Informed Consent to Treatment and Office Procedures

Thank you for taking the time to review this document and the contents included. It is my goal that you are well-informed about the process of our work together and that any questions and concerns will be sufficiently addressed within this packet.

Much like a consumer purchasing a product, you have the right to be fully informed about the services you are seeking. As such, please review this material prior to our meeting and note any questions or concerns that occur to you as you read so I can help answer and clarify. PLEASE REVIEW IT CAREFULLY. When you sign this document, it will represent an agreement between us about the terms of our work together. A copy of this document can be provided upon request. It is my hope that the language used in this document is clear and understandable. If anything is not and needs further explanation, please bring it to my attention.

Again, thank you and I look forward to working with you.

Sincerely,
Julia Rosholt, Psy.D.

Informed Consent to Treatment and Office Privacy Policies

1) Credentials

Julia Rosholt, Psy.D. is a licensed clinical psychologist by the California Board of Psychology, license number PSY30242 and the Colorado Department of Regulatory Agencies, license number PSY.0005201. She obtained a Psy.D. in Clinical Psychology from the California School of Professional Psychology at Alliant International University in San Francisco. The primary focus of her clinical training was on clinical applications of psychological treatments in adult outpatient populations. Dr. Rosholt's training and professional experience includes the Department of Veteran's Affairs, the Department of Defense, and Kaiser Permanente. She has worked with adults from a wide range of backgrounds and presenting issues and is considered a generalist in her field. Her theoretical orientation is primarily cognitive-behavioral, but she views each individual uniquely and considers the nature of their presenting problem, the time available to work with a patient, and the patient's preferences when working together. Although she holds the title of "doctor", Dr. Rosholt is not authorized to provide medical advice or prescribe medications. However, she has worked closely with these providers in the past, facilitating seamless treatment for patients.

2) Confidentiality

Confidentiality is similar to the concept of doctor / patient privilege, in information discussed is kept between you and Dr. Rosholt, including verbal, written, or otherwise communicated information. Additionally, this includes personal information about your identity, address, billing information, things specifically unrelated to our clinical work together.

However, in some instances, the privilege described above must be temporarily breached due to laws requiring disclosure or for administrative purposes. Please initial each to indicate understanding and willingness to proceed. These instances include:

- Disclosure or suspicion of child, elder, and/or dependent adult abuse or neglect. _____Initial
- Communication of a serious desire or intent to harm oneself, others, or property. _____Initial
- Disclosure by a close family member indicating a patient presents a serious threat to self, others, or property. _____Initial
- Inability to meet one's minimum and basic daily needs (Gravely Disabled). _____Initial
- California Assembly Bill 1775 mandates the reporting of any disclosures made in the course of a professional, therapeutic relationship regarding the viewing, possession, distribution, or production of images involving the sexual abuse and/or exploitation of minors to appropriate Child Welfare Services and/or local law enforcement. _____Initial

- Providing Protected Health Information (PHI) to contracted or third parties (i.e., insurance) to obtain payment. _____Initial

- If a court of law orders me to release information, I may be legally required to provide that specific information to the court. _____ Initial

- If you make or threaten a legal, administrative, or ethical claim against me. _____ Initial

In these instances, only the most necessary information for an appropriate continuum of care will be disclosed.

Additionally, the United States Patriot Act of 2001 (Public Law 107-56) allows Federal Law Enforcement Agents to access otherwise protected information in the event of suspected terrorist activity without a court order or other legal permission. Additionally, should this rare event occur, disclosure of the Government's access to the patient's information is prohibited._____Initial

Beyond these limitations, any disclosure of information or acknowledgement of a patient seeking services by Dr. Rosholt or her office requires a valid and current release of information (ROI) documenting