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TREATMENT CONTRACT
AND
INFORMATION ON POLICIES AND PROCEDURES

Welcome to my practice! Thank you for your interest in working together. I appreciate how hard it can be to start a venture such as psychotherapy and congratulate you for having the courage and willingness to take this step towards making some helpful changes in your life.

This document and supporting materials contain important information about my professional services and business policies. I have prepared this contract for two reasons. First, it allows me to comply with the requirement that I obtain informed consent from my clients (Ethical Principles of Psychologists and Code of Conduct, http://www.apa.org/ethics/code). Second, it allows me to establish a legally enforceable business relationship with my clients and avoid risks of such business issues that may become the bases for misunderstandings, boundary violations, and ethical dilemmas or complaints. Although this Treatment Contract is long and sometimes complex, it is essential that you read it carefully before signing. *Your signature on these documents represents a binding agreement between us*.

I can appreciate that the relative size of this document may seem somewhat daunting. I assure you that everything contained herein is designed to facilitate our work together. By having you undertake this task, I am: 1) introducing you to one of the central features of CBT, which is “homework;” 2) allowing you to take as much time as necessary to completely understand my policies and form any questions or concerns that you would like to address; and 3) essentially reserving our time together for important content issues by restricting the amount of time spent reviewing administrative matters. At our next meeting, you will have an opportunity, using whatever time necessary, to ask any questions and address any concerns to your satisfaction.

Thank you for attending to these necessary administrative matters. I am really looking forward to getting to know you and working with you towards your therapy goals.

Sincerely,

Dr. Karen Lee Gillock
Licensed Clinical Psychologist

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CONTRACT SUMMARY

I have read Dr. Gillock's Treatment Contract and Information on Policies and Procedures dated 1/1/2017 so that *I understand and acknowledge* the following *summary* points.

1. Dr. Gillock will be working with and supervising Ms. St. Laurence until September 2017, and the Treatment Contract and Information on Policies and Procedures dated 1/1/2017 includes and applies to both Dr. Gillock and Ms. St. Laurence (even when the contract and this summary refer only to Dr. Gillock).
2. Ms. St. Laurence's clients must, as a condition of her supervision requirements, agree to audio-recordings that will be used in complete confidentiality only by Ms. St. Laurence and Dr. Gillock.
3. The important tenets of CBT as identified herein have been used in order to make an informed decision to undertake this particular form of psychotherapy.
4. CBT with Dr. Gillock/Ms. St. Laurence can have both benefits and risks, and that especially in the case of risk, I will call 911 and/or contact my local hospital emergency department if in crisis.
5. I have read, had an opportunity to discuss, and understand the contents of the Notice of Privacy Practices (HIPAA) and Behavioral Health Participant Rights and Responsibilities (CIGNA) documents supplementing this contract. I agree to the arrangements outlined within them and have signed the Notice of Privacy Practices.
6. I have had an opportunity to discuss with Dr. Gillock/Ms. St. Laurence and am comfortable with the safeguards to my clinical records and the limits of psychologist-client confidentiality as outlined in this document.
7. Dr. Gillock's office hours are generally Monday, Tuesday, Thursday, and Friday, 9:00-8:00, and Ms. St. Laurence's office hours are Wednesday 9:00-5:00.
8. Dr. Gillock is a sole practitioner and does not have an administrative assistant; therefore, returning calls/email may take as long as 48-72 hours (2-3 days), not including weekends, holidays, absences, and vacations. If I experience a psychological emergency (one involving potential life threat or harm to self or others) and feel that I cannot wait for at least 48-72 hours (not including weekends, holidays, absences, and vacations) to speak with Dr. Gillock or Ms. St. Laurence, I will call 911 and/or contact my local hospital emergency room (e.g., nearest or one covered by your insurance company) and ask for the psychiatrist on call.
9. Email is preferred as a primary means of communicating logistical information, with reasonable confidentiality safeguards, and under no circumstances should email be used to address crisis issues.
10. My initial work with Dr. Gillock/Ms. St. Laurence will involve an assessment of my therapy needs, an outline of my initial therapy goals, and an agreement of our fit for purposes of achieving those goals. I have completed the General Information Form and signed the Release of Information Consent.
11. It is important to maintain a therapy schedule, and I will do my best to arrive on time, hold to the 45-50 minute session duration, attend therapy regularly, and absolve Dr. Gillock/Ms. St. Laurence of responsibility if I elect not to respond to repeated attempts to re-engage.
12. Unless otherwise agreed-to, all therapy sessions are to be conducted in Dr. Gillock's office, and any sessions conducted in another format (i.e., telehealth) will be my financial responsibility.
13. I will make sincere efforts to engage in therapy homework assignments, with the understanding that I am doing so voluntarily, and will view any non-compliance as a manageable therapy issue rather than as a therapy failure.
14. The Lending Library is a resource for enhancing my therapy work, and I agree to use this opportunity responsibly.
15. With the exception of winter weather travel issues, I am to provide 24 hours notice when cancelling an appointment, and it is my responsibility to ensure that Dr. Gillock has received the notice.
16. My signature on this document constitutes a binding agreement to abide by all financial policies contained herein, and I understand and agree to pay the fees for late cancellations and no-shows regardless of my reason for non-attendance.
17. I have willingly and voluntarily provided Dr. Gillock with credit card information and authorization to make charges for any fees that are not paid at the time the services are rendered.
18. [For CIGNA clients only] I have willingly and voluntarily authorized Dr. Gillock to bill CIGNA to obtain direct payment for any contracted service. I have completed and signed the Health Insurance Claim Form (CMS-1500) so that Dr. Gillock can submit claims directly to CIGNA on my behalf.
19. [For CIGNA clients only] I am aware that Dr. Gillock is required that I provide my insurance company with information relevant to the services that I have received, including a clinical diagnosis.
20. I have willingly and voluntarily affixed my signature indicating that I have read the information in this document and agree to abide by its terms during our professional relationship, and that I may revoke this agreement in writing at any time.

Print Name	Sign Name	Date

SUPERVISION INFORMATION FOR JENNIFER ST. LAURENCE, CLINICAL INTERN

This year (through August 2017) I am mentoring a clinical intern – Jennifer St. Laurence, who is completing her Master of Science degree in Mental Health Counseling at Springfield College School of Human Services while working full time as the Director of Career Services at the Thayer School of Engineering at Dartmouth.* As one of the best ways for students to learn is through experiential opportunities, an important part of Ms. St. Laurence's training is this clinical internship which will include observing and conducting psychotherapy sessions. Ms. St. Laurence is very motivated to learn the approach of evidence-based Cognitive Behavioral Therapy as she prepares for a career as a psychotherapist. Similar to a resident at a hospital who is training to become a medical doctor, a clinical mental health counseling intern works with clients under the supervision of a licensed clinician. Student clinicians are bound by the same ethics, laws, and limits of confidentiality as licensed clinicians.

Dr. Gillock's Clients:

As this is a teaching relationship, I would like to be able to offer Ms. St. Laurence the opportunity of "observing" CBT sessions via audio-recording some of my sessions for her to review in confidence. Your participation is completely voluntary, and you are by no means under any obligation to consent to this. If you are even slightly uncomfortable with the idea of audio-recording our sessions, I *strongly encourage* you to assert your right to keep our sessions private. Yes, it is important to me to help train the next generations of mental health professionals – but even more so it is important to me that our work together feel safe and be effective, so if you have any qualms about this, I would *sincerely appreciate* your refusal of this request.

If you are interested in participating, read and sign the Consent for Audio-Recording on the next page. At our next meeting, you will have an opportunity to ask any and all questions you have and voice any and all concerns that you have so that we can make an informed decision. However, please also understand that offering to have sessions audio-recorded does not automatically mean that we will be doing so – there are many logistical factors involved, and not taking you up on your very kind offer does not mean that you are not a good candidate for training purposes. Remember that Ms. St. Laurence is observing me rather than you, and our ability to take advantage of everyone's generosity may not be feasible. Finally, you may revoke this consent at any time before or during a session by simply stating to me your preference not to audio-record the session.

