Laurie B. Mintz, Ph.D.
New Client Information Sheet

Type text here
____ ____________ __________________
Last Name First Name Middle Initial Birthdate SS#

____
Street Address including apartment # if relevant

____
City State Zip Code

Okay to send correspondence to this address? Y N

Phone Numbers:	Okay to call?	Okay to leave message?
Home: ________________________	Y N	Y N
Work: ________________________	Y N	Y N
Cell: ________________________	Y N	Y N

Email: ______________________________

OK to send emails to confirm/change appointment times and discuss any payment issues only? Y N

Please explain what issues or concerns brought you here today.

____

____

____

Is this concern due to an accident? Y N If yes, date of accident: ______________________________________

How did you find my services? ____

If a person, do I have your permission to thank this person for the referral, without disclosing any information about your concerns (i.e., only that you have contacted me for an appointment)? Y N

The following section will help me get a bit more information on your current life situation and background. Specifically, below you will find a few basic questions to assist me in the process getting to know you. Certainly, there is much more I hope to learn about you during our work together.

Are you currently employed? (circle one) YES NO

If yes, please describe your position and work ____

____

If yes, how satisfied are you with your current employment? ___________________________________

Below are questions about people important to you and/or in your life. Please skip any sections that do not pertain to you (i.e., if you do not have a spouse/partner or children, leave these sections blank).

Spouse/Partner:

Name:___________________Age _______

Length of Relationship____________circle one: married/lifetime partner living together dating

Children:

Name:___________________Age_______

Name:___________________Age_______

Name:___________________Age _______

Additional living family members important to you (including adult children or close, extended family):

Name:_______________Present age_______Relationship to you: _____________________________

Name:_______________Present age_______Relationship to you: _____________________________

Name:_______________Present age_______Relationship to you: _____________________________

Name:_______________Present age_______ Relationship to you: _____________________________

Significant deceased family members:

Name:________________Relationship to you:____________________________Year of Death: _________

Name:________________Relationship to you:____________________________Year of Death: _________

Name:________________Relationship to you:____________________________Year of Death: _________

Name:________________Relationship to you:____________________________Year of Death: _________

List everyone with whom you currently live.

____

How would you rate your social support network (i.e., friends or family who you trust and who provide you with support and/or who you discuss your concerns with?) Please circle your reply below.

Excellent Good Fair Poor

Provide any explanation of your circled choice above that you deem relevant. Also, feel free to name any friends you deem important if you so desire:

____

____

Please rate your overall health (excellent, good, fair, poor): ____

List any significant current or past medical illnesses surgeries____

____

Are you currently taking any medications? If so, please list: ____

____

Prior therapy or mental health treatment:

Approximate Dates Concern(s) Addresses Your Satisfaction with treatment process and outcome

____

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____

Is there anything else you think it would be important for me to know that you would like to share on paper before we meet (e.g., importance of a specific gender, ethnic/racial, or sexual orientation identity; a significant event in your past; current use of substances; family history of substance abuse and/or mental illness)? Feel free to fill this section out or leave blank, depending on if there is anything you'd like to share and your comfort sharing it on paper.

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Laurie B. Mintz, Ph.D.
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Gainesville, Florida 32606
Florida Psychology License PY8658[1]
352-260-4876
laurie@drlauriemintz.com

Practice Information Sheet & Notice of Privacy Practices

The following information has to do with both the federal and local laws governing the practice of psychotherapy, my approach to therapy, and policies of my practice. While detailed, I ask that you please read it carefully. If you have any questions or concerns after reading or at any time, please don't hesitate to discuss them with me. **Please sign and return to Dr. Mintz and keep a signed copy for yourself.**

MY APPROACH TO THERAPY

Whether working with a couple or individual, I view therapy as a joint effort between myself and my client(s). I provide clients with a safe space and expertise gained with training and experience, and my clients provide their expert knowledge on themselves, their experiences, their thoughts, and their feelings.

I believe that quality therapy involves mutually agreed upon goals and a way to evaluate when goals have been met. Thus, together my clients and I set goals with the following question in mind: *What do you want to be different when we finish therapy?* I also work with my clients to continually monitor the goals we set, to make sure progress is being made, and to change or re-vamp the goals as needed. I continually check-in with my clients to make sure that therapy is working for them and that we are on the right pathway for their change, adjusting our focus working together as needed.

