

A. J. Johnson Psychological Services, PLLC

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Patient Services Agreement/Informed Consent Form

Welcome to my practice. This document (the Agreement) contains important information about my professional services and business policies. It also contains summary information about the Health Insurance Portability and Accountability Act (HIPAA), a federal law that provides privacy protections and patient rights with regard to the use and disclosure of your Protected Health Information (PHI) used for the purpose of treatment, payment, and health care operations. HIPAA requires that I provide you with a Notice of Privacy Practices (the Notice) for use and disclosure of PHI for use and disclosure of PHI for treatment, payment, and health care operations. The Notice, which is attached to this Agreement, explains HIPAA and its application to your personal health information in greater detail. The law requires that we obtain your signature acknowledging that we have provided you with this information at the end of this session. Although these documents are long and sometimes complex, it is very important that you read them carefully before the first session. We can discuss any questions you have about the procedures at that time. When you sign this document, it will also represent an agreement between us.

PROFESSIONAL DISCLOSURE STATEMENT

Overview: Psychological treatment is not easily described in general statements. It varies depending on the personalities of the clinician and patient, and the particular problems you are experiencing. There are many different methods I may use to deal with the problems that you hope to address. Psychotherapy is not like a medical doctor visit. Instead, it calls for a very active effort on your part. In order for the therapy to be most successful, you will have to work on things we talk about both during our sessions and at home.

Psychotherapy can have benefits and risks. Since therapy often involves discussing unpleasant aspects of your life, you may experience uncomfortable feelings like sadness, guilt, anger, frustration, loneliness, and helplessness. Obviously, we feel strongly that psychotherapy has stronger benefits than risks. Therapy often leads to better relationships, solutions to specific problems, and significant reductions in feelings of distress. But there are no guarantees of what you will experience.

Our first few sessions will involve an evaluation of your needs. By the end of the evaluation, I will be able to offer you some first impressions of what our work will include and a treatment plan to follow, if you decide to continue therapy. You should evaluate this information along with your own opinions whether you feel comfortable working with me. Therapy involves a large commitment of time, money, and energy, so you should be very careful about the therapist you select. If you have questions about my procedures, we should discuss them whenever they arise. If your doubts persist, I will be happy to help you set up a meeting with another mental health professional for a second opinion.

MEETINGS

General Information

I typically conduct an informal evaluation that will last from 2-4 sessions. During this time, you and I can decide if I am the right person to provide the services you need in order to meet your treatment goals. If

Patient or Parent/Guardian Signature: _____

psychotherapy is begun, then usually sessions are 50 minutes in length and occur weekly or every other week.

Once an appointment hour is scheduled, you will be expected to pay for it unless you provide 24 hours advance notice of cancellation [unless we both agree that you were unable to attend due to circumstances beyond your control]. It is important to note that insurance companies do not provide reimbursement for cancelled sessions. A need to cancel appointments due to inclement weather does not apply.

Child Supervision

Children under the age of 15 are required to have a responsible adult on the premises at all times and should be directly supervised in the waiting area by a responsible adult when I am meeting with a parent.

PROFESSIONAL FEES

My fee for sessions is \$195. Payment is requested at the time services are rendered. In addition to weekly appointments, we charge this amount for other professional services you may need, though we will break down the hourly cost if we work for periods of less than one hour. Other services include report writing, telephone conversations lasting longer than 30 minutes, consulting with other professionals with your permission, preparation of records or treatment summaries, and the time spent performing any other service you may request.

CONTACTING DR. JOHNSON

Due to my work schedule, I am often not immediately available by telephone. When I am unavailable a phone message can be left for me and I will return your call as soon as possible. I will make every effort to return your call on the same day you make it, with exception of weekends and holidays. If you are difficult to reach, please include in your message, times and days that you will likely be available. If you are unable to reach me and feel that you cannot wait for me to return your call, contact your family physician or the nearest emergency room. I do not offer 24-hour care, thus, in the event of an emergency; call 911 or your nearest emergency room.

DR. JOHNSON'S INCAPACITY OR DEATH

In the event that your therapist becomes incapacitated or dies, it will become necessary for another therapist to take possession of your files and records. By signing this form, you give your consent to allow another licensed mental health professional selected by your therapist to take possession of your records and provide you with copies upon request, or to deliver them to a therapist of your choice

LIMITS OF CONFIDENTIALITY

The law protects the privacy of all communications between a patient and a mental health professional. In most situations, we can only release information about your treatment to others if you sign a written authorization form that meets certain legal requirements imposed by HIPPA. There are situations that require only that you provide written, advance consent. Your signature on this Agreement provides consent for those activities as follows:

- I may occasionally find it helpful to consult other health and mental health professionals about a case. During a consultation, I make every effort to avoid revealing the identity of my patients. The other 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 (which is called "PHI" in our Notice of Psychologist's Policies and Practices to Protect the Privacy of Your Health Information).