Ms. St. Laurence's Clients:

For those clients who will be working with Ms. St. Laurence, it is to be understood in this document that references to Dr. Gillock are to be equally applied to Ms. St. Laurence. All policies, practices, contractual obligations and ethical/legal expectations stated herein are as applicable to Ms. St. Laurence as they are for Dr. Gillock (even when the contract refers only to Dr. Gillock).

Ms. St. Laurence's clients must, as a condition of her supervision requirements, agree to audio-recordings that will be used in complete confidentiality only by Ms. St. Laurence and Dr. Gillock. The Consent for Audio-Recording on the next page must be signed and enacted during the first part of the first session with Ms. St. Laurence. If any client is not comfortable with this requirement, the first session will be suspended immediately and referral to another clinician will be offered.

As a final reminder, Ms. St. Laurence is completing her training as a mental health practitioner and is currently gaining hours towards independent licensure. She is a clinical intern supervised by Dr. Gillock. This means that Ms. St. Laurence and Dr. Gillock work collaboratively to provide you with the best care possible. If you have any concerns about your work with Ms. St. Laurence we ask you to first discuss it with her and then contact Dr. Gillock if your concerns remain unresolved.

* Ms. St. Laurence is employed by Dartmouth College; however, it is to be understood that her work with Dr. Gillock is a private business that exists as an independent entity separate from Dartmouth College. The services provided during her private business hours at Dr. Gillock's office are in no way connected to her position as an employee with Dartmouth College.

CONSENT FOR AUDIO-RECORDING

I hereby freely give my consent to allow my psychotherapy sessions with Dr. Karen Gillock and/or Ms. Jennifer St. Laurence to be audio-recorded. Ms. St. Laurence is a counselor-in-training at Springfield College who is completing her clinical requirements at the office of Dr. Karen Gillock, Cognitive Behavioral Therapy.

I understand this recording will be used only for the purpose of providing clinical supervision with Ms. St. Laurence as outlined on page 5 of the Treatment Contract and Information on Policies and Procedures dated 1/1/2017. Ms. St. Laurence, as a student clinician, is bound by the same ethics, laws, and limits of confidentiality as Dr. Gillock, a licensed clinician. I understand my case will not be discussed by any other person and the recording will be destroyed before Ms. St. Laurence completes her internship with Dr. Gillock on August 31st, 2017.

I also understand that I may revoke this agreement at any time simply by asking that the recorder – which will always be in full sight when in use – be turned off.

I have read the above statement and have been given the opportunity to have all questions regarding the use of this recording to be answered to my satisfaction.

Client's Printed Name _____

Client's Signature _____

Date_____

Provider's Signature_____

Date_____

PSYCHOTHERAPY DEFINED AND GENERAL GUIDELINES

Psychotherapy is not easily described in general statements. It varies depending on the personalities of the psychologist and client, as well as the particular issues that are presented. There are many different methods that can be used to deal with the changes that you hope to make. My approach is CBT.

Cognitive Behavioral Therapy (CBT). CBT is my orientation to psychological treatment. CBT is a very general term for a classification of therapies with similarities (i.e., Cognitive Therapy, Dialectical Behavior Therapy, Self-Instructional Training, Acceptance and Commitment Therapy, etc). Very different from other forms of psychotherapy (i.e., psychoanalytic, psychodynamic, etc.), CBT as a therapy emphasizes the important role of thinking in how we feel and what we do. Most cognitive-behavioral therapies have the following characteristics:

- CBT is based on the idea that our *thoughts cause our feelings and behaviors*, not external things, like people, situations, and events. The benefit of this fact is that we can change the way we think to feel/act in healthier ways even if the situation does not change.
- CBT is brief and time-limited. CBT is considered among the most rapid in terms of results obtained. What enables CBT to be more efficient is its highly instructive nature and the fact that it makes use of homework assignments. CBT is time-limited in that it is understood at the very beginning of the therapy process that there will be a point when the formal therapy will end.
- CBT does not focus on the therapeutic relationship. Some forms of therapy assume that the main reason people get better in therapy is because of the positive relationship between the psychologist and client. Cognitive-behavioral psychologists believe that a good trusting relationship is important, but not sufficient – that clients change rather because they learn how to think differently and they act on that learning. Therefore, CBT psychologists focus on teaching rational self-counseling skills.
- CBT is a collaborative effort between psychologist and client. Cognitive-behavioral psychologists seek to learn what their clients want out of life and then help them achieve those goals. The psychologist's role is to listen, teach, and encourage, while the client's roles is to express concerns, learn, and implement that learning.
- CBT uses the Socratic Method. Cognitive-behavioral psychologists want to gain a very good understanding of their clients' concerns. That's why they often ask questions. They also encourage their clients to ask questions of themselves, like, "How do I really know what those people are thinking about me?" "Could they be thinking something else?"
- CBT is structured and directive. Cognitive-behavioral psychologists have a specific agenda for each session. Specific techniques and concepts are taught during each session. CBT focuses on the client's goals rather than telling clients what their goals "should" be, or what they "should" tolerate. Cognitive-behavioral psychologists are directive in the sense that they show clients how to think and behave in ways in order to obtain what they want. Therefore, CBT psychologists do not tell their clients *what* to do -- rather, they teach their clients *how* to do.
- CBT is based on an educational model. CBT is based on the scientifically supported assumption that most emotional and behavioral reactions are learned. Therefore, the goal of therapy is to help clients *unlearn* their unwanted reactions and to learn a new way of reacting. Therefore, CBT is not "talk therapy." People can "just talk" with anyone. The educational emphasis of CBT has an additional benefit -- it leads to long term results. When people understand *how and why* they are doing well, they know *what* to do to continue doing well.
- CBT theory and techniques rely on the Inductive Method. A central aspect of *rational* thinking is that it is based on *fact.* Often, we upset ourselves about things when, in fact, the situation isn't like we think it is. If we knew that, we would not waste their time upsetting ourselves. Therefore, the inductive method encourages clients to look at their thoughts as being hypotheses or guesses that can be questioned and tested. If they find that their hypotheses are incorrect (because they have new information), then they can change their thinking to be in line with how the situation really is.
- Homework is a central feature of CBT. Goal achievement could take a very long time if a person were only to think about the techniques and topics taught for one hour per week. That's why CBT psychologists assign readings and encourage clients to practice the techniques learned.

Benefits and Risks. As with other therapies, CBT can have both benefits and risks. Since therapy often involves discussing unpleasant aspects of your life, you may experience uncomfortable feelings like sadness, guilt, anger, frustration, and helplessness. Generally such discomfort can be managed independently; however, at times you may feel the need for assistance with negative reactions between

therapy sessions. Unfortunately, the nature of my sole-practitioner practice does not allow me to be a crisis counselor or available outside of normal business hours. Therefore, it is important for us to have an agreed-upon plan to manage any between-session difficulties if they occur. Certainly we can try to schedule additional sessions or speak briefly over the phone. However, *if during the course of our work together, you experience a psychological emergency (one involving potential life threat or harm to self or others) and you feel that you cannot wait for at least 48-72 hours (not including weekends, holidays, absences, and vacations) to speak with me, you are to call 911 and/or contact your local hospital emergency room (e.g., nearest or one covered by your insurance company) and ask for the psychiatrist on call.*

On the other hand, psychotherapy has been shown to have benefits for people who actively engage in it. Therapy often leads to better relationships, solutions to specific problems, and significant reductions in feelings of distress and other symptoms. And while no guarantees can be made regarding the success of treatment, it has been my real privilege to have worked with people who have done difficult things they thought were all but impossible – things like kicking self-defeating behaviors, taking a flight to visit loved ones, finishing a dissertation, cultivating better interpersonal relationships, and overcoming all manner of anxiety, stress, trauma, and depression in order to pursue healthy, happy, productive lives.