I take an active approach to therapy. My goal is to offer my clients more than a place to vent. I try to provide my clients with feedback, ideas, and directions to address problems and make their lives better. Sometimes this means challenging and confronting clients. However, my goal is always to provide such challenges in the context of a very safe and trusting relationship where my clients know that I truly have their best interests at heart.

I realize that developing trust takes time and I do all that I can to develop a safe and trusting relationship with my clients. I ask my clients to be open and honest with me, and I work to provide a transparent style of therapy with my clients.

I believe that therapy is a place where clients should be able to speak the unspeakable. I believe therapy is a place where clients should feel both understood and challenged to make changes in their lives. I believe that if clients are open to the process of therapy and if they find a therapist who is a good fit for them, therapy can be life altering. I do all that I can to provide such therapy for my clients.

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[1] I am also licensed in California (PSY11809) and Missouri (RO294). If you reside in one of these states, or in Florida but prefer teletherapy, please also complete and sign "Informed Consent for Telepsychology Services" form. See section titled "Remote Therapy" below for additional details.

During our first session, I will explain my approach and training for conducting therapy in greater detail and discuss if you are comfortable with my approach and if I believe that I will be able to provide you with the assistance you desire. If not, I will refer you to another therapist and/or provide other resources.

Likewise, if at any point in our work together, you are unhappy with what is happening in therapy, I hope you will talk about it with me so that I can respond to your concerns, and make adjustments to our work together in order to provide you with the best services possible.

CONFIDENTIALITY

Except from the situations outlined below, you have the right to the absolute confidentiality of your therapy. I cannot and will not tell anyone else anything that you have told me, or even that you are in therapy with me. To release any information about you, I would need your written permission. You may ask me to share information about you with anyone you choose, and you may revoke this permission at any time. Even when I have your written consent to release information, I will still protect your privacy and use my best judgment in sharing only information relevant to that person or that request.

The following are important legal exceptions to your right to confidentiality:

1. If I have good reason to believe that you are abusing or neglecting a child or a disabled or elderly adult, or if you give me information about someone else who is, I am required by law to report this to the appropriate state agency. The agency will determine whether to investigate further.
2. If I have good reason to believe that you are intending to harm another person, I am legally allowed to take actions that I deem appropriate to protect/warn that person (i.e., call the police, inform the victim). If such a situation does come up, I will fully discuss the situation with you before I do anything, unless there is a very good reason not to.
3. If I believe that you are in imminent danger of harming yourself, I may legally break confidentiality and inform those whom I believe could be of assistance to you (i.e., a family member, police, Alachua County Crisis Center). If such a situation arises, I will attempt to discuss the matter with you prior to taking action, unless there is a good reason not to. I will also attempt to explore with you all other options to ensure your safety prior to breaking confidentiality. However, please be aware that if I believe your life is in immediate danger, I may release information which would protect your life, without your permission if I cannot get it. If this situation ever occurs, I will discuss this with you as soon as possible afterwards.
4. In general, if you get involved in court proceedings you can prevent me from testifying about what you have told me. This is called privilege and it is always your choice to invoke it or to waive it (allowing me to testify). However, there are some situations where the judge may require me to testify because the judge believes the court needs my information to make a good decision: a) in child custody or adoption proceedings where your fitness as a parent is in question; b) where your emotional, mental, or psychological condition is an important consideration; c) during a malpractice or disciplinary hearing against a therapist; d) in a civil commitment where someone is being placed in a psychiatric hospital; and e) if you are seeing me for court-ordered psychological evaluations or treatment.
5. Please read the attached Notice of Privacy Practices at the end of this letter. As they explain, federal regulations allows me to use or disclose protected health information from your record in order to provide treatment to you, to obtain payment for the services I provide, and for other professional activities known as health care operations. By signing the consent at the end of this letter, I am asking you to give me explicit permission to use or disclose your protected health information for these activities.

a. The section below titled *Confidentiality: Insurance Filing and Accounts with Overdue Balances* contains additional details about the disclosure of your protected health information so please read that section carefully as well.