Patient or Parent/Guardian Signature: _____

There are some situations where I am permitted or required to disclose information without either your consent or Authorization:

- If you are involved in a court proceeding and a request is made for information concerning your diagnosis and treatment, such information is protected by the clinician-patient privilege law. We cannot provide any information without your (or your legal representative's) written authorization **or a court order**. If you are involved in contemplating litigation, you should consult with your attorney to determine whether a court would be likely to order us 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 patient files a complaint or lawsuit against his/her clinician, that clinicians may disclose relevant information regarding that patient in order to defend themselves.

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 a patient's treatment. These situations are unusual in my practice.

- If I have cause to believe that a child under 18 has been or may be abused or neglected (including physical injury, substantial threat of harm, mental or emotional injury, or any kind of sexual contact or conduct), or that a child is a victim of a sexual offense, or that an elderly or disabled person is in a state of abuse, neglect or exploitation, the law requires that I make a report to the appropriate governmental agency, usually the Department of Family Protective Services. Once such report is filed, I may be required to provide additional information.
- Private information may be disclosed without the informed written consent of the patient when disclosure is necessary to protect against a clear and substantial risk of imminent serious harm being inflicted by the patient on the patient or another individual. In such a case the private information is to be disclosed only to appropriate professional workers, public authorities, the potential victim, or the family of the patient.

While this written summary of exceptions to confidentiality should prove helpful in informing you about potential problems, it is important that you discuss any questions or concerns that you may have now or in the future with me. The laws governing confidentiality can be quite complex, and I am not an attorney. In situations where specific advice is required, formal legal advice may be needed.

Minors & Parents

Prior to beginning treatment, it is important for you to understand my approach to child therapy and agree to some rules about your child's confidentiality during the course of his/her treatment. The information herein is in addition to the information contained in the Patient-Services Agreement.

One risk of child therapy involves disagreement among parents and/or disagreement between parents and therapist regarding the best interests of the child. If such disagreements occur, I will strive to listen carefully so that I can understand your perspectives and fully explain my perspective. We can resolve such disagreements, or we can agree to disagree, so long as this enables your child's therapeutic progress. Ultimately, you will decide whether therapy will continue. If the parent decides that therapy should end, I

will honor that decision, however I ask that you allow me the option of having a few closing sessions to appropriately end the treatment relationship.

Therapy is most effective when a trusting relationship exists between the psychologist and the patient. Privacy is especially important in securing and maintaining that trust. One goal of treatment is to promote a stronger and better relationship between children and their parents. However, it is often necessary for children to develop a “zone of privacy” whereby they feel free to discuss personal matters with greater freedom. This is particularly true for adolescents who are naturally developing a greater sense of independence and autonomy. By signing this agreement, you will be waiving your right of access to your child’s treatment records.

It is my policy to provide you with general information about treatment status. I will raise issues that may impact your child either inside or outside the home. If it is necessary to refer your child to another mental health professional with more specialized skills, I will share that information with you. I will not share with you what your child has disclosed to me without your child’s consent. I will tell you if your child does not attend sessions. At the end of your child’s treatment, I will provide you with a treatment summary that will describe what issues were discussed, what progress was made, and what areas are likely to require intervention in the future.

If your child is an adolescent, it is possible that he/she will reveal sensitive information regarding sexual contact, alcohol and drug use, or other potentially problematic behaviors. Sometimes these behaviors are within the range of normal adolescent experimentation, but at other times they may require parental intervention. We must carefully and directly discuss your feelings and opinions regarding acceptable behavior. If I ever believe that your child is at serious risk of harming him/herself or another, I will inform you.

Although my responsibility to your child may require my involvement in conflicts between parents, I need your agreement that my involvement will be strictly limited to that which will benefit your child. This means, among other things, that you will treat anything that is said in session with me as confidential. If multiple parents are involved in treatment, no one will attempt to gain advantage in any legal proceeding between parties from my involvement with your children. In particular, I need your agreement that in any such proceedings, no party will ask me to testify in court, whether in person, or by affidavit. You also agree to instruct your attorneys not to subpoena me or to refer in any court filing to anything I have said or done.

