REIF BEHAVIORAL SOLUTIONS

Applying the Science of Psychology to Life

CONSENT TO USE AND DISCLOSE YOUR HEALTH INFORMATION

This form is an agreement between you, _____

and me/us, Dr. Reif. When we use the words "you" and "your" below, this can mean you, your child, a relative, or some other person if you have written his or her name

here _____

When we examine, test, diagnose, treat, or refer you, we will be collecting what the law calls "protected health information" (PHI) about you. We need to use this information in our office to decide on what treatment is best for you and to provide treatment to you. We may also share this information with others to arrange payment for your treatment, to help carry out certain business or government functions, or to help provide other treatment to you. By signing this form, you are also agreeing to let us use your PHI and to send it to others for the purposes described above. Your signature below acknowledges that you have read or heard our notice of privacy practices, which explains in more detail what your rights are and how we can use and share your information.

If you do not sign this form agreeing to our privacy practices, we cannot treat you. In the future, we may change how we use and share your information, and so we may change our notice of privacy practices. If we do change it, you can get a copy from our website, www.reifbehavioralsolutions.com, or by calling us at, (630)329-2233 or from our privacy officer.

If you are concerned about your PHI, you have the right to ask us not to use or share some of it for treatment, payment, or administrative purposes. You will have to tell us what you want in writing. Although we will try to respect your wishes, we are not required to accept these limitations. However, if we do agree, we promise to do as you asked. After you have signed this consent, you have the right to revoke it by writing to our privacy officer. We will then stop using or sharing your PHI, but we may already have used or shared some of it, and we cannot change that.

_____	_____
Signature of client or his or her personal representative	Date
_____	_____
Printed name of client or personal representative	Relationship to the client
_____	_____
Signature of Reif Behavioral Solutions LLC Representative	Date of NPP

REIF BEHAVIORAL SOLUTIONS

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CLIENT INFORMATION CONTRACT

Welcome to Reif Behavioral Solutions (RBS). This document contains important information about the professional services and business policies of RBS. Please read it carefully and jot down any questions you might have so that we can discuss them at our next meeting. When you sign this document, it will represent an agreement between us.

PSYCHOLOGICAL SERVICES

Psychotherapy is not easily described in general statements. It varies depending on the personalities of the psychologist and patient, and the particular problems you bring forward. 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 on your own, outside of therapy sessions.

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. On the other hand, psychotherapy has also been shown to have benefits for people who go through it. 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 1-2 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 an initial treatment plan to follow, if you decide to continue with therapy. You should evaluate this information along with your own opinions of whether you feel comfortable working with me.

Therapy involves a large commitment of time, money, and energy, so you should be 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.

You may feel free to air any grievances about Dr. Reif, or Reif Behavioral Solutions to the respective licensing board of your state:
For California: http://www.bbs.ca.gov/consumers/consumer_complaints.html
For Illinois: http://www.idfpr/admin/complaints.asp

MEETINGS

I normally conduct an evaluation that lasts from 1 to 2 sessions. During this time, we can both decide if I am the best person to provide the services you need in order to meet your treatment goals. If psychotherapy is begun, I will usually schedule one 45-50-minute session per week at a time we agree on, although some sessions may be longer or more frequent. 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). If it is possible, I will try to find another time to reschedule the canceled appointment.

PROFESSIONAL FEES

My evaluation fee is $200 per 50 min session. My fee per 50-minute session of counseling is $200. In addition to weekly appointments, I will charge a fee of $200 per hour for other professional services you may need, including telephone conversations lasting longer than 10 minutes, attendance at meetings with other professionals you have authorized, preparation of records or treatment summaries, and the time spent performing some other services you may request of me. If you become involved in legal proceedings that require my participation, you will be expected to pay for my services. Because of the difficulty of legal involvement, I charge $300 per hour for preparation and attendance at any legal proceeding.

PAYMENTS

You will be expected to pay for each session at the time it is held. You may pay in cash, with a personal check, or by credit card. Payment schedules for other professional services will be agreed to when they are requested. (In circumstances of unusual financial hardship, I may be willing to negotiate a fee adjustment or payment installment plan.)

CONTACTING ME

I am often not immediately available by telephone. I usually do not answer the phone when I am with a patient. When I am unavailable, my telephone is answered by voicemail that I monitor frequently. I will make every effort to return your call as soon as possible and within 24 hours, with the exception of weekends, holidays, and when I am out of town. If you are difficult to reach, please inform me of some times when you will be available. If you are unable to reach

me and feel that you can't 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. If I will be unavailable for an extended time, I will provide you with the name of a colleague to contact, if necessary.

PROFESSIONAL RECORDS

The laws and standards of my profession require that I keep treatment records. You are entitled to receive a copy of your records, or I can prepare a summary for you instead. Because these are professional records, they can be misinterpreted and/or upsetting to untrained readers. If you wish to see your records, I recommend that you review them in my presence so that we can

discuss the contents. (I am sometimes willing to conduct a review meeting without charge.) Patients will be charged an appropriate fee for any professional time spent in responding to information requests.

CONFIDENTIALITY

In general, the privacy of all communications between a patient and a psychologist is protected by law, and I can only release information about our work to others with your written permission. But there are a few exceptions.

In most legal proceedings, you have the right to prevent me from providing any information about your treatment. In some proceedings involving child custody and those in which your emotional condition is an important issue, a judge may order my testimony if he/she determines that the issues demand it.

There are some situations in which I am legally obligated to take action to protect others from harm, even if I have to reveal some information about a patient's treatment. For example, if I believe that a child, elderly person, or disabled person is being abused, I must file a report with the appropriate state agency.

If I believe that a patient is threatening serious bodily harm to another, I am required to take protective actions. These actions may include notifying the potential victim, contacting the police, or seeking hospitalization for the patient. If the patient threatens to harm himself/herself, I may be obligated to seek hospitalization for him/her or to contact family members or others who can help provide protection.

These situations have rarely occurred in my practice. If a similar situation occurs, I will make every effort to fully discuss it with you before taking any action.

While this written summary of exceptions to confidentiality should prove helpful in informing you about potential problems, it is important that we discuss any questions or concerns that you may have at our next meeting. I will be happy to discuss these issues with you if you need specific advice, but formal legal advice may be needed because the laws governing confidentiality are quite complex, and I am not an attorney.

Electronic Communication: Because confidentiality is paramount in the therapeutic relationship,

I have a policy for communication via email. While often convenient, email does not guarantee security and confidentiality. Because there is no way for me to be completely sure that you are the sender of emails, I will not respond to emails sent to me once we enter treatment. While you are free to communicate information to me regarding cancellations

of appointments, I prefer that you telephone me for questions regarding treatment. This is the only way I can ensure your confidentiality is maintained.

Use of Smartphone Apps: There are more than 500 self-help apps on the apple app store. Some of them can be a nice way to augment treatment, and to encourage and enhance homework practice between sessions. While I may encourage you to try a few that pertain to your treatment, I cannot take responsibility for the confidentiality of the information you input, and you should consider them to be used at your own risk. Many apps have passcode protection and I encourage you to use it. Although it is sometimes an option, I do not allow my clients to email me through the apps, for reasons stated above. Please share your progress during our sessions.

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

Signed_____ Date_____

AGREEMENT TO PAY FOR PROFESSIONAL SERVICES

I request that the therapist named below provide professional services to me or to _____,

who is my_____, and I agree to pay this therapist's fee of $200 per session for these services.

I agree that this financial relationship with this therapist will continue as long as the therapist provides services or until I inform him or her, in person or by phone or mail,that I wish to end it. I agree to meet with this therapist at least once before stopping therapy. I agree to pay for services provided to me (or this client) up until the time I end the relationship.

I agree that I am responsible for the charges for services provided by this therapist to me (or this client), although other persons or insurance companies may make payments on my (or this client's) account. I understand that I will be charged for the full SESSION, NOT JUST THE CO-PAY for any sessions canceled less than 24 hours in advance.

I have also read this therapist's "Client Information Contract" and agree to act according to everything stated there, as shown by my signature below.

_____ _____

Signature of client (or person acting for client) Date

_____

Printed name

I, the therapist, have discussed the issues above with the client (and/or the person acting for the client). My observations of
the person's behavior and responses give me no reason to believe that this person is not fully competent to give informed and willing consent.

_____ _____

Signature of therapist Date

Good Faith Estimate

I understand that it is the expectation that therapy will take place once per week, at a cost of $200 per session. On average, therapy is expected to last approximately 12 weeks, for a total cost of $2,400. However, it could last for as many as 52 weeks of the year, for a total of $10,400. It is also possible that alternative treatment plans could increase service fees, such as with intensive therapy.

If you are billed for more than this Good Faith Estimate, you may dispute your bill. Go to www.cms.gov/nosurprises/consumers or call 1-800-985-3059.

CONSENT TO TREATMENT / TELETHERAPY

I acknowledge that I have received, have read (or have had read to me), and understand the "Client Information Contract" brochure and/or other information about the therapy I am considering. I have had all my questions answered fully, and understand the risks and benefits of therapy, the importance of confidentiality, and the limits to confidentiality.

I understand that my therapist has had her Ph.D. since 1997, and has had a private practice since 2013.

I do hereby seek and consent to take part in the treatment by the therapist named below at a rate of $200 per session. I understand that developing a treatment plan with this therapist and regularly reviewing our work toward meeting the treatment goals are in my best interest. I agree to play an active role in this process.

I understand that no promises have been made to me as to the results of treatment or of any procedures provided by this therapist.

I understand that there are some risks and benefits that specifically pertain to teletherapy. I understand that my therapist will provide me with a HIPAA compliant therapy platform with which to log in for therapy. However, that doesn't mean that there couldn't be technical difficulties, or other interruptions, for which my therapist will work to eliminate. I will also do my part to minimize distractions on my end, and know that it is up to me to maintain the level of privacy that I would like. I also understand that teletherapy affords the possibility of engaging in therapy from the comfort of your own space, without commuting to an office, and having transportation costs. It also allows the therapist to become a part of my "physical world," which can often enhance certain types of therapy such as exposure, or relaxation training.

I understand that my therapist is required to post their license in their office space- whether it is in person or teletherapy I am engaged in. I can ask to see it at any time.

I am aware that I may stop my treatment with this therapist at any time. The only thing I will still be responsible for is paying for the services I have already received. I understand that I may lose other services or may have to deal with other problems if I stop treatment. (For example, if my treatment has been court-ordered, I will have to answer to the court.)

I know that I must call to cancel an appointment at least 24 hours before the time of the appointment. If I do not cancel and do not show up, I will be charged for that appointment.

I am aware that an agent of my insurance company or other third-party payer may be given information about the type(s), cost(s), date(s), and providers of any services or treatments I receive. I understand that if payment for the services I receive here is not made, the therapist may stop my treatment.

My signature below shows that I understand and agree with all of these statements.

_____ _____

Signature of client (or person acting for client) Date

_____ _____

Printed name Relationship to client (if necessary)

I, the therapist, have discussed the issues above with the client (and/or his or her parent, guardian, or other representative). My observations of this person's behavior and responses give me no reason to believe that this person is not fully competent to give informed and willing consent.

_____ _____

Sam F. Reif, Ph.D., LCPC, LCPP Date

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