In addition to these legal limits to confidentiality:

1. I may sometimes consult (talk) about your treatment with other professionals, usually therapists. I do so in order to assure I am providing you with the best treatment possible. In such consultations, I do not reveal your name, and the other professionals are also legally bound to maintain the confidentiality of what we discuss.

2. When I am out of town or unavailable, another professional might answer phone calls to my office and I sometimes need to give him or her some information about my clients; I will only give the minimum information necessary. I will discuss this with you beforehand.

3. I am required to keep treatment records. My records include any forms that you complete for me, brief summaries of each of our sessions, and any other documents that are relevant to your treatment. While the physical record belongs to me, the content of the record belongs to you, and you may ask at any time about the content of your record. I keep them in a secure location in my office. I am required by law to keep these records for 7 years after our last contact. They will be destroyed after 7 years.

CONFIDENTIALITY IN COUPLES COUNSELING

In cases where I am seeing you and your partner for couples counseling, I view your relationship as my client. Nevertheless, I may determine that it is beneficial to hold individual sessions with one or both of you. In this situation, I will inform you of my reasoning and we will make the decision about this together, exploring the benefits and risks of such a situation. However, if we do hold individual sessions**, it is critical for you to understand and consent to the following**: Information disclosed during your individual session may be revealed by me to your partner at a subsequent joint or individual session (i.e., individual session information is not confidential from your partner). In making the determination of what information would be disclosed, I use the categories of “private information” versus “secret information.” *Private information* is that which may be hurtful to share (e.g., “I sometimes wish I had married someone else.”) but is not having an ongoing negative impact on your relationship and/or undermining our work in couple’s counseling. On the other hand, *secret information* is that which is currently having a negative impact on the couple relationship, and/or that would have such an effect if discovered, and/or is undermining our work in couples counseling (e.g., having an ongoing affair while trying to work on the relationship in couple’s counseling; trying to work on your couple sexual relationship when an unrevealed sexual fetish is contributing to your and your partner’s sexual difficulties). At times, distinguishing between *private information* and *secret information* is difficult, and I will always discuss the determination with the revealing party. I will also work with the revealing party on the least harmful way to deal with the revealed secret. In sum, please be aware that I cannot work effectively with a couple in which *secret information* (as defined above) is revealed and I thus reserve the right to disclose information revealed to me during an individual session to your partner and/or to terminate couples counseling (with or without revealing the reason for termination). In cases of termination, I will provide referrals for both individuals to other therapists.

Additionally, my policy is that you must agree that if counseling does not resolve relationship difficulties, or if you are seeing me for another issue, and you seek a divorce, you will not request my testimony for either side although the court may order me to testify.

COMMUNICATING WITH ME OUTISDE OF REGULARLY SCHEDULED SESSIONS

Unless we have arranged otherwise, I am generally not available outside of our session times. However, if you need to reach me in an emergency, you may call my office phone at 352-260-4876 (this phone forwards to my cell phone so is answered as quickly as possible). This phone does not accept text messages. If you can't reach me at this number, and you are in imminent danger, please call the Alachua County Crisis Center at 352-264-6789. The Crisis Center has people available 24 hours a day. (Note that after we have established a therapy relationship, I may provide you with my cell phone number and we will discuss under what circumstances text messages are an acceptable form of communication).

If you need to communicate with me to change or cancel an appointment, please call my office phone (352-260-4876) or send me an email at laurie@drlauriemintz.com. Use email only for appointment-related issues and not to discuss therapy issues. In using email, please note that while I am the only person checking this email, email is not considered a secure form of communication.

I do not routinely charge for phone calls with clients or others who the client authorizes me to speak to (e.g., other health providers) unless the call extends beyond 15 minutes. If it is an extended call, my fee will be prorated based on my customary hourly rate. If I am called upon to attend meetings (e.g., testify as a witness in court), I expect my usual fee for travel time and the time spent at the proceeding (along with reimbursement for any unusual expenses related to travel).

You will be informed ahead of time of any days I will be unable to be reached. In these situations, we will work out who you can speak to in case of an emergency (e.g., Crisis Center, another therapist).

