Wellman Psychology & Associates S.C.

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ILLINOIS NOTICE FORM

Informed Consent

Notice of Psychologist's Policies and Practices to Protect the Privacy of Your Health Information

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

I. General Information

Thank you for selecting Wellman Psychology & Associates, S.C. Dr. James D. Wellman, Clinical Psychologist, is the owner and CEO. The intention of this document is to inform you of our office policies, State and Federal Laws, and your rights as a client. We currently have 4 clinicians on staff: Dr. James D. Wellman, Psy.D; Dr. Gurpreet Paul, Psy.D; Dr. Jonathan Katz, Psy.D; Dr. Patrick Szafan, Psy.D, each of them earned their Doctorate Degree in Clinical Psychology. Each is licensed as a Clinical Psychologist by the state of Illinois. Each doctor tailors his or her therapy treatments to the individual needs of each of his or her clients and takes whatever extra steps are necessary in ensuring that their clients get the care they need. These doctors specialize in: anxiety, ADHD, impulse control disorders, mood disorders/depression, sexual orientation, and neuropsychological testing for children, adolescents, and adults. If you have any questions at any time, please feel free to ask and we will do our best to get you the information that you request. You are also welcome to visit our website: www.wellmanpsychology.com to access additional information.

II. Confidentiality and Emergency Information:

Dr. James D. Wellman's office policies are intended to protect your rights to privacy. All records and verbal communication with your doctor are strictly confidential. A valid form of identification of you will be needed at the initial visit to verify identity and a copy will be kept in your file. All your records and information will be locked up to be kept safe and secured. Some exceptions to this include: a) some details like dates of service and diagnosis codes will be shared with your insurance company for the purpose of processing your claims; b) when you sign a release form allowing specified information to be received or shared with or from a specific person; c) by Illinois State Law I am obligated to report any indicated information to the affect of any physical or sexual abuse of a minor to the Department of Children and Family Services; d) if you share any information that you are in danger of harming anyone else or yourself; e) information necessary for a supervised case or consultation; f) or when required by law. If the client or guardian feels that immediate attention is necessary, the client or guardian understands it is their responsibility to contact emergency services (911) in such case of an emergency. Your respective doctor will follow up on the emergency services with therapy and support to the client and family of the client as soon as possible.

By initialing below I verify that I have read, understood, and agree to the terms in the previous section "*Confidentiality and Emergency Information."*

Initials:_____

III. Financial and Insurance Concerns:

The office of Dr. Wellman asks that payment of services be paid at time of appointment. Credit cards, cash, and checks are all acceptable forms of payment. Any returned checks may result in additional fees. We will need to make a copy of your insurance card and will be held in your file. Upon the initial visit we will contact the insurance company to verify benefits (in/out of network, deductable, out-of-pocket, co-insurance, co-pays, allowed number of visits, and any other financial information the you will be responsible for). We bill insurance companies on a weekly basis. After claims have been processed by the insurance company, we will then bill the client for any remaining balance for any deductable not met or other amounts not covered by insurance. We are aware that there may be some unforeseen circumstances that do not allow payment to be made on time. We will work with you to ensure that payments are made if necessary. However, if payments have not been made for more than 60 days and no arrangements of payment have been made, we will be forced to take more extensive actions that may result in this bill going to a collections agency. If for any reason you cannot make your appointment, we ask that you give us a **24 HOUR NOTICE** by contacting us to either cancel or reschedule. Any scheduled appointment that has not been canceled or rescheduled 24 hours prior to the appointment time, will be charged as a full session. You will still be financially responsible for any and all services rendered even after treatment has come to an end.

By initialing below I verify that I have read, understood, and agree to the terms in the previous section "*Financial and Insurance Concerns."*

Initials:_____

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

The office of Dr. Wellman may *use* or *disclose* your *protected health information* (*PHI*), for *treatment, payment, and health care operations* purposes with your *written authorization*. 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 [office, clinic, practice group, etc.] such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.
- "*Disclosure*" applies to activities outside of my [office, clinic, practice group, etc.], such as releasing, transferring, or providing access to information about you to other parties.
- "*Authorization*" is your written permission to disclose confidential mental health information. All authorizations to disclose must be on a specific legally required form.

By initialing below I verify that I have read, understood, and agree to the terms in the previous section "*Uses and Disclosures for Treatment, Payment, and Health Care Operations."*

Initials:_____

V. Other Uses and Disclosures Requiring Authorization

The office of Dr. Wellman may use or disclose PHI for purposes outside of treatment, payment, or health care operations when your appropriate authorization is obtained. In those instances when I am asked for information for purposes outside of treatment, payment, or health care operations, I will obtain an authorization from you before releasing this information. I will also need to obtain an authorization before releasing your Psychotherapy Notes. "*Psychotherapy Notes*" are notes I have made about our conversation during a private, group, joint, or family counseling session, which I have kept separate from the rest of your record. These notes are given a greater degree of protection than PHI.