Client Rights. Two appendices, the Notice of Privacy Practices (HIPAA) and Behavioral Health Participant Rights and Responsibilities (CIGNA), on pages 21-24 of this contract, describe your rights as a psychotherapy client. Both of these documents can also be found on my website and I am happy to discuss any of these rights with you.

The Health Insurance Portability and Accountability Act, or HIPAA, provides you with rights with regard to your clinical records and disclosures of your PHI. These rights include requesting that I amend your record; requesting restrictions on what information from your clinical records is disclosed to others; requesting an accounting of most disclosures of your PHI that you have neither consented to nor authorized; determining the location to which PHI disclosures are sent; having any complaints you make about my policies and procedures recorded in your records; and the right to a paper copy of this Treatment Contract and the Notice of Privacy Practices form. HIPAA requires that I provide you with a Notice of Privacy Practices for use and disclosure of protected health information (PHI) for treatment, payment, and health care operations, and the law requires that I obtain your signature acknowledging that I have provided you with this information by the end of our first session.

CIGNA Behavioral Health supports informing clients of their rights and responsibilities related to the provision of care and service. As a CIGNA Behavioral Health practitioner, I am required: to facilitate clients' awareness of the CIGNA Behavioral Health Participant Rights and Responsibilities statement at their first appointment; to offer to help clients get more information about any of the items in the statement; to notify clients how to access services, including service outside of normal business hours; and to discuss the services available to clients and possible charges for those services. As I think these are good procedures in general, I am offering them to all my clients, whether or not they are with CIGNA.

Professional Records. The laws and standards of my profession require that I keep Protected Health Information (PHI) about you in your Clinical Record. Your Clinical Record is primarily stored in a laptop computer that is protected in a manner that is in keeping with the Ethical Principles of Psychologists and Code of Conduct (http://www.apa.org/ethics/code). While I have exercised due diligence in protecting the confidentiality of your PHI/Clinical Record both on the laptop computer and paper records stored in my office, I cannot provide a complete guarantee against an unanticipated event (i.e., accident, theft). Given computer safeguards, I do not believe your PHI will be at any greater risk than if a paper copy of the information was stored in a file cabinet in my office. If you are uncomfortable with these arrangements, please discuss this with me when you return this Treatment Contract.

Except in unusual circumstances that involve danger to yourself and/or others, or the record makes reference to another person (unless such other person is a health care provider) and I believe that

access is reasonably likely to cause substantial harm to such other person, you may examine and/or receive a copy of your Clinical Record, if you request it in writing. Because these are professional records, they can be misinterpreted and/or upsetting to untrained readers. For this reason, I require that you initially review them in my presence, or have them forwarded to another mental health professional with whom you can discuss the contents. In most circumstances, I am allowed to charge a copying fee of $1 per page (and for certain other expenses).

Confidentiality. The law protects the privacy of all communications between a client and a psychologist. In most situations, I can only release information about your treatment to others if you sign a written authorization form that meets certain legal requirements imposed by HIPAA. There are other situations that require only that you provide written advance consent. Your signature on this Treatment Contract provides written advance consent for those activities, as follows.

- If I believe that a client presents an imminent danger to his/her health or safety, I am legally and ethically obligated to intervene appropriately to provide for the client's protection. Such interventions may include dispatching police and/or emergency rescue services to his/her home, seeking hospitalization for him/her, or contacting family members or others who can help.
- Consultations/collaborations with other health and mental health professionals is helpful and professionally warranted. During such communications, I make every effort to avoid revealing the identity of my clients. Other health professionals are also legally bound to keep the information confidential. If you don't object, I will not tell you about these consultations unless I feel that it is important to our work together. I will note all consultations in your Clinical Record.
- Business contracts with corporate service firms, as required by HIPAA, require a formal business associate contract with these entities, in which they promise to maintain the confidentiality of data except as specifically allowed in the contract or otherwise required by law. If you wish, I can provide you with the name of these entities and/or a copy of these contracts.
- Disclosures required by health insurers to collect overdue fees are discussed elsewhere in this Treatment Contract.

There are some situations where I am permitted or required to disclose information without either your consent or authorization, as follows.

- If you are involved in a court proceeding and a request is made for information concerning the professional services that I provided you, such information is protected by the psychologist-client privilege law. However, I may be legally bound to provide requested information if I am presented with a court order. If you are involved in or contemplating litigation, you should consult with your attorney to determine whether a court would be likely to order me to disclose information.
- If a government agency is requesting the information for health oversight activities, I may be required to provide it for them.
- If a client files a complaint or lawsuit against me, I may disclose relevant information regarding that client in order to defend myself.
- If a client files a workers' compensation claim, and my services are being compensated through workers' compensation benefits, I must, upon appropriate request, provide a copy of the client's record to his/her employer or the Industrial Commission.

There are some situations in which I am legally obligated to take actions which I believe are necessary to attempt to protect others from harm, and I may have to reveal some information about the client's treatment. These situations are unusual in my practice.

- If I have cause to suspect that a child under 18 or a dependent elderly person is abused or neglected, or if I have reasonable cause to believe that a disabled adult is in need of protective services, I will file all necessary reports with the appropriate state agencies, as per my ethical and legal mandates in the State of New Hampshire. Once such a report is filed, I may be required to provide additional information.
- If I believe that a client presents an imminent danger to the health and safety of another, I may be required to disclose information in order to take protective actions, including warning the potential victim, if identifiable, initiating hospitalization, and/or calling the police.

If such situations arise, I will make every effort to fully discuss it with you before taking any action and I will limit my disclosure to what is necessary.

Minors. Confidentiality is a bit different for minor clients. If you are under 18 years of age and are not emancipated, please be aware that the law may provide your parents the right to examine your treatment records. Because privacy in psychotherapy is often crucial to success, particularly with teenagers, it is my policy to request an agreement from parents that they consent to give up their access to your records. If they agree, during treatment I will provide them only with general information about our work together, including progress in treatment and attendance at scheduled sessions. Any other communication will require your authorization, unless I feel that you are in danger or a danger to someone else, in which case I will notify your parents of my concern. Before giving them any information, I will discuss the matter with you, if possible, and do my best to handle any objections you may have with what I am prepared to discuss.

CONTACT GUIDELINES

My typical workweek is Monday, Tuesday, Thursday, and Friday, 9:00-8:00, but my days/hours can vary greatly. I am often not available during these times because I am a sole practitioner, do not have an administrative assistant, and will not answer the phone/email when I am with another client. My preferred means of contact is via email, but please be advised that while I am the only person with access to it, I cannot vouch for the security, privacy, or confidentiality of electronic transmissions in general. Therefore, please limit email to logistical issues (i.e., scheduling), and for matters of a more clinical nature, use the telephone, which is attached to a confidential electronic answering machine.

I will make every effort to return your call/email within 48-72 hours (2-3 days), not including weekends, holidays, absences, and vacations. While this may seem like an inordinate amount of time, I believe that it is crucial for maintaining the personal-professional boundaries necessary for my mental and physical health, in order for me to provide you, to the best of my ability, with the service you deserve. *If, during the course of our work together, you experience a psychological emergency (one involving potential life threat or harm to self or others) and you feel that you cannot wait for at least 48-72 hours (not including weekends, holidays, absences, and vacations) to speak with me, you are to call 911 and/or contact your local hospital emergency room (e.g., nearest or one covered by your insurance company) and ask for the psychiatrist on call.*

If you are comfortable with the confidentiality parameters, or potential lack thereof, you can email information you would like me to have that can be discussed in subsequent in-office or phone sessions. Understand that I will not reply directly to such emails, but will use them to prepare for our next scheduled session.

Under no circumstances should you use email to address crisis issues. I consider email to be a privilege, not a right, and if you abuse it by sending messages of a critical, desperate, or threatening nature, I will consider it a boundary violation and will refuse to accept subsequent emails and will block your address from my email account.

