demographic data that relates to: 1) The individual's past, present, or future physical or mental health or condition; 2) the provision of health care to the individual; or 3) the past, present, or future payment for the provision of health care to the individual, and that identifies the individual or for which there is a reasonable basis to believe can be used to identify the individual. Individually identifiable health information includes many common identifies (e.g. name, address, birth date, social security number, etc.)."

Notice of Privacy Practices (NPP)

The following uses and disclosures of PHI will be made only with a client's (or authorized representative's) written authorization: 1) most uses and disclosures of psychotherapy notes, (*See* 45 C.F.R. § 164.501 for definition of "psychotherapy notes" under HIPAA), if applicable; 2) uses and disclosures of PHI for marketing purposes; 3) uses and disclosures that constitute a sale of PHI; and 4) other uses and disclosures not described in the NPP. Furthermore, you will be notified if there is a breach of unsecured PHI.

Privacy, Security, and Breach Notification

If I become aware of a potential breach of your protected health information (PHI), I am legally required to perform a risk assessment, and then mitigate breaches and report them to affected clients, the federal government, and in some cases, the media.

A "breach" is defined in the new 2013 rule effective September 23rd, 2013 as the improper "acquisition, access, use, or disclosure of protected health information…which compromised the security or privacy of the protected health information" (45 C.F.R. § 164.402). Furthermore, the rule clarifies that there is a presumption of a breach under the above definition unless a risk assessment by a provider or business associate demonstrates a low probability that protected health information has been compromised.

The final breach notification provision rule establishes four factors to consider in analyzing and deciding whether to notify individuals:

1) The nature and extent of protected health information (PHI), including types of identifiers and likelihood of re-identification (e.g., improper acquisition or loss of social security numbers and sensitive clinical information likely would call for a notice);
2) Who the unauthorized person was who used or received the PHI;
3) Whether the PHI was actually acquired or viewed; and
4) The extent to which the risk has been mitigated.

Under the HIPAA Omnibus Rule is that, at the client's request, counselors may not disclose treatment information to the client's health insurance carrier for which the client has paid out-of-pocket, unless the disclosure is required by law.

I have read the HIPPA Notice of Privacy Practices and Client Rights, and have had my questions about rights, privacy, and confidentiality answered to my satisfaction. I understand that the HIPPA Notice of Privacy Practices is incorporated by reference into this agreement in addition to the HIPPA Final Rule effective 9/23/2013. I am aware that a copy of the HIPPA Notice of Privacy Practices and Clients Rights are available to access at my convenience at www.childpsychaz.com. I also have a right to request a hard copy of these documents at any time. _____ (Initials)

Procedural and Financial Issues

Payment is expected at the time the service is rendered. By signing this document, you are agreeing to pay for the services rendered and any additional expenses that may be accrued. Please refer to the Fee Schedule in your Registration paperwork for a full list of fees. The initial interview, or "intake" session, runs approximately **60 minutes** in length and is billed at **$200**. Psychotherapy sessions run approximately **30, 40, and 50 minutes** in length and are billed at **$82.50, $137.50 and $175.00 per session, respectively**. Session length is determined by clinical necessity, my established professional rates, and if using insurance, what your insurance company will authorize.

If additional documentation or letter writing is needed, it is billed at **$25.00** (e.g. to another treatment provider, etc.). If lengthy documentation or ongoing follow up is required, this is billed at **$175 per hour.**

Consultation with other treatment providers (e.g. physicians, psychologists, counselors, etc.), attorneys, and/or mediators is billed at **$175.00** per hour. For legal and/or court testimony (including records review and preparation, travel time, and actual testimony), please refer to legal policies and schedule of fees.

Regular attendance at your scheduled appointment time is one of the keys to successful outcomes. It is important to arrive on time, as appointments cannot be extended beyond the allotted appointment time. Appointment availability varies, and high demand appointment times (e.g. afternoons and early evenings) are likely to be more challenging to secure. It is strongly encouraged that you schedule your appointments accordingly and in advance.

By signing this form, you are agreeing to pay fees before each session. Cancellations must be made **24 hours** in advance. You will be billed **$82.50** of the scheduled service for a 2nd late cancellation or missed appointment and **$175.00** for each subsequent session cancelled without 24 hour advanced notice, as this time has been reserved especially for you. Waiver of the late cancellation fee will be made on a case by case basis.

Please note that you can leave a message at 602-795-1670, and your message will be returned within 24 hours. Please note that if you leave a message on Friday, it will be returned no later than the following Monday. This practice does **not** have the capability to respond immediately to therapeutic emergencies. In the event of an emergency, please call 911. Crisis services are available through the Maricopa County Crisis hotline at 602-222-9444, via mobile crisis unit, Empact, at 480-784-1500, the Banner helpline at 602-254-4357, Aurora Behavioral Health helpline at 480-345-5420, or Childhelp hotline at 1-800-422-4453.

In the event that Dr. Outhier is out of town, the name of another therapist will be provided for on call consultation. Dr. Outhier reserves the right to disclose confidential information, including personally identifiable information, to this on-call therapist to facilitate the coverage of your care in the psychologist's absence.

