GROWING EDGES

Individualized therapy for dealing with life challenges

ILYSSA SWARTOUT, Psy.D.
LICENSED CLINICAL PSYCHOLOGIST

WELCOME TO GROWING EDGES
& THE OFFICE OF DR. ILYSSA SWARTOUT

INTRODUCTION

Welcome. I am looking forward to the prospect of our work together and would like to introduce you to some important information about my professional services and business policies. Please read this carefully and feel free to write down any questions you might have so that we can discuss them at our next meeting. In addition to my policies and procedures, this form also contains information regarding Health Portability and accountability Act (HIPAA). HIPAA is a federal law that is aimed to protect the use and disclosure of your Protected Health Information (PHI). In this form under the section entitled "HIPAA Notice of Privacy Practices" I have included the Notice of Privacy Practices that will explain more fully your rights for PHI. After fully reading through this form and receiving answers to any questions you may have, please sign the last page to indicate that you have read and fully understood the arrangement being made 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 are experiencing. I may use many different methods, but generally my approach invites your close attention to your internal experience, to your perceptions of your world around you, and to the manner in which you pursue or limit making your way. I believe that therapy is a process of experiencing and understanding who you really are and creating a greater sense of personal alignment with the goal of healing wounded parts of you and living up to your full potential. In our work, I may invite you to explore by talking about material or experimenting with behaviors. You always have the right to decline or agree to these invitations, and it is appropriate at any time to question what we are doing. However, it is important for you to understand that psychotherapy is not like a medical doctor visit. Instead, in order for psychotherapy to be effective, it calls for a very active effort on your part. The more honest, truthful, and genuine you are with me about what you are believing, thinking, feeling, saying/doing, in your daily life outside of my office and with me in my office, the more likely it is that you will really understand yourself, I will really understand you, and we will together help you heal. In the same way, I will be honest with you. In order for therapy to really work, our honesty and

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genuineness with each other is essential. While I provide expertise regarding how to do meaningful therapy, you are the source of what is important to you and your level of satisfaction. Since therapy seeks to enhance your ability to care for yourself, I will support your being in charge of yourself. My deepest intention is that you find within yourself a deep and lasting sense of wholeness, worth, and esteem.

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 with therapy. You should evaluate this information along with your own opinions of whether you feel comfortable working with me. Most clients with whom I meet feel their problems are adequately resolved in 8-24 sessions, and they feel capable of working through the remaining aspects of their concerns without therapy. Some clients return when they have encountered a new aspect of their problem and they would like some help. Since I believe our relationship is an important one, I ask that we talk, face-to-face in session, about ending your therapy before you stop coming. If the ending of our relationship feels clean and clear to both of us, it is much more likely we will feel good about ourselves and the therapy we have completed. 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.

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 many benefits. Therapy often leads to better relationships, solutions to specific problems, a better understanding of yourself, and significant reductions in feelings of distress. But there are no guarantees of what you will experience.

MEETINGS

My assessment normally occupies the bulk of the first session and may last from 2 to 4 sessions. During this time, we can both decide if I am the best person to provide the services that you need in order to meet your treatment goals. If psychotherapy is begun, I will usually schedule one appointment hour of 45 to 55 minutes duration 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.**

PROFESSIONAL FEES

My hourly fee is $200 for a 55-minute therapy sessions. In addition to scheduled appointments, I charge this amount for other professional services you may need, though I will break down the hourly cost if I work for periods of less than one hour. Other services include report writing, telephone conversations lasting longer than 10 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 of me. If

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you become involved in legal proceedings that require my participation, you will be expected to pay for all of my professional time, including preparation and transportation costs, even if I am called to testify by another party. Because of the difficulty of legal involvement, I charge $350 per hour for preparation and attendance at any legal proceeding as a fact witness only. I require payment in advance and the attorneys involved must commit to a scheduled amount of time. If I am required to be a fact witness in court I contract for quarter day minimum.

I do not do disability cases or workman's compensation cases, nor any paperwork associated with a disability and workman's compensation. I also do not do therapy with any individual who is working with an entity that requires therapy treatment plans and/or progress reports. If you are seeking therapy related to any of the above, I am probably not the best therapist for you.