INITIAL SESSIONS

In addition to the above-mentioned general psychotherapy guidelines of my practice, I would like to address in writing the specific expectations I have regarding our work together. By providing this information at the outset of therapy, it is my hope that you can make an informed decision about engaging in CBT with me. The tasks for our first sessions are three-fold – assessment, fit, and goals.

Assessment. Our first priority involves developing a basic shared understanding of your needs and motivations for coming to therapy at this time. I will be asking you questions such as “what brings you here today?” and “what changes would you like to make?”. By the end of our first session or two, in order to make the most effective use of your therapy, we will want to have made a clear assessment of the problem you wish to address and the motivations/strengths with which you bring to your therapy efforts.

Fit. During these initial sessions, we can both decide if I am the best person and if CBT is the best means to provide the services you need in order to meet your therapy goals. If I think that we are a good fit for meeting your needs and goals, I will be able to offer you some first impressions of what our work may involve if you decide to continue with therapy. You should evaluate this information along with your own opinions about how comfortable you feel in being able to work with me in a CBT framework. Therapy involves a commitment of time, money, and energy, so you should be careful about the psychologist you select. By the end of the evaluation period, if I believe that I cannot provide you with the appropriate services, I will make all reasonable efforts to secure suitable referrals. Likewise, if you have questions about my procedures, we should discuss them whenever they arise. If your concerns persist, I will be happy to help you set up a meeting with another mental health professional for a second opinion.

Goals. CBT is goal-focused. Well thought out statements of objectives are critical to making effective use of and achieving maximum benefit from therapy. At the end of our first sessions together, we will be able to define initial goals that we will use throughout our work together to monitor progress and suggest course alterations as appropriate. Please take a few moments at this time and consider what you would like to achieve in therapy – in essence, what changes you would like to make such that, if those changes were made, you would know that therapy had fulfilled its purpose for you. To make sure your goals are clear and reachable, they should be SMART:

- Specific (simple, sensible, significant) – in order to focus your efforts and feel truly motivated to achieve your goals.
- Measurable (meaningful, motivating) – so that you can track your progress, stay motivated, and know when the goal has been accomplished.
- Achievable (agreed, attainable) – goals need to be realistic and attainable to be successful. They should stretch your abilities but still remain possible. Beware of setting goals that someone else has power over – focus on achievements that are entirely up to you.
- Relevant (reasonable, realistic and resourced, results-based) – ensure that your goals matter to you, that they are worthwhile and applicable to you.
- Time-bound (time-based, time limited, time/cost limited, timely, time-sensitive) – so that you have a deadline to focus on and something to work toward.

Condensed from https://www.mindtools.com/pages/article/smart-goals.htm

Additional Tasks. Another initial task involves securing background and demographic information that can be important to filling out a more complete picture of you, your needs, and what you bring to therapy. While some of this information will be covered during our discussion of assessment, fit, and goals, much secondary data is also required in order for me to have a complete picture. To that end, I ask that you take the time now to complete the General Information Form on pages 25-27. If you have any questions or concerns about providing any of the requested data, I will gladly address it in our next session.

Also, because provider collaboration often results in better treatment and outcomes, I have included a Release of Information Consent form (page 29). If you have health professionals with whom you feel it would be of benefit for me to correspond, please include all on this form, along with their telephone numbers and/or email addresses. Don't worry about the rest – we can check the appropriate boxes together when we review the form.

SUBSEQUENT SESSIONS

Once therapy has begun, sessions are typically scheduled weekly at a time we agree on, although sessions can be more or less frequent depending on your particular concerns or scheduling logistics.

Duration and Timing. Sessions are 45-50 minutes in duration. Barring the rare emergency, you will be seen at the scheduled time. This time is set aside just for you, so it is important that you be on time if you wish to make full use of the session. Because the standard therapy hour according to insurance regulations is 38-52 minutes, if you are more than 15 minutes late for an appointment, you will be billed out-of-pocket at my standard rate (see below). Insurance does not cover these types of charges.

Sessions end at 45-50 minutes of the hour regardless of the time you present for your appointment. Although this can at times feel artificial, especially if we are discussing emotionally-laden issues, it is necessary in order to maintain therapeutic boundaries and an efficient office schedule. Further, it has been found to be counterproductive to allow sessions to go over the agreed-upon time as it undermines the necessary structure of therapy.

Attendance. Regular attendance in therapy is important to your progress and goal attainment. Nevertheless, life at times has a way of interfering with the best-laid plans, and as a result, sessions sometimes need to be rescheduled. The preferred method of rescheduling is via email, complete with current appointment time and two to three specific options for reschedule dates/times. I will make every effort to respond to your email or call, but it is your responsibility to confirm that I receive the message with sufficient notice.

Irregular attendance can be a sign of therapy disengagement. At times people find that they are not ready to approach their problems with CBT. Sometimes the fit between psychologist and client is not as suitable as initially thought. Occasionally financial realities necessitate prematurely ending therapy. If you miss two appointments (cancellations, reschedules, or no-shows) in a two-month period, we will discuss engagement obstacles and make alterations accordingly. If you miss three appointments in a three-month period, we will assume that there are engagement problems, we will end/suspend therapy for at least a period of six months, and I will make referrals to other practitioners as necessary.

While the collaborative nature of CBT is useful in allowing for an open discussion of irregular attendance or therapy disengagement, I understand that some people are just not comfortable having such a conversation. I will make appropriate efforts to contact you; however, if you do not respond to three communications in a three-month period, I will have to assume that you are no longer interested in pursuing therapy at the time and/or with me, and will close your file whether or not I have been able to communicate directly with you.

Structure. It is important for clients to know what to expect in a typical CBT session in order to make an informed decision about starting this type of therapy. Structure is a very important ingredient in effective CBT treatment. First we engage in a status check that allows you to provide information about salient events or changes since our last session. Typically I will start by asking an open-ended question, often as simple as “how are you?” or “what has your week been like?”. I will be looking for thoughts, emotions, and behaviors – information that may be used to direct that particular session’s CBT skill development towards your larger therapy goals. This "setting the agenda" allows us to collaboratively determine how to best spend our time during the session and ensure that we remain on-target with your goals. If I have any items for the agenda, I will introduce them at this time. We can also discuss continuing issues of importance from last therapy session, and we'll discuss any "homework" you did during the week. Next, we will discuss agenda items in detail. This is a fluid process, but typically involves a combination of problem-solving and challenging the helpfulness of thoughts and beliefs in the identified situations. You will learn or practice new CBT skills that will help you modify unhelpful thoughts, feelings, and behaviors in order to solve problems independently. Finally, at 45 minutes to the hour, I will ask you to draw conclusions and summarize important points in your own words. We'll also collaboratively create homework assignments, which usually consists of programmatic workbook reading and exercises, implementing behavioral solutions to problems, monitoring/challenging unhelpful thinking, and/or practicing other cognitive and behavioral skills.

Location/Telehealth. The above description assumes that the sessions were conducted on site in my office. This is my preferred setting, as it allows for verbal and non-verbal feedback, as well as liberal use of the whiteboard for demonstrating CBT concepts, and providing written materials.

At times, though, face-to-face interactions are not an option. Telehealth has been defined as the use of technology (e.g., phone, video-conference) for the delivery of some medical and psychological services. A potential benefit of this format is that sessions can be provided when clients are not able to attend in-

person sessions due to various reasons including physical limitations, physical distance, or lack of transportation. Research indicates that telehealth can be effective in the treatment of various disorders; however, some potential risks include having less control over confidentiality, decreased emotional connection between therapist and client due to lack physical proximity, and reducing the likelihood of insurance reimbursement. While I am currently researching the options, I am not yet set up for video-conferencing. While many of the available services claim to be HIPAA compliant and reliable, I am concerned about the aforementioned risks.