Email, Website/Web Searches, and Social Media

Email communication is a convenience and not appropriate for emergencies or time-sensitive issues. The security and privacy of email communication cannot be guaranteed; thus, highly sensitive or personal information should not be communicated via email. Transmission security must also be considered for email communication of PHI, as your provider, Dr. Outhier can send unencrypted emails **ONLY** if you are advised of the risks. Dr. Outhier is not responsible for information lost due to technical failures.

_____ **Initials**	**I am aware that email communication is a convenience and that it is not to be used for emergencies or time-sensitive information. All of the information contained in and or attached to electronic messages is privileged and confidential and is covered by the Electronic Communications Privacy Act, 18 U.S.C._2510-2521. I consent to email communication.**

I have a website that you are free to access. I use it for professional reasons to provide information to others about me and my practice. You are welcome to access and review the information that I have on my website, and if you have questions about it, we should discuss this during your scheduled therapy session.

I will not use web searches to gather information about you without your permission. I believe that this violates your privacy rights; however, I understand that you might choose to gather information about me in this way. In this day and age there is an incredible amount of information available about individuals on the Internet, much of which may actually be known to that person and some of which may be inaccurate or unknown. If you encounter any information about me through web searches, or in any other fashion for that matter, please discuss this with me during our time together so that we can address it and its potential impact on your treatment.

Recently, it has become fashionable for clients to review their health care provider on various websites. Unfortunately, mental health professionals cannot respond to such comments and related errors because of confidentiality restrictions. If you encounter such reviews of me or any professional with whom you are working, please share it with me so that we can discuss it and its potential impact on your therapy. Please do not rate my work with you while we are in treatment together on any of these websites as it has a significant potential to damage our ability to work together.

I do not communicate with, or contact, any of my clients through social media platforms like Twitter and Facebook. In addition, if I discover that I have accidentally established an online relationship with

you, I will cancel that relationship because these types of casual social contacts can create significant security risks for you.

I participate in professional social networks. If you have an online presence, there is a possibility that you may encounter me by accident. If that occurs, please discuss it with me during our time together. I believe that any communication with clients online has a high potential to compromise the professional relationship. In addition, please do not try to contact me in this way. I will not respond and will terminate online contact no matter how accidental.

Insurance

Dr. Outhier is contracted with select insurance companies. Insurance claims will be billed by the psychologist for which they are contracted; however, it is very important that you call your insurance company to explore your mental health benefits, extent of coverage, and client rights and responsibilities, including financial responsibility. If you have questions about the coverage, call your plan administrator. Due to the rising costs of health care, insurance benefits have increasingly become more complex. It is sometimes difficult to determine exactly how much mental health coverage is available or will be authorized. "Managed Health Care" plans such as HMOs and PPOs often require authorization before they provide reimbursement for mental health services. These plans are often limited to short-term treatment approaches designed to work out specific problems that interfere with a person's usual level of functioning. It may be necessary to seek approval for more therapy after a certain number of sessions. While a lot can be accomplished in short-term therapy, some clients feel that they need more services after insurance benefits end. Some managed-care plans will not permit provision of services to you once your benefits end. If this is the case, referral to another provider can be made. You should also be aware that most insurance companies require a clinical diagnosis, and information such treatment plans or summaries, or copies of the entire record (in rare cases). Not all conditions/problems/diagnoses, which are the focus of psychotherapy, are reimbursed by insurance companies. Likewise, your insurance company may limit the number of sessions based on their assessment of medical necessity or other factors. It is important to remember that you always have the right to pay for therapy services privately to avoid the problems described above [unless prohibited by contract], and a cash discount is available. You are 100% responsible for fees incurred for services rendered that are not covered by your insurance and have not been paid in 90 days.

Records Maintenance

Your treatment records are maintained for a **minimum of six years** after the last date of the received mental health services (See Arizona Revised Statute 12-2297).

In the untimely event of death or incapacity, or the termination or selling of the practice, client records of those who are actively receiving services (e.g. seen within the last month) will be given to one or more local behavioral health professional(s) to facilitate the continuation of treatment. In such situation, you have the right to continue treatment with this professional, discontinue treatment, or ask for referral. Records for inactive clients will be handled by a "records custodian," which may be an individual or company. The custodian will be responsible for satisfying records requests and destroying records when the legal time frames for records retention have been satisfied. Please refer to Arizona Revised Statute 32-3211 for more information.

Dr. Outhier wishes to answer your questions clearly and completely. Please ask for clarification of any results, opinions, findings, or recommendations at any time. If at any time you have concerns, please communicate directly with Dr. Outhier. Dr. Outhier can assist you in making appropriate treatment referrals, etc. and will work with you to terminate therapy in a clinically appropriate manner.

Adult Client

I, _____ understand and agree to the information regarding confidentiality and financial responsibility. I hereby consent to therapeutic services.

_____

Signature Date

Treatment Provider

_____

Lisa Elder Outhier, Psy.D. Date
Psychologist; License #3909