HIPPA NOTICE OF PRIVACY PRACTICES – PATIENT RIGHTS

As a client, you have certain rights to your Protected Health Information (PHI). These rights include access to your PHI, the right to inspect and request a copy of your PHI, the right to request corrections to your PHI, the right to request that your PHI be restricted for various uses and disclosures, the right to request confidential communication, and the right to know what disclosures of your PHI have been made by me to others during the past 6 years. As HIPAA requires that I provide you with this Notice of Privacy Practices and obtain your signature indicating that I have provided you with this information, please be sure and sign the last page of the form indicating that you have read this section.

CONTACTING ME

Due to my work schedule, I am often not immediately available by telephone. When I am unavailable, my telephone is answered by an answering machine that I monitor frequently. Please leave a message on this system. I will make every effort to return your call promptly. The system works during standard business hours, five days/week, except on holidays. Please leave your call- back number with your message. I may be away from the office when I receive your message, and therefore be unable to consult your chart for your telephone-contact information. You may also reach me at my voice mail number. 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, one of my colleagues will reply to your message and will put you in touch with the psychologist who is covering for me. Please know that when I am not in the office I may forward all my calls from my office phone to my cellular phone. I will make every effort to inform you in advance of any planned absences.

LIMITS ON CONFIDENTIALITY

The law protects the privacy of all communications between a patient 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

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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 patient. 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 my Notice of Psychologist's Policies and Practices to Protect the Privacy of Your Health Information).

- You should be aware that I practice with other mental health professionals and that I employ administrative staff. In most cases, I need to share protected information with these individuals for both clinical and administrative purposes, such as scheduling, billing and quality assurance. All of the mental health professionals are bound by the same rules of confidentiality. All staff members have been given training about protecting your privacy and have agreed not to release any information outside of the practice without the permission of a professional staff member.

- I also have a contract with Accurate Medical Billing, Inc, which is the company I use for my billing. As required by HIPAA, I have a formal business associate contract with this business, in which it promises to maintain the confidentiality of this data except as specifically allowed in the contract or otherwise required by law. If you wish, I can provide you with the names of these organizations and/or a blank copy of this contract.

- Disclosures required by health insurers or to collect overdue fees are discussed elsewhere in this Agreement.

- If a 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.

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 the professional services I provided you, such information is protected by the psychologist-patient privilege law. I cannot provide any information without your or your legal representative's written authorization, or 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.

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- If a government agency is requesting the information for health oversight activities, I may be required to provide information for it.

- If a patient files a complaint or lawsuit against me, I may disclose relevant information regarding that patient in order to defend myself.

- If a patient files a worker's compensation claim, and I am providing services related to that claim, I must, upon appropriate request, provide appropriate reports to the Workers Compensation Commission or the insurer.

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 reason to believe that a child under 18 who I have seen or whom you have told me about, is or has been the victim of injury, sexual abuse, neglect or deprivation of necessary medical treatment, the law requires that I file a report with the appropriate government agency, usually the Office of Child Protective Services. Once such a report is filed, I may be required to provide additional information.

- If I have reason to believe that any adult patient who is either vulnerable and/or incapacitated and who has been the victim of abuse, neglect or financial exploitation, the law requires that I file a report with the appropriate state official, usually a protective services worker. Once such a report is filed, I may be required to provide additional information.

- If a patient communicates an explicit threat of imminent serious physical harm to a clearly identified or identifiable victim, and I believe that the patient has the intent and ability to carry out such threat, I must take protective actions that 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.

If such a situation arises, 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.

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 now or in the future. 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.

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PROFESSIONAL RECORDS

Laws and standards of my profession require that I keep Protected Health Information about you in your clinical record. Your clinical record includes information about your reasons for seeking therapy, a description of the ways in which your problem impacts on your life, your diagnosis, the goals that we set for treatment, your progress towards those goals, your medical and social history, your treatment history, any past treatment records that I receive from other providers, reports of any professional consultations, your billing records, and any reports that have been sent to anyone, including reports to your carrier. Except in unusual circumstances that involve danger to yourself and others or where information has been supplied to me by others confidentially, 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 recommend that you initially review them in my presence, or have them forwarded to another mental health professional so you can discuss the contents. If I refuse your request for access to your records, you have a right of review, which I will discuss with you upon request.