When it is only feasible to speak via telephone, I am willing to consider this venue on a situation-by-situation basis with established clients. Telephone sessions are billed at the standard rate and are not subject to insurance reimbursement policies given that insurance does not cover these sessions. However, especially in situations where the cancellation policy would necessitate an out-of-pocket payment (i.e., late cancellation) anyway, some clients have found this to be a workable compromise such that they are able to pay for and have a phone session rather than no session at all.

Homework. Psychotherapy is not like most medical appointments, in that it calls for very active effort on your part. Goal achievement could take a very long time if you only think about the techniques and topics taught for one hour per week. For example, if, when you attempted to learn your multiplication tables, you spent only one hour per week studying them, you might still be wondering what 7 X 6 equals. You very likely spent a great deal of time at home studying your multiplication tables, maybe with flashcards. The same is the case with CBT. In order for your therapy to be most successful, you will have to work on things we talk about both during and in between our sessions. That's why homework plays a major role in your CBT therapy.

We will work collaboratively to develop assignments to practice in “real life” the skills/techniques learned in session. And the good news is, unlike the homework you were forced to do in school, CBT homework cannot be done “wrong.” In fact, if you don’t do the work we agreed upon, that in and of itself becomes an agenda item for the session and we can challenge the thoughts that interfered with your ability/ willingness to do the assignment. So please don’t think of it as a punishment or something to dread, but rather as a way to increase your therapy efforts outside of the sessions to ensure success in reaching your therapy goals!

Materials. CBT is fairly unique amongst the psychotherapies in that they are widely researched and empirically supported. As a result, I often use handouts and will suggest workbooks or manuals to enhance our work together. Documents and handouts that I have personally created will be made available free of charge. In the past I have also provided suggested texts, workbooks, and manuals free of charge; however, to contain the general costs of therapy sessions, I am now providing these materials at cost. Our work together is not contingent on the purchase of suggested materials, and I do not believe that the benefit of therapy is defined by using or forgoing the use of workbooks or other aids. When I suggest one of these items, you will be given an opportunity of reviewing it free of charge by checking it out of the Lending Library. If you decide that the material would be of benefit to you in achieving your therapy goals, you can either purchase it directly from me, or buy it at your favorite bookstore or online merchant. A current Materials Price List is available on my website, at the Lending Library, and upon request. Please be aware that insurance companies will not reimburse for psychotherapy materials.

Many published therapy manuals as well as self-help and reference books are available to anyone through the Lending Library in the waiting room. If you wish to borrow something, simply sign it out with your initials, the title, and the date. I only ask that you do not keep any materials for more than 30 days so that others can have equal access to them. Periodically I will check the list for outstanding materials, and occasionally people have either not marked the materials as returned or have not returned what they have borrowed. If, after making reasonable efforts to have the materials returned, you still retain them, the cost of any unreturned materials will be automatically assessed via the credit card information you provide, and I will mail you the receipt with a billing statement identifying the charge. Once you have been charged for materials, they are yours and cannot be returned.

ENDING THERAPY

CBT is not an open-ended, never-ending process. CBT is typically brief and time-limited. It is considered among the most rapid in terms of results obtained. The average number of sessions clients receive (across all types of problems and approaches to CBT) is approximately 20. Other therapies, like psychoanalysis, can take years. What enables CBT to be briefer is its highly instructive nature and the fact that it makes use of homework assignments.

Because CBT is time-limited, it is understood at the very beginning of the therapy process that there will be a point when the formal therapy will end. Ideally, psychotherapy is discontinued when treatment goals are met, the psychologist and client agree that it's time to stop, and the client knows where to obtain follow-up services if needed in the future. To handle termination as smoothly as possible, it helps to think of it as a process and begin planning for the end of therapy at the outset of treatment.

However, sometimes transitions are not mutually agreed upon. Often such sudden and unforeseen terminations can be challenging. And sometimes they are marked by a lack of discussion, such that people leave and simply don't come back. In these latter cases, 90 days of non-activity, defined as no contact or scheduled sessions and no pre-arranged plans for continued contact, means that, by default, we have ended our therapy relationship and the client's file will be closed.

This is in no way to suggest that a client cannot return after 90 days of non-activity. I encourage clients to think of therapy as a tool for making changes. As change can often be a waxing and waning process, oftentimes people who weren't ready to make changes when they initially began therapy can be in a very different mindset later. When they are ready, and they decide that psychotherapy can play a role in their change efforts, I hope that they will feel comfortable reaching out to me, even if it has been over 90 days and their file is technically closed.

Regardless of the reason for ending therapy, as much as possible, I will always be available to provide referral information. A simple email or phone call asking for recommendations is all it takes.

CANCELLATION POLICY

In the event that you need to cancel an appointment, you are *required to provide at least 24 hours advance notice*. You will be charged the full standard fee for sessions canceled with less than 24 hours notice or if you do not show up for an appointment that you did not cancel. Please be aware that insurance companies will not reimburse for late-cancelled or missed sessions.

It is your responsibility to see that I am informed of any appointment changes or cancellations. Usually a telephone or email message will suffice, but you should make reasonable attempts to confirm that I have received your message.

At the conclusion of every session, when we are confirming our next appointment time, I will email confirmation or provide an appointment card if email is not a viable option. If you miss a session due to confusion about dates or times, and cannot produce an email or appointment card, it will be assumed that the mistake was yours and you will be charged for a missed session.

It is my tendency to give everyone a "warning" rather than charge for the first instance of late-cancellation or no-show; however, you will be charged for subsequent un-notified missed appointments *regardless of the reason* (with the standard exception of inclement weather in the winter – see below). While this may seem harsh, two irrefutable issues are at work here – missing an appointment without sufficient notice for me to fill your spot forces me to 1) forfeit an appointment that another client could have used, which 2) results in double lost revenue from the session as well as incurs additional administrative expenses in scheduling and rescheduling the appointment. It is my choice to enforce the policy regardless of your reason because I believe that is a fairer arrangement than trying to determine what constitutes extenuating circumstances in one case and not another.

In trying to ensure fairness for everybody, I do recognize that this particular policy can be considered rigid and inflexible. It is not my intention to create a situation that can lead to resentment for being charged or alienate busy people. Therefore, it is important that you carefully consider how his policy impacts your decision to begin psychotherapy with me.

Late cancellation and no-show fees will be automatically assessed at the time of the scheduled appointment via the credit card information provided below, and I will provide you with the receipt at our next scheduled session.

Weather Exception: Because living in New England assumes harsh winters, this cancellation policy is summarily waived for unsafe travel conditions due to weather conditions. I do not expect or want you to endanger yourself in order to make an appointment. So if the weather is bad, call or email me as soon as you can to let me know that you will not be able to make the appointment, and even if it is less than 24 hours before your appointment, you will not be charged.

FINANCIAL POLICY

Although psychotherapy is often an emotionally-laden undertaking, the actualities of life necessitate that I be appropriately reimbursed for the services I provide. Further, in order for us to set realistic treatment goals and priorities, it is important to evaluate what resources you have available to pay for your treatment. If you have a health insurance policy, it will usually provide some coverage for behavioral/ mental health treatment. However, you (not your insurance company) are responsible for full payment of my fees.

Fees/Rates. Service fees are based on $150 per "therapy hour" (45-50 minute psychotherapy session). Fees for services of longer or shorter duration will be determined as a percentage of this rate:

0-15 minutes	=	no charge
16-30 minutes	=	$75.00
31-45 minutes	=	$112.50
45-60 minutes	=	$150.00
61-75 minutes	=	$187.50
76-90 minutes	=	$225.00
91-105 minutes	=	$262.50
106-120 minutes	=	$300.00

Applicable Services. The above rates apply to, but are not limited to, the following: in-office or telehealth (telephone) psychotherapy sessions, telephone calls of a clinical nature (not administrative, i.e., rescheduling), collaborative contacts between Dr. Gillock and another health provider, report writing, interacting with third parties (i.e., insurance companies, other service providers), attending meetings with other professionals, etc.