I do not use social media (e.g., Facebook, Instagram) to communicate with clients. If you send me a friend request on Facebook, I will not accept it. If you discover something I have written on social media or one of my public blogs that is concerning to you or that you have questions about, please discuss it with me.

USE OF CASE EXAMPLES IN TEACHING AND WRITING

I teach classes at the University of Florida, provide national lectures/presentations, and write both popular press books and blogs. In my teaching, speaking, and writing, I use case examples. The American Psychological Association Code of Ethics for Psychologists allow for the use of such examples if steps are taken to disguise the identity of the person. In my use of case examples, I always take great care to disguise identity, including for example changing a person's demographic information (i.e., sex, race, sexual orientation) and/or melding two case examples together. To illustrate, a prior client gave me permission to use our work in my popular press book on low sexual desire, provided that her identity was disguised. Upon reading, she stated that she could not figure out which person she was.

By signing this letter, you are allowing me to use our work in my public writing, teaching, and speaking, provided I do not reveal your identity and indeed, take precaution to make sure to disguise your identity. However, if you do not want me to ever use our work as a case example in my speaking or writing or teaching, put an X through this section to indicate consent is not being provided.

REMOTE THERAPY

I am set up to provide such remote therapy (i.e., video and/or audioconferencing sessions) to clients who request this (e.g., due to residing outside of Gainesville; limited mobility; not available at my usual hours). If you have agreed to see me for remote therapy, please also read and sign the *Informed Consent for Telepsychological Services* form.

Additionally, if you believe that at any point in time you will want a remote session (e.g., due to illness, an extended absence, or any other reason), please fill out this form so that we both have it on file.

Finally, if I need to be away from the office for an extended period of time and am able to do so, I will offer needed services remotely. In this situation, if you have not already signed the *Informed Consent for Telepsychological Services* form, I will ask you to do so prior to commencing remote sessions.

FEES AND PAYMENTS

The fee for my initial session (which will be 60 -75 minutes) is $175.00. All subsequent sessions are for 50 - 60 minutes and are $150.00. You will be advised of any fee increases at least three months before an increase occurs; if there is a problem, I would be happy to discuss it with you.

Regardless of if you are using insurance or not, I ask that you pay for the session at the time of each visit.

If you are paying by insurance, I will provide you with a Superbill (generally on a monthly basis but at more frequent intervals if desired) to send to your insurance company. They will then provide reimbursement directly to you. Your insurance will generally only cover a portion of my fee, and if you are using insurance, you should be aware of the conditions of your particular policy (such as the amount of coverage per year, restrictions on services or providers, the amount of your deductible, pre-existing conditions, etc.).

Please be aware that most insurance companies do not cover couples counseling, unless the relationship issues are due to an identifiable, diagnosable issue of one partner and then the sessions can be included in this manner on the superbill described above. If you and your partner are seeing me for couples counseling, I will discuss this with you after the first session. Specifically, I will discuss if I can provide you with a Superbill that can be sent to insurance companies in which one partner is identified as the primary patient.

If at any point, either submitting a Superbill to your insurance company and/or paying after each session is not possible, please discuss this with me. I will work with you to the best of my ability to develop an alternative plan.

All balances over 60 days old will incur a $25 handling fee per month. If a balance is unpaid for two months with no efforts to communicate about it, it will be forwarded to a collection agency. You are liable for the collection agency's additional fees and interest charges.

Confidentiality: Insurance Filing and Accounts with Overdue Balances

If you will be submitting a Superbill to your insurance company, I will be required to provide some information about our sessions, including the type of session (e.g., in-person, telehealth, couple, individual), my fee, what you paid, and our meeting dates). I will also be required to give you a diagnosis. The diagnoses that I will use come from a book called the DSM-V. I will share this information with you at your request, and I will be glad to talk with you about the implications of the diagnosis. On rare occasions, your insurance will ask me for a

treatment plan or summary of your treatment. It is against the law for insurers to release any data about our office visits without your written permission. While I believe that the insurance company will act ethically and legally, I cannot control who sees this information at the insurer's office. You have been asked to sign a statement allowing me to release needed information to your insurance company. Please ask any questions you have on this before signing this letter.

If I must turn an unpaid account over to a collection agency, I will provide the agency only the information they require in order to collect on the account.