Note that such agreement may not prevent a judge from requiring my testimony, even though I will work to prevent such an event. If I am required to testify, I am ethically bound not to give my opinion about any party’s custody or visitation suitability. If the court appoints a custody evaluator, guardian ad litem, or parenting coordinator, I will provide information as needed (if appropriate releases are signed or a court order is provided), but I will not make any recommendation about the final decision. Furthermore, if I am required to appear as a witness, the party responsible for my participation agrees to reimburse me at my hourly rate for time spent traveling, preparing reports, testifying, being in attendance, and any other case-related costs. Fees will be charged for court appearances, telephone conversations lasting longer than 30 minutes regarding court issues, consulting with other professionals with your permission, preparation of treatment summaries, and the time spent performing any other service you may request. Court fees will not be billed to insurance and are the patient’s responsibility.

Patient or Parent/Guardian Signature: _____

BILLING & PAYMENTS

You will be expected to pay for each session at the time it is held unless we agree otherwise. Payment schedules for other professional services will be agreed to when they are requested.

RECORDS

I understand it is stated law that psychologists maintain a record of the treatment given to me. This record will contain the information that will allow Amalyssa Johnson, Ph.D. to chart the course of therapy. She will use it only for that purpose. It is her intent that no one will ever see what is contained in the file. I understand I may get a copy of the file only by providing her with a signed release of information request. Amalyssa Johnson, Ph.D. may provide me with a synopsis of the course of treatment and outcome in lieu of the actual record. I agree I will pay in advance for either the copying cost of the actual record or the time required for the preparation of the treatment summary. This includes providing copies or reports to any court or legal representative or designate. If the therapy sessions contain more than one patient, I agree that no one person may get the complete treatment file. Amalyssa Johnson, Ph.D. will attempt to maintain separate records on each patient. However, only that individual is entitled to his/her own record. I agree Amalyssa Johnson, Ph.D. may synopsize the course of each individual’s treatment as opposed to providing a copy of what notes may have been made during any therapy session.

If Amalyssa Johnson, Ph.D. becomes incapacitated or dies, it will become necessary for another therapist to take possession of your files and records. By signing this form, you give your consent to allow another licensed mental health professional, selected by Dr. Johnson, to take possession of your records and provide you with copies upon request, or to deliver them to a therapist of your choice.

YOUR SIGNATURE BELOW INDICATES THAT YOU HAVE READ THIS AGREEMENT AND AGREE TO ITS TERMS AND GIVE CONSENT FOR THERAPY. THIS ALSO SERVES AS AN ACKNOWLEDGEMENT THAT YOU HAVE RECEIVED THE HIPAA NPP FORM DESCRIBED ABOVE.

Patient Signature _____
Date

**IF PATIENT IS A MINOR CHILD, THEN AS A PARENT, LEGAL GUARDIAN, OR
MANAGING CONSERVATOR OF THIS MINOR CHILD, I DO HEREBY AUTHORIZE AJ
JOHNSON PSYCHOLOGICAL SERVICES, PLLC TO PROVIDE THERAPEUTIC SERVICES
AND AGREE TO THE TERMS OF THIS FORM TO MY CHILD.**

Parent or Guardian Signature _____
Date

Patient or Parent/Guardian Signature: _____

INFORMED CONSENT FOR TELEPSYCHOLOGY

This Informed Consent for Telepsychology contains important information focusing on doing psychotherapy using the phone or the Internet. Please read this carefully, and let me know if you have any questions. When you sign this document, it will represent an agreement between us.

Benefits and Risks of Telepsychology

Telepsychology refers to providing psychotherapy services remotely using telecommunications technologies, such as video conferencing or telephone. One of the benefits of telepsychology is that the patient and clinician can engage in services without being in the same physical location. This can be helpful in ensuring continuity of care if the patient or clinician moves to a different location, takes an extended vacation, or is otherwise unable to continue to meet in person. It is also more convenient and takes less time. Telepsychology, however, requires technical competence on both our parts to be helpful. Although there are benefits of telepsychology, there are some differences between in-person psychotherapy and telepsychology, as well as some risks. For example:

- Risks to confidentiality. Because telepsychology sessions take place outside of the therapist's private office, there is potential for other people to overhear sessions if you are not in a private place during the session. On my end I will take reasonable steps to ensure your privacy. But it is important for you to make sure you find a private place for our session where you will not be interrupted. It is also important for you to protect the privacy of our session on your cell phone or other device. You should participate in therapy only while in a room or area where other people are not present and cannot overhear the conversation.
- Issues related to technology. There are many ways that technology issues might impact telepsychology. For example, technology may stop working during a session, other people might be able to get access to our private conversation, or stored data could be accessed by unauthorized people or companies.
- Crisis management and intervention. Usually, I will not engage in telepsychology with patients who are currently in a crisis situation requiring high levels of support and intervention. Before engaging in telepsychology, we will develop an emergency response plan to address potential crisis situations that may arise during the course of our telepsychology work.
- Efficacy. Most research shows that telepsychology is about as effective as in-person psychotherapy. However, some therapists believe that something is lost by not being in the same room. For example, there is debate about a therapist's ability to fully understand non-verbal information when working remotely.