Please recognize that, other than in-office psychotherapy sessions, most insurance plans do not cover the other listed services for which I charge. Insurance coverage typically reimburses only for "medically necessary" services, so any "non-covered" services will be billed to you and not to your insurance company. As much as is feasibly possible, I will inform you prior to undertaking any of these "non-covered" services on your behalf.

Additional Services. If you become involved in legal proceedings that require my participation, you will be expected to pay for my professional time even if I am called to testify by another party. Because of the difficulty of legal involvement, I charge a different per hour rate for preparation and attendance at any legal proceeding. These rates will be negotiated on an as-needed basis.

Payment. *All fees, including but not limited to any portion of the agreed upon charges that are not paid by a third party (i.e., insurance company), are your responsibility*. In the interest of fairness, no exceptions will be made; however, if you expect or experience undue hardship as a result of these policies, please do not hesitate to approach me with options.

If you are not using insurance benefits or if you are filing claims with an insurance company for which I am an out-of-network provider, *you are expected to pay for each session at the time of service*. If you are a participant of a CIGNA insurance plan, with whom I am a contracted provider, *you are expected to pay for any deductibles or co-payments at the time of service*. This can be handled in a number of ways:

- Direct payment at the time of service. You can pay for each session/co-pay when you attend a session. Acceptable forms of payment include cash, check, or credit card. However, do note that I do not keep cash in the office, so if you want to pay with cash, you will need to bring the exact amount.
- Automatic credit card payment. I can run your credit card information through my card processor automatically for the total amount due either after the session or at the time that I post the insurance reimbursement (for those using their CIGNA benefits). Typically I submit insurance claims at the end of the month and receive reimbursements in the middle of the month. Please complete the Credit Card Authorization below.
- Electronic checks. If you prefer to make arrangements to have your bank send a check, I am agreeable with that plan, provided that the payment is received within a week of the session. Please include the date of service in the note/comment area so that I can accurately annotate my books.

Prompt payment is your responsibility. If you get behind on your payments, such that I have to provide you with a statement as a reminder, you will also be billed, at the aforementioned rates, for the amount of time I spend creating that statement.

Checks returned for non-sufficient funds (NSF) will incur the equivalent of the processing fees assessed to me by the bank plus a $75 administrative fee to cover my time and expenses.

Default. Failure to pay for services may result in my seeking outside assistance to collect charges due. Balances left unpaid beyond 60 days will be referred to a collection agency or small claims court. If such action is necessary, and an additional 33% of the balance will be due to cover associated collection fees. In most collection situations, the only information I will release regarding a client's treatment is his/her name, the nature of services provided, and the amount due.

Guarantee of Payment. To avoid collection situations, as well as streamlining the administrative demands associated with tracking deductibles and/or co-pay balances, cancellation/no-show payments, and materials fees, I require that you provide me with credit card information and authorization to make charges for any fees that are not paid at the time the services are rendered. This includes immediate charges for late cancellations or no-show sessions. *You will not be notified prior to any charges being made*, and a receipt will be provided to you at our next appointment.

Insurance. CIGNA is the only insurance company with whom I am a contracted provider. If you have any questions or concerns about insurance coverage or benefits, you should contact CIGNA directly for confirmation of coverage. By signing this contract, you are authorizing me to bill CIGNA to obtain direct payment for any contracted service. The last page of this contract is a Health Insurance Claim Form (CMS-1500) that you will need to complete, sign, and return to me so that I can submit claims directly to CIGNA on your behalf.

Because your health insurance policy is a contract between you and CIGNA, it is your responsibility to obtain an authorization for service prior to your first visit, and to work with me to ensure that all visits are authorized and paid by CIGNA. It is also your responsibility to pay for any balance on your account should the insurance payments differ from what was expected, not to exceed the contracted rates I have agreed to accept from CIGNA for covered services. It is important that you understand that any/all information about insurance coverage or payment that I obtain on your behalf is only a "quote" of benefits and is not a guarantee of coverage and/or payment, and that an authorization for care is not an absolute

guarantee that CIGNA will pay for services. An authorization only guarantees that coverage exists for medically necessary services. In the event that CIGNA does not reimburse for mistakes they or you have made (e.g. claims processing errors or data loses, failure to let me know that your plan has renewed or changed), you will be responsible for full payment of my standard fees.

If you have health insurance through a company other than CIGNA, it will usually provide some coverage for behavioral/mental health treatment. However, you (not your insurance company) are responsible for full payment of my fees. Due to the excessive administrative demands involved, I am no longer willing to work with out-of-network insurance carriers to secure a “single-case agreement” or exception. I will provide you with a statement of services and fees that you can independently submit to your insurance carrier, and will certainly work with you and them to clarify any parts of the statement that are hindering reimbursement, but you will be responsible for paying for our sessions at the time the service is rendered at my full rate.

You should also be aware that your contract with your health insurance company requires that I provide them with information relevant to the services that I provide to you. I am required to provide a clinical diagnosis. Sometimes I am required to provide additional clinical information such as treatment plans or summaries, or copies of your entire Clinical Record. In such situations, I will make every effort to release only the minimum information about you that is necessary for the purpose requested. This information will become part of the insurance company files and will probably be stored in a computer. Though all insurance companies claim to keep such information confidential, I have no control over what they do with it once it is in their hands. In some cases, they may share the information with a national medical information databank. I will provide you with a copy of any report I submit, if you request it. By signing this Treatment Contract, you agree that I can provide requested information to your carrier.

When/if I communicate with your insurance company or other health professionals, I may do so by telephone, regular mail, email, fax, or computer/internet. If you object to such communication, please discuss this with me when you return this Treatment Contract.

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SIGNATURE PAGES

Your signatures below indicate that you have read the information in this document and agree to abide by its terms during our professional relationship.

You may revoke this agreement in writing at any time. That revocation will be binding on me unless I have taken action in reliance on it, if there are obligations imposed on me by your health insurer in order to process or substantiate claims made under your policy, or if you have not satisfied any financial obligations you have incurred.

This document replaces all previous contracts and notices of changes signed prior to 1/1/2017.

I have read, had an opportunity to discuss, and understand the contents of this "Treatment Contract and Information on Policies and Procedures" document dated 1/1/2017 and I agree to the arrangements outlined within it. I have been given a copy of the materials for my records.

Client's Printed Name _____

Client's Signature _____

Date_____

Provider's Signature_____

Date_____

I agree to the use of email as a primary means of communicating logistical information with Dr. Gillock, understanding that she cannot vouch for the security, privacy, or confidentiality of electronic transmissions in general. Telephone communications are a completely acceptable form of communication if I decide not to take the risk of having email seen by a third party.

Client's Email Address _____

Client's Printed Name _____

Client's Signature _____

Date_____

Provider's Signature_____

Date_____

I agree to assume all responsibility for all professional fees imposed by Karen Lee Gillock, PhD, Cognitive Behavior Therapy, including but not limited to any portion of the agreed upon charges that are not paid by a third party (i.e., insurance company). I choose to fulfill my financial responsibility to Dr. Gillock as follows:

Payment Type (circle one): At time of service Credit card (automatic) Electronic check

Client's Printed Name _____

Client's Signature _____

Date_____

Provider's Signature_____

Date_____

I hereby authorize charges to the credit card designated below for services rendered by Karen Lee Gillock, PhD, PLLC, as outlined in the Treatment Contract dated 1/1/2017. I understand that it is my responsibility to notify Dr. Gillock of changes in credit card companies and/or numbers, and to update the expiration date of my credit card when necessary. I also understand that this document will be used for any disputed charges with my credit card company.