Canceling or Missing Sessions

If you miss a session without canceling or cancel with less than twenty-four hours-notice to me, you must pay your session fee before or at our next regularly scheduled meeting. Missed sessions cannot be billed to insurance, so you will be responsible for these payments and they will not be included on your insurance Superbill.

A FINAL NOTE

Finally, again let me emphasize that you have the right to ask questions or express concern about anything that happens in therapy. I'm always willing to discuss how and why I have done something and to explore other alternatives that might work better for you. You can ask me about my training for working with your concerns and can request that I refer you to someone else if you decide I'm not the right therapist for you. You are free to leave therapy at any time. If you are unhappy with what is happening in therapy, I hope you will talk about it with me so that I can respond to your concerns. I will take such criticism seriously. If you believe that I have behaved unethically, you can complain about my behavior to either the Ethics Committee of the American Psychological Association, 750 1st Street NE, Washington DC 20002-4242, or the Florida Department of Health[2] by calling 850-245-4339 or filing a claim form online at https://www.flhealthcomplaint.gov/

Please sign, acknowledging that you have read to and understand this document, and the attached HIPPA Notice of Privacy Practices (Please return a signed copy to Dr. Mintz and keep one for your records).

Printed Name: ____

____

Signature **Date**

[2] If you reside in California and are seeing me remotely, you may file a complaint by calling (866) 503-3221 or online at https://www.psychology.ca.gov/forms_pubs/form.pdf. If you reside in Missouri and are seeing me remotely, you may file a complaint by completing the following form: https://pr.mo.gov/psychologists-complaint-forms.asp.

HIPPA Notice of Privacy Practices

Privacy and confidentiality have always been important to the practice of psychology. Privacy is regulated by federal and state government, as well as by professional organizations. The Health Insurance Portability and Accountability Act of 1996 (HIPAA) sets a minimum national standard for privacy of records. HIPAA requires everyone to receive a privacy notice such as this one. This notice describe how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

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

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

- "PHI" refers to information in your health record that could identify you and must be protected.
- 'Treatment, Payment and Health Care Operations"
  - Treatment means to provide, coordinate or manage your health care and other services related to your health care. An example of treatment would be to consult with another health care provider, such as your family physician or another mental health provider. Under most circumstances uses of PHI for treatment purposes will first be explained and discussed with you, so that your concerns and preferences can be taken into consideration.
  - Payment means obtaining reimbursement for your healthcare. Common examples of disclosing PHI for payment are disclosure of your PHI to your health insurer to obtain reimbursement for your health care or to determine your eligibility or coverage. Most insurers want to know your diagnosis and the type of treatment you are receiving before they will pay for the treatment.
  - Health Care Operations are activities that relate to the performance and operation of a practice. Examples of health care operations are quality assessment and improvement activities, business-related matters such as audits and administrative services, case management and care coordination
- "Use" applies only to activities within an office, such as utilizing, examining, and analyzing information that identifies you.
- "Disclosure" applies to activities outside of this office such as releasing, transferring or providing access to information about you to other parties

Your treatment provider will use or disclose the least amount of information necessary to accomplish the goal of the use or disclosure.

Uses and Disclosures That Require Your Authorization

Your treatment provider may use or disclose PHI for purposes other than for 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 your treatment provider is asked for information for purposes outside of treatment, payment, and health care operations, your authorization is necessary to release this information. If your treatment provider keeps psychotherapy notes, these are kept separately from the rest of your record and are given a greater degree of protection than your PHI. "Psychotherapy notes" are notes made about conversations occurring during a private, group, joint, or family counseling session.

You may revoke all such authorizations at any time, provided each revocation is in writing.You may not revoke an authorization after your treatment provider has already acted on it or 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.

Emergencies

Please make your preferences regarding emergency notifications known to your treatment provider.

Uses and Disclosures with Neither Consent nor Authorization

Your treatment provider may use or disclose PHI without your consent or authorization in the following circumstances:

- Child Abuse: Any information or suspicion that a child is abused, abandoned, or neglected by a parent, legal custodian, caregiver or other person responsible for the child's welfare, by law must be reported to the Florida Department of Children and Families.