Electronic Communications

We will decide together which kind of telepsychology service to use. You may have to have certain computer or cell phone systems to use telepsychology services. You are solely responsible for any cost to you to obtain any necessary equipment, accessories, or software to take part in telepsychology.

For communication between sessions, I only email communication and only for administrative purposes unless we have made another agreement. This means that email exchanges and text messages with my office should be limited to administrative matters. This includes things like setting and changing appointments, billing matters, and other related issues. You should be aware that I cannot guarantee the confidentiality of any information communicated by email or text. Therefore, I will not discuss any

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clinical information by email or text and prefer that you do not either. Also, I do not regularly check my email or texts, nor do I respond immediately, so these methods **should not** be used if there is an emergency.

Treatment is most effective when clinical discussions occur at your regularly scheduled sessions. But if an urgent issue arises, you should feel free to attempt to reach me by phone. I will try to return your call within 24 hours except on weekends and holidays. If you are unable to reach me and feel that you cannot wait for me to return your call, contact your family physician or the nearest emergency room and ask for the psychologist or psychiatrist on call.

Confidentiality

I have a legal and ethical responsibility to make my best efforts to protect all communications that are a part of our telepsychology. However, the nature of electronic communications technologies is such that I cannot guarantee that our communications will be kept confidential or that other people may not gain access to our communications. I will try to use updated encryption methods, firewalls, and back-up systems to help keep your information private, but there is a risk that our electronic communications may be compromised, unsecured, or accessed by others. You should also take reasonable steps to ensure the security of our communications (for example, only using secure networks for telepsychology sessions and having passwords to protect the device you use for telepsychology).

The extent of confidentiality and the exceptions to confidentiality that I outlined in my Patient Services Agreement still apply in telepsychology. Please let me know if you have any questions about exceptions to confidentiality.

Appropriateness of Telepsychology

From time to time, we may schedule in-person sessions to “check-in” with one another. I will let you know if I decide that telepsychology is no longer the most appropriate form of treatment for you. We will discuss options of engaging in in-person counseling or referrals to another professional in your location who can provide appropriate services.

Emergencies and Technology

Assessing and evaluating threats and other emergencies can be more difficult when conducting telepsychology than in traditional in-person therapy. To address some of these difficulties, we will create an emergency plan before engaging in telepsychology services. I will ask you to identify an emergency contact person who is near your location and who I will contact in the event of a crisis or emergency to assist in addressing the situation. I will ask that you sign a separate authorization form allowing me to contact your emergency contact person as needed during such a crisis or emergency.

If the session is interrupted for any reason, such as the technological connection fails, and you are having an emergency, do not call me back; instead, call 911, or go to your nearest emergency room. Call me back after you have called or obtained emergency services.

If the session is interrupted and you are not having an emergency, disconnect from the session and try to call in again after 30 seconds. If you do not receive a call back within two (2) minutes, then call me on the phone number I provided you (281-242-2595 x203).

If there is a technological failure and we are unable to resume the connection, you will only be charged the prorated amount of actual session time.

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Fees

The same fee rates will apply for telepsychology as apply for in-person psychotherapy.

Records

The telepsychology sessions shall not be recorded in any way unless agreed to in writing by mutual consent. I will maintain a record of our session in the same way I maintain records of in-person sessions in accordance with my policies.

Informed Consent

This agreement is intended as a supplement to the general informed consent that we agreed to at the outset of our clinical work together and does not amend any of the terms of that agreement.

Your signature below indicates agreement with its terms and conditions.

Patient Signature

Date

Amaryssa Johnson, Ph.D., LP

Date

Complaint Notification:

Amaryssa Johnson, PhD, Texas License 38217
Texas State Board of Examiners of Psychologists Complaint 1-800-821-3205
License Verification: <https://vo.licensing.hpc.texas.gov/datamart/selSearchType.do>

Amaryssa Johnson, PhD, Minnesota License LP5520
Minnesota Board of Psychology Complaint 612-617-2230
License Verification: <https://mnit.force.com/license/SearchBox>