Card Type (circle one): Mastercard VISA Discover American Express

Card # _____

Expiration Date _____

Billing Zip Code _____

Client's Printed Name _____

Client's Signature _____

Date_____

Provider's Signature_____

Date_____

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

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

HIPAA requires that I provide you with a Notice of Privacy Practices for use and disclosure of protected health information (PHI) for treatment, payment, and health care operations, and the law requires that I obtain your signature acknowledging that I have provided you with this information by the end of our first session.

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

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

- "*PHI"* refers to information in your health record that could identify you.
- *"Treatment, Payment and Health Care Operations"*
  – *Treatment* is when I provide, coordinate or manage your health care and other services related to your health care. An example of treatment would be when I consult with another health care provider, such as your family physician or another psychologist.
  - *Payment* is when I obtain reimbursement for your healthcare. Examples of payment are when I disclose your PHI to your health insurer to obtain reimbursement for your health care or to determine eligibility or coverage.
  - *Health Care Operations* are activities that relate to the performance and operation of my practice. Examples of health care operations are quality assessment and improvement activities, business-related matters such as audits and administrative services, and case management and care coordination.
- "*Use*" applies only to activities within my practice group such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.
- "*Disclosure*" applies to activities outside of my practice group such as releasing, transferring, or providing access to information about you to other parties.

II. Uses and Disclosures Requiring Authorization

I may use or disclose PHI for purposes outside of treatment, payment, and health care operations when your appropriate authorization is obtained. An "*authorization"* is written permission above and beyond the general consent that permits only specific disclosures. In those instances when I am asked for information for purposes outside of treatment, payment and health care operations, I will obtain an authorization from you before releasing this information.

You may revoke all such authorizations at any time, provided each revocation is in writing. You may not revoke an authorization to the extent that (1) I have relied on that authorization; or (2) if the authorization was obtained as a condition of obtaining insurance coverage, and the law provides the insurer the right to contest the claim under the policy.

III. Uses and Disclosures with Neither Consent nor Authorization

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

- **Child Abuse:** If you give me information which leads me to suspect child abuse, neglect, or death due to maltreatment, I must report such information to the appropriate State agencies. If asked by a State agency representative to turn over information from your records relevant to a child protective services investigation, I must do so.
- **Adult and Domestic Abuse:** If information you give me gives me reasonable cause to believe that a disabled adult is in need of protective services, I must report this to the appropriate State agencies.
- **Health Oversight:** The New Hampshire Psychology Board has the power, when necessary, to subpoena relevant records should I be the focus of an inquiry.
- **Judicial or Administrative Proceedings:** If you are involved in a court proceeding, and a request is made for information about the professional services that I have provided you and/or the records thereof, such information is privileged under state law, and I must not release this information without your written authorization or a court order. This privilege does not apply when you are being evaluated for a third party or where the evaluation is court ordered. You will be informed in advance if this is the case.
- **Serious Threat to Health or Safety:** I may disclose your confidential information to protect you or others from a serious threat of harm by you.
- **Worker's Compensation:** If you file a workers' compensation claim, I am required by law to provide your mental health information relevant to the claim to your employer and the New Hampshire Industrial Commission.

IV. Patient's Rights and Psychologist's Duties

Patient's Rights:

- *Right to Request Restrictions* –You have the right to request restrictions on certain uses and disclosures of protected health information about you. However, I am not required to agree to a restriction you request.
- *Right to Receive Confidential Communications by Alternative Means and at Alternative Locations* – You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations. (For example, you may not want a family member to know that you are seeing me. Upon your request, I will send your bills to another address.)
- *Right to Inspect and Copy* – You have the right to inspect or obtain a copy (or both) of PHI in my mental health and billing records used to make decisions about you for as long as the PHI is maintained in the record. I may deny your access to PHI under certain circumstances, but in some cases, you may have this decision reviewed. On your request, I will discuss with you the details of the request and denial process.
- *Right to Amend* – You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. I may deny your request. On your request, I will discuss with you the details of the amendment process.
- *Right to an Accounting* – You generally have the right to receive an accounting of disclosures of PHI for which you have neither provided consent nor authorization (as described in Section III of this Notice). On your request, I will discuss with you the details of the accounting process.
- *Right to a Paper Copy* – You have the right to obtain a paper copy of the notice from me upon request, even if you have agreed to receive the notice electronically.

Psychologist's Duties:

- I am required by law to maintain the privacy of PHI and to provide you with a notice of my legal duties and privacy practices with respect to PHI.
- I reserve the right to change the privacy policies and practices described in this notice. Unless I notify you of such changes, however, I am required to abide by the terms currently in effect.
- If I revise my policies and procedures, I will verbally inform patients of any changes, post a revised notice in the office, and have copies of the notice available for patients at their request.

V. Questions and Complaints

If you have questions about this notice, disagree with a decision I make about access to your records, have other concerns about your privacy rights, believe that your privacy rights have been violated and wish to file a complaint, you should contact the Office for Civil Rights, U. S. Department of Health and Human Services, JFK Federal Building – Room 1875, Boston, MA 02203, (617)565-1340, (617)565-1343 (TDD). You can obtain a Fact Sheet on How to File a Health Information Privacy Complaint with the Office for Civil Rights, which outlines the steps for filing a written complaint, either at http://www.hhs.gov/ocr/privacyhowtofile.htm or directly from me by request.
You have specific rights under the Privacy Rule. I will not retaliate against you for exercising your right to file a complaint.

VI. Effective Date, Restrictions and Changes to Privacy Policy

This notice went into effect on Monday April 14, 2003
I reserve the right to change the terms of this notice and to make the new notice provisions effective for all PHI that I maintain. If I revise my policies and procedures, I will verbally inform clients of any changes, post a revised notice in the office, and have copies of the notice available for clients at their request.

I have read, had an opportunity to discuss, and understand the contents of this "Notice of Policies and Practices to Protect the Privacy of Your Health Information" document dated 1/1/2017. I agree to the arrangements outlined within it.

Client's Printed Name _____

Client's Signature _____

Date_____

Provider's Signature_____

Date_____

CIGNA Behavioral Health Participant Rights and Responsibilities

Participant Rights and Responsibilities

As a participant, you have the right to receive services:

- That respect your privacy and dignity.
- That are provided in a prompt, courteous and respectful manner.
- That respect your cultural and ethnic identity, religion, disability, gender, age, marital status and sexual orientation.
- That are provided in a physical environment that is safe, sanitary, allows for effective treatment, which safeguards the privacy and confidentiality of interactions with your practitioner, and is free from observation by third parties, unless consent is obtained from you.
- From practitioners who are qualified, competent, focused on your care, and reasonably accessible to you.
- That emphasize your participation in developing a treatment plan specific to your needs, and include your agreement to work toward defined goals.
- That in relation to admission, discharge, or treatment is free of discrimination on the basis of age, sex, race, creed, color, national origin, ethnicity, religion, marital status, disability or sexual orientation.

As a participant, you have the right to current information concerning:

- Your diagnosis, recommended medically appropriate treatment options that relate to your care, potential alternatives and accompanying risks, benefits, and costs (in writing for Medicare participants). This information, regardless of cost or benefit coverage, will be explained in terms and in a language that you can reasonably understand.
- Written financial agreements you entered for treatment services rendered.
- Possible consequences of refusing treatment plan recommendations.
- Circumstances or conditions under which you may be transferred to another treatment program or facility, and the accompanying risks, benefits and cost of such a transfer.
- CIGNA Behavioral Health (CIGNA), its services, and the names and credentials of practitioners and providers involved in your care.
- Your responsibilities to ensure better treatment outcomes.
- Your records, and having information explained or interpreted as necessary, except when protected or restricted by law.
- How to access services, including any emergency services needed outside of normal business hours or when you are away from your usual place of residence or work, by using the indicated number on the benefit card, or by independently accessing CIGNA Behavioral Health On-line resources, or through arrangement with an existing treatment provider.
- How CIGNA Behavioral Health evaluates new technology for inclusion as a covered benefit.
- Assistance in selecting a new behavioral healthcare delivery office or practitioner if your current practitioner is affected by termination or closure.
- Resources and procedures available through CIGNA Behavioral Health for communicating concerns or questions, for expressing dissatisfaction with services or care, and for requesting an appeal if not satisfied with any decisions regarding dissatisfaction with services or care including the provision of language services for the complaint and appeal process.
- Services available to you and charges for those services including services not covered under your health plan's benefits.
- Resources and procedures available through CIGNA Behavioral Health to make suggestions about CIGNA Behavioral Health's rights and responsibilities policies.