- Adult and Domestic Abuse: Any information or suspicion that a vulnerable adult (disabled or elderly) has been or is being abused, neglected, or exploited, by law, must be immediately reported to the Florida Abuse Hotline (1-800-962-2873).

- Health Oversight: If a complaint is filed against your treatment provider with the Florida Department of Health, the Department has the legal authority to subpoena confidential mental health information relevant to that complaint. Your treatment provider could be asked to release information to governmental agencies that check on whether privacy laws are being obeyed.

- Judicial or Administrative Proceedings: If you are involved in a court proceeding and a request is made for information about your diagnosis or treatment and the records thereof, such information is privileged under state law, and will not be released without a written authorization from you or your legal representative, or a court order, or a subpoena of which you have been properly notified and you have failed to inform your treatment provider that you are opposing the subpoena. The 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: If you present a clear and immediate probability of physical harm to yourself, to other individuals, or to society, your treatment provider may communicate relevant information concerning this to the potential victim, appropriate family member, or law enforcement or other appropriate authorities. Your treatment provider will talk to you in situations when public health authorities encourage or require confidential reporting of dangerous or defective products, as well as of diseases that can be easily spread between people. Law enforcement officials have the right to request and receive protected health information when they are investigating a crime, a criminal, or a missing person. If you disclose information about illegal activity during a psychotherapy or counseling session, or in the course of treatment for this sort of behavior, we may not disclose that information to law enforcement officials.

- Worker's Compensation: If you file a worker's compensation claim, your treatment provider must, upon request of your employer, the insurance carrier, an authorized qualified rehabilitation provider, or the attorney for the employer or insurance carrier furnish your relevant records to those persons.

Patient's Rights and Provider'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, your treatment provider is not required to agree to a restriction you request. You will be notified, in writing, if your requested restriction or other privacy request cannot be accommodated, and why not.

- 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 receiving treatment. Upon your request, your bills can be sent to another address.)

- Right to Inspect and Copy - You have the right to inspect or obtain a copy (or both) of PHI in your treatment provider's mental health and billing records used to make decisions about you for as long as the PHI is maintained in the record. On your request, your treatment provider will discuss with you the details of the request process. In the rare event that your treatment provider has a strong reason to object to your access, an alternative solution will be sought.

- Right to Amend - You have the right to request an amendment of your PHI for as long as the PHI is maintained in the record. Your treatment provider may deny your request. If your record cannot be amended, you may write a statement of disagreement that will be maintained in your record. On your request, your treatment provider 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 regarding you. This accounting does not include uses and disclosures of information for the purposes of treatment, payment, or operations; disclosures or uses made to you or made at your request; uses or disclosures that fulfill an authorization signed by you; relevant uses or disclosures made to family or friends who are involved in your care or in paying for your care; or uses or disclosures needed to notify family or friends of your location or condition. On your request, your treatment provider will discuss with you the details of the accounting process.

- Right to a Paper Copy - You have the right to a paper copy of the notice, even if you have agreed to receive the notice electronically.

Provider's Duties:

- Your treatment provider is required by law to maintain the privacy of PHI and to provide this notice of her legal duties and privacy practices with respect to PHI.
- Your treatment provider reserves the right to change the privacy policies and practices described in this notice. Unless you are notified, in person or by mail, of such changes, the terms currently in effect will prevail.
- If your treatment provider does revise any policies or procedures, you will be notified in writing, in person or by mail, at the most recent preferred address that you have provided to the office staff.

Complaints

If you are concerned that your treatment provider has violated your privacy rights, or you disagree with a decision made about access to your records, you may contact your treatment provider at directly. You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services. You may also file a complaint to the addresses provided in letter above. I promise that I will not in any way limit your care or take any actions against if you file a complaint.

Effective Date, Restrictions, and Changes to this Privacy Policy

This notice will go into effect on July 15, 2003. In the future, the terms of this notice may need to be changed, creating new notice provisions effective for all PHI currently maintained. If a change is made, it will be you will be provided a copy of the revised notice.