In addition, I also sometimes keep a set of Psychotherapy Notes. These Notes are for my own use and are designed to assist me in providing you with the best treatment. While the contents of Psychotherapy Notes vary from client to client, they can include the contents of our conversations, my analysis of those conversations, and how they impact on your therapy. They also contain particularly sensitive information that you may reveal to me that is not required to be included in your Clinical Record. These Psychotherapy Notes are kept separate from your Clinical Record. While insurance companies can request and receive a copy of your Clinical Record, they cannot receive a copy of your Psychotherapy Notes without your written, signed Authorization. Insurance companies cannot require your Authorization as a condition of coverage nor penalize you in any way for your refusal. You may examine and/or receive a copy of your Psychotherapy Notes unless I determine that such access is clinically contraindicated.

If you are coming to see me as part of a couple or family, I keep one file for the unit. If one person's records are court ordered it is not viable to separate records and therefore all records will be sent. I do not keep separate records for individuals who are part of the couple or family unit if I see them individually during the episode of therapy. Therefore, both the individual and unit records may have to be sent. It is important to know that when seeing a couple, I find it best not to keep secrets if I happen to see each of you individually. Therefore, if you do not want your partner to know something sensitive, please do not tell me during our individual sessions. As part of my work with couples I may be video taping your session in order to review myself or with another professional. During your first session, I will be giving you an authorization form to read and sign to allow me to video record your sessions. This form will also explain the details involved in the recording process both during and following the recording.

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Upon termination of your therapy with me, I will maintain your full and complete file for a total of 7 years or, when a minor client has reached the age of 21, whichever is longer. I will not make any attempt to contact you prior to destroying your records, unless I am closing my practice. Files will be destroyed by an insured and bonded, commercial shredding service.

Clients will be charged an appropriate fee for any professional time spent in responding to information/ record requests.

CONFLICT OF INTEREST AND MULTIPLE RELATIONSHIPS

In the event that I discover that our therapy represents a conflict of interest in which I am required to fulfill 2 roles that conflict, I may need to withdraw from my therapeutic roll and will provide you with several recommendations for other mental health professionals. Additionally, in the event that I discover that our therapy presents a multiple relationship in which I am engaged in more that one role with you (such as therapist and educator), I may need to withdraw from these roles and will provide you with several recommendations for other mental health professionals.

RIGHT TO REFUSE SERVICE

I maintain the right to refuse service to clients at any time. In the event that a client presents to therapy under the influence of a substance, the session will be cancelled and he/she will still be responsible to pay for the cancelled session. In the event that I feel that my safety is endangered, I reserve the right to terminate therapy and present the client with several recommendations for other mental health professionals.

REFERRALS

When in need of referrals to other professionals, I will gladly provide you with several names and numbers. Do not feel obligated to use only the names of the individuals I have provided as there are often many additional professionals available and able to assist you. Additionally, I cannot guarantee that the referrals that I provide you will be available for service or will be able to help you. Although it is my intent to provide you with names of individuals with excellent standards and qualifications, I cannot guarantee that you will find these referrals helpful. In addition to the referrals that I may provide you, please feel free to visit the Arizona Psychological Association website www.azpa.org in which you will find a list of psychologists in your area who may be able to assist you with your needs.

MINORS & PARENTS

Patients under 18 years of age who are not emancipated and their parents should be aware that the law may allow parents to examine their child's treatment records. Because privacy in psychotherapy is often crucial to successful progress, particularly with teenagers, it is sometimes my policy to request an agreement from parents that they consent to give up their access to their child's records. If they agree, during treatment, I

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will provide them only with general information about the progress of the child's treatment, and his/her attendance at scheduled sessions. I will also provide parents with a summary of their child's treatment when it is complete. Any other communication will require the child's authorization, unless I feel that the child is in danger or is a danger to someone else, in which case, I will notify the parents of my concern. Before giving parents any information, I will discuss the matter with the child, if possible, and do my best to handle any objections he/she may have.