If you would like to express a concern or dissatisfaction with the care or services you have received, please contact CIGNA Behavioral Health or the office of the practitioner where you received services, and inquire as to the steps of the Complaint and Appeal process.

As a participant, you have the right to protection of privacy and confidentiality:

- In case discussions, examinations, and treatment services.
- In communications and records pertaining to care, except in cases such as suspected child abuse and danger to yourself or others, when reporting is permitted or required by law, or in instances of medical emergency, or when the coordination of care with a primary care physician is required by a health plan, or when disclosure is authorized by court order or court subpoena.
- If you use a medical benefits plan to pay for services and you are not the person who signed up for the coverage as the primary policy holder, be aware that billing statements, claim information and coordination of benefits questions will be sent to the primary policy holder, not to you, unless you contact Customer Service at 800.926.2273 and ask for correspondence to be sent directly to you.

Statement on confidentiality of alcohol and drug abuse records: CIGNA Behavioral Health staff and network practitioners will not identify a participant as involved in alcohol or substance abuse treatment to others outside the treatment program, unless:

- The participant consents in writing; OR
- The disclosure is allowed by court order; OR
- The disclosure is made to medical personnel in a medical emergency or to qualified personnel for research, audit, or program evaluation; OR
- The disclosure is made to a primary care physician to coordinate care when required by a health plan and the participant consents verbally or in writing; OR
- The participant commits or threatens to commit a crime at the treatment program or against any person who works for the program; OR
- There is suspected child abuse or neglect or a danger to yourself or others when reporting is permitted or required under state laws to appropriate state or local authorities.
-

As a participant, you are responsible for:

- Being honest about facts, feelings or ideas that relate to your care.
- Supplying information that your practitioner(s) and/or provider(s) need in order to provide care and/or that CIGNA Behavioral Health may need to determine benefit coverage.
- Attempting to understand clinical problems that are identified and attempting to follow the plans and instructions for care you have agreed on with your practitioner.
- Taking an active part in your treatment planning and therapy.
- Keeping appointments and cooperating with CIGNA Behavioral Health staff and participating practitioners.
- Knowing the names of persons who are providing your care.
- Reporting changes in your condition to your practitioner.
- Informing your practitioner if you anticipate problems in following prescribed treatment.

Revision Date: July 2011

GENERAL INFORMATION

Demographic and Current Social Information:

Name:_____

Phone: (Home)_____(Work)_____(Cell)_____

At which phone numbers may I contact you and/or leave messages?_____

Email:_____

May I email you?_____

Home Address:_____

Gender: Male_____Female_____ Date of Birth:_____

Social Security Number:_____

Marital Status: _____

Describe any previous relationships/marriages:_____

_____

Present Living Arrangements (relationships, not names, and duration):_____

_____

Who is the person you are closest to? (briefly describe relationship and duration, including age, gender, ethnicity, marital status, and occupation):_____

_____

_____

Any history of abuse (emotional, physical, sexual) in current or previous relationships? YES NO

How many children do you have? (ages, genders, and significant problems if applicable):_____

_____

_____

Current Employment Status: Full Time_____ Part Time_____

Student_____ Homemaker_____ Retired_____ Disabled_____

Other: _____

Employer:_____ Occupation:_____

How long have you worked there?_____How long in this occupation?_____

Any significant work experiences? Any problems with performance, attendance, difficulties with co-workers? YES NO

Education (list highest level of education attained or last completed grade if currently in school): _____

_____

Any significant school experiences? Any problems with truancy, suspensions, special education, social or academic performance? YES NO

List any clubs and organizations you belong to:_____

_____

Where does your greatest source of socialization/social support come from?_____

_____

What do you do for pleasure and relaxation?_____

_____

Cultural Background: _____

Military Experience: _____

Religious Affiliation: _____

Emergency contact name and phone number:_____

Family History:

Please provide ages (or date of death), marital status, occupation, and quality of relationship (none, poor, fair, or good) for the following family members:

Mother:_____

Father:_____

Siblings:_____

_____

Other:_____

_____

Briefly describe your childhood and adolescence (include home atmosphere, relationship with parents, etc):_____

_____

Any history of significant life events such as death, abuse, divorce, separation, etc? YES NO

Health Information:

Primary Physician:_____ Specialty:_____ Phone:_____

Other Physician:_____ Specialty:_____ Phone:_____

Other Physician:_____ Specialty:_____ Phone:_____

List any significant current health problems:_____

_____

List any significant health problems you have had in the past:_____

_____

List any significant family history of health problems :_____

_____

List any allergies you have or have had in the past:_____

List any medications you are taking and the dosage:_____

List any vitamins and supplements you are taking and the dosage:_____

List any drug, alcohol, caffeine, and nicotine use (current and past):_____

Any personal history of drug and/or alcohol abuse? YES NO

Any family history of drug and/or alcohol abuse? YES NO

Alternative health practices regularly engaged in (i.e., yoga, chiropractic, etc): _____

Have you seen someone for psychological treatment before? YES NO

If yes, when and with whom?_____

Give a brief description of treatment:_____

List any significant family history of psychological problems :_____

Additional Health Information (use space as necessary): _____

Referral Information:

How were you referred to Dr. Gillock? Self_____ Family/Friend_____ Health Professional _____

Online Service (i.e., Psychology Today)_____ Website _____ Other_____

If referred by a health professional, may I send a thank you note to that person?_____

Name and contact information: _____

Briefly, what is the issue that prompted this referral?_____

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CONSENT TO RELEASE & EXCHANGE INFORMATION FOR CLINICAL SERVICES

I want the following information shared for treatment planning and/or service coordination. By signing this form, I am allowing service providers or agencies to exchange information that will be useful in planning current treatment, and/or will make it easier for them to work together effectively in planning and/or providing services.

Patient's Full Name _____

Patient's Date of Birth _____ Patient's Social Security Number_____

My relationship to the Patient is: □ Self □ Parent □ Guardian

I want the following confidential information about the Patient to be exchanged:

□ Psychological/Psychiatric Assessment Information
□ Psychological/Psychiatric Treatment Records
□ Synopsis of Psychological/Psychiatric Treatment
□ Psychological/Psychiatric Diagnosis
□ Educational/Criminal Justice Records/Files
□ Medical Assessment Information
□ Medical Treatment Records
□ Synopsis of Medical Treatment
□ Medical Diagnosis
□ Other _____

I want Dr. Karen Gillock and/or Ms. Jennifer St. Laurence and the following service providers or agencies to exchange this information: (Please fill in names and telephone numbers/email addresses.)

□ Primary Care Physician/Nurse/Assistant_____

□ Specialty Physician/Nurse/Assistant_____

□ Psychologist/Therapist/Counselor_____

□ Psychiatrist/Psychiatric Nurse_____

□ Hospital/Inpatient Facility_____

□ Partial Hospital Program_____

□ Other _____

I want information to be shared in the following form (check all that apply; typically check all three):

□ Written Information □ In Meetings or by Telephone □ Computerized Data

I want to share additional information received after this consent is signed: □ Yes □ No

This consent is good until: _____/_____/_____ (typically 1 year from today)

I can withdraw this consent at any time by telling the referring agency. This will stop the listed parties from sharing information after they know my consent has been withdrawn. I have the right to know what information has been shared, and why, when, and with who it was shared. If I ask, each party will provide me with this information. I want the parties listed above to accept a copy of this form as consent to share information.

Signature _____ Date Signed_____