INFORMED CONSENT FOR TELEPSYCHOLOGICAL SERVICES WITH LAURIE MINTZ, PH.D.
(sign if we have agreed to meet remotely or if you believe that at some point you will want a remote meeting)

By signing below, you acknowledge that you understand and agree to the following prior to commencing therapy conducted over video and audio conferencing:

- There are potential benefits and risks of remote (i.e., video and/or audio) therapy that differ from in-person sessions.
- Confidentiality still applies for telepsychology services, and neither the therapist nor the client shall record the session, unless there is a compelling reason to do so and it has been discussed and agreed to in advance (e.g., to record a homework assignment).
- We will use a HIPPA-compliant video platform for our virtual sessions. Specifically, at your appointment time, you will go https://pixidoc.com/drlauriemintz and sign into the virtual waiting room, where I will see you are waiting and start the video (or audio) session. (Dr. Mintz reserves the right to change to a different HIPPA-compliant platform; if so, you will be notified in advance and instructed on use).
- You will need to use a webcam or smartphone during the session.
- It is important that you be in a quiet, private space that is free of distractions during the session.
- It is important that you use a secure internet connection rather than public/free Wi-Fi.
- The following is our back-up plan to in the event of technical problems in starting or during the session: We will do our best to re-start the video session (i.e., end the session and start again with the same login procedure described above). If this doesn't work, please call Dr. Mintz at 352-260-4876, and we will either agree to reschedule the session or finish the session by phone or another means (e.g., Facetime), after discussing the fact that these alternative means of communication would not be HIPPA-compliant. (If Dr. Mintz doesn't receive a telephone call from you within five minutes of the session not starting or ending due to technological difficulties, she will call you on the phone number provided in your initial paperwork).
- We have discussed the following safety plan in the event you have a psychological emergency:
    - If you live in the same city as Dr. Mintz, we will find an in-person time to meet and if such a time cannot be readily found you will either contact the following person to provide in-person support (fill in:_____________________) and/or will go to the closest emergency room (please fill in the name and location here:_____________________).
    - If you live in a different city than Dr. Mintz, you will either contact the following person to provide in-person support (fill in:___________________) and/or will go to the closest emergency room (please fill in the name and location here:_____________________).
- You will need to confirm with your insurance company that the remote sessions will be reimbursed. If your insurance does cover remote therapy, you will need to pay for your session and seek reimbursement via a Superbill provided to you (see *Notice of Office and Privacy Practice & Billing and Insurance Information* forms also provided to you for additional details).
- Dr. Mintz reserves the right to determine telepsychology is no longer appropriate and depending on your location, provide you with the option to meet with her and/or another provide in-person.

Client Name: ____________________________ Client Signature: ____________________________

Date: ____________________________

Laurie B. Mintz, Ph.D.
Billing Information Sheet

Form of payment (PLEASE CHECK):

_____ Exclusively Self-Pay (i.e., No Superbill Requested)
_____ Will Pay After Each Session and Submit Superbill to My Insurance
Note:

- I will provide this Superbill to you monthly. If you prefer it be provided more or less than once a month, please discuss this with me.
- You will be provided with a hard copy of this Superbill in person. If you are seeing me remotely, the Superbill will be transmitted via an encrypted format.

If Using Insurance, Please Sign Below:

Permission is hereby granted for information related to your treatment to be included on the Superbill provided to you to send to your insurance company and for release of psychological records to your insurance carrier as needed for reimbursement:

Signature___________________________________Date___________________

Please see *Practice Information Sheet* & *Privacy Notice* for more details on the Federal Laws and Regulations governing your signature above

Paying After Each Session

You can pay after each session in cash, check, or credit card. If you prefer to pay your bill on an ongoing basis by credit card without swiping your card after each session, please fill out the following. Dr. Mintz will automatically charge your credit card after each session for the agreed upon amount.

I,___________________________________, give Laurie B. Mintz, Ph.D. the authorization to charge my credit card after each session

Credit card number_____________________________

Expiration Date________________________________

CVC number___________________________________

Name on credit card_____________________________

Zip Code Associated with Card: __________________

Do you want receipt emailed? YES NO

Please note receipts are mailed directly by the credit card billing company (Square) to you. The receipts have my business name on them (Laurie B. Mintz, Ph.D., LLC) but do not state what the service was (i.e., only my name and the amount paid shows). These emails are not encrypted in any way.

If yes, provide email address: __________________________________

Signature___________________________________ Date: _____________