BILLING AND PAYMENTS

You will be expected to pay for each session at the time it is held. Payment schedules for other professional services will be agreed to when they are requested. Payment for my services will be collected prior to the session and must be received for therapy or assessment to take place. The following forms of payment are accepted and include: cash (exact amount), personal check, Visa, Master Card, Discover Card and American Express.

If your account has not been paid for more than 60 days and arrangements for payment have not been agreed upon, I have the option of using legal means to secure the payment. This may involve hiring a collection agency or going through small claims court which will require me to disclose otherwise confidential information. In most collection situations, the only information I release regarding a patient's treatment is his/her name, the nature of services provided, and the amount due. If such legal action is necessary, its costs will be included in the claim.

At the time that you fill out the paper work for therapy, I will include a form for you to fill out and sign, allowing me to charge your credit card under certain circumstances, outlined in this form.

MUTUAL RESPECT

After reading through this form, please feel free to discuss with me any thoughts, questions, or concerns you may have. As I value our potential work together as a team, I am more than willing to discuss these concerns with you. Please read, sign, and return this form to me by our second meeting or bring it with you to our first session to discuss your questions.

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YOUR SIGNATURE BELOW INDICATES THAT YOU HAVE READ THIS AGREEMENT AND AGREE TO ITS TERMS DURING OUR PROFESSIONAL RELATIONSHIP. YOUR SIGNATURE ALSO SERVES AS AN ACKNOWLEDGEMENT THAT YOU HAVE RECEIVED THE HIPAA NOTICE FORM.

Printed Name _____

Signed _____ Date_____

I have read and agree to Dr. Swartout's Social Media Policy, found on her website under Client Forms.

Signed: _____ Date: _____

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CANCELLATION POLICY

Growing Edges LLC requires that cancellations for scheduled appointments be received 24 hours in advance. In the event that cancellations are made less than 24 hours prior to a scheduled session, you will be responsible to pay the full fee for the session.

At the end of every session you will receive an appointment card with the date and time of your next appointment. Please keep this card in case there is a misunderstanding concerning the date or time of your appointment. If you miss or cancel an appointment in less than 24 hours from the time of your scheduled appointment, or arrive for an appointment on the wrong day or time, you will be responsible for paying for that session.

If I cancel an appointment in less than 24 hours of your scheduled time, or if I have put you in my schedule at the wrong time, then your next session is free. This will be verified when you bring in the appointment card you were given.

Additionally, in the event you arrive late to our scheduled session, I will be happy to meet with you but I must end our session at the scheduled time and you will still be charged the full fee.

I have read and understand the above stated policy of Growing Edges LLC. And agree to abide by its terms.

Printed Name _____

Signature _____ **Date** _____

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FORENSIC AND LEGAL ACTIONS

Individuals sometimes request that I provide information related to forensic (legal) actions following an evaluation or therapy session(s). Please be advised that any request for an expert opinion related to litigation will not be provided. For example, issues related to custody, visitation, competency, mental health status, and/or other court related issues will not be provided.

I agree that under no circumstances shall Ilyssa Swartout, Psy.D. be asked to release records to an attorney or professional associated with the court. I agree that I shall not request copies of records for use in a divorce. I agree that Ilyssa Swartout, Psy.D. will never be subpoenaed or asked to testify about the therapeutic process.

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

Printed Name _____

Signature _____ **Date** _____

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FOR COUPLES AND FAMILY THERAPY ONLY

Within my practice, I see many couples for therapy related to their relationship or marital issues. In the beginning of couple's therapy, I will discuss with each of you your goals for therapy. As each member's goals may be different, we will do our best to discuss these differences and decide on mutually agreed upon goals for all involved. When I begin therapy for both members of a couple, my role will be as therapist for both members. This will be done to ensure that the mutual respect established by all parties will be maintained. Please keep in mind that records for therapy will only be released when both members have signed a release of information form. I will not release information to only one member without the consent of both members. Nor will I release information to a third party without the consent of both members of the couple.

Within my practice I do see families for family therapy. To maintain confidentiality of all members involved, all participating members of the family must sign the release of information form for information to be released.

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

Printed Name _____

Signature _____ **Date** _____

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