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

By initialing below I verify that I have read, understood, and agree to the terms in the previous section "*Other Uses and Disclosures Requiring Authorization."*

Initials:_____

VI. Uses and Disclosures without Authorization

The office of Dr. Wellman may use or disclose PHI without your consent or authorization in the following circumstances: a) *Child Abuse* – If I have reasonable cause to believe a child known to me in my professional capacity may be an abused child or a neglected child, I must report this belief to the appropriate authorities; b) *Adult and Domestic Abuse* – If I have reason to believe that an individual (who is protected by state law) has been abused, neglected, or financially exploited, I must report this belief to the appropriate authorities; c) *Health Oversight Activities* – I may disclose protected health information regarding you to a health oversight agency for oversight activities authorized by law, including licensure or disciplinary actions; d) *Judicial and*

Administrative Proceedings – If you are involved in a court proceeding and a request is made for information by any party about your evaluation, diagnosis and treatment and the records thereof, such information is privileged under state law, and I must not release such information without a court order. I can release the information directly to you on your request. Information about all other psychological services is also privileged and cannot be released without your authorization or a court order. The privilege does not apply when you are being evaluated for a third party or where the evaluation is court ordered. You must be informed in advance if this is the case; e) *Serious Threat to Health or Safety* – If you communicate to me a specific threat of imminent harm against another individual or if I believe that there is clear, imminent risk of physical or mental injury being inflicted against another individual, I may make disclosures that I believe are necessary to protect that individual from harm. If I believe that you present an imminent, serious risk of physical or mental injury or death to yourself, I may make disclosures I consider necessary to protect you from harm; or f) *Worker's Compensation* – I may disclose protected health information regarding you as authorized by and to the extent necessary to comply with laws relating to worker's compensation or other similar programs, established by law, that provide benefits for work-related injuries or illness without regard to fault.

By initialing below I verify that I have read, understood, and agree to the terms in the previous section "*Uses and Disclosures without Authorization."*

Initials:_____

VII. Client's Rights and Psychologist's Duties

Client's Rights: 1) *Right to Request Restrictions* – You have the right to request restrictions on certain uses and disclosures of protected health information. However, I am not required to agree to a restriction you request; 2) *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. On your request, I will send your bills to another address); 3) *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 and Psychotherapy Notes. On your request, I will discuss with you the details of the request for access process; 4) *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; 5) *Right to an Accounting* – You generally have the right to receive an accounting of disclosures of PHI. On your request, I will discuss with you the details of the accounting process; 6) *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: 1) 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; 2) 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; 3) If I revise my

policies and procedures, I will . . . [*Notice must also describe how the psychologist will provide individuals with a revised notice, e.g., by mail*.]
By initialing below I verify that I have read, understood, and agree to the terms in the previous section "*Client's Rights and Psychologist's Duties."*

Initials:_____

VIII. Client's and Psychologist's Responsibilities

Clients Responsibilities

1) Your mental health is the purpose of entering into a therapeutic relationship with a psychologist. We place a high emphasis on your participation and believe it is essential in the process. It is important that you bring up your concerns, questions, and requests during therapy and keep an open line of communication. It is expected that there will be complete honesty, respect, responsibility, and involvement in every session from you. Every client's plan of treatment will vary upon what each person's needs are. Therapy is a team effort for both you and your doctor to work together in creating the best form of treatment to those needs.

2) In case of an emergency, your doctor will make every effort to be available through phone. If you are unable to reach our office, please call 911 and they can direct you in where you can get the help you need. Your doctor will follow up with you once he or she has been informed of the situation. If it is a non emergency situation, please feel free to leave a voice message for your doctor and he or she will return your message at the earliest availability.

3) Wellman Psychology & Associates, S.C. appreciates punctuality so we ask that you be on time for your scheduled appointments. If you cannot make the scheduled appointment please contact dr@wellmanpsychology.com to reschedule that appointment for the next best availability. Any "no call, no show's" will be charged as a full session.

4) Homework may be given to you depending upon the agreed terms of your treatment. The doctors ask that you put as much work into those assignments as you do in your sessions with him.

5) It is your right and choice to stop treatment at any time. Wellman Psychology & Associates, S.C. asks that you discuss this with your doctor so that treatment can end with you feeling comfortable, safe and ready to move on and give any referrals, if necessary.

6) The following space is designed for you to share any thoughts you want considered for being added to this agreement:

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Psychologist's Responsibilities

1) The doctors will be on time for his scheduled appointment with you. Each session will last about 60 minutes unless duration of time is agreed upon for your treatment plan. If your doctors is unable to meet for your scheduled appointment, he or she will notify you within 24 hours and reschedule for the next available time slot, except in case of an emergency. In case of an emergency he will contact you as soon as possible to reschedule your appointment.

2) The doctors will conduct themselves in a professional manner while following the ethical and professional guidelines designed by the American Counseling Association and the American Mental Health Counselor's Association as well as adhering to federal/state laws and guidelines associated to his profession.

3) If the agreed upon treatment plan includes working with other health care professionals, your doctor will work in your best interest to collaborate and communicate effectively with these health professionals.

4) Each doctor will make every effort to be available either through cell phone or email in non emergency and emergency situations. In case of an emergency and you cannot reach the office, please contact 911 for help. Your respective doctor will follow up with you as soon as he or she is able to.

By initialing below I verify that I have read, understood, and agree to the terms in the previous section "*Client's and Psychologist's Responsibilities."*

Initials:_____

IX. Questions and Complaints

If you have questions about this notice, disagree with a decision I make about access to your records, or have other concerns about your privacy rights, you may contact **James Wellman, Psy.D.** at **(773) 683-1731or dr@wellmanpsychology.com**.

If you believe that your privacy rights have been violated and wish to file a complaint with *me/my* office, you may send your written complaint to **James Wellman, Psy.D.** at **3660 North Lake Shore Drive, Suite 210 Chicago, IL 60613.**

You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services. The person listed above can provide you with the appropriate address upon request.

You have specific rights under the Privacy Rule. Wellman Psychology & Associates, S.C. will not retaliate against you for exercising your right to file a complaint.

X. Voluntary Consent

By signing below I verify that the Informed Consent given to me by the office of Dr. James D. Wellman has been read (to me or by me), understood and all initial's in this form are mine. I agree to the conditions presented and am willing to freely participate in therapy for myself or dependant at this time. If any questions or concerns arise I agree to address the issue before the next visit so therapy can continue unhindered.

Client Name:_____

Print Name:_____

Signature:_____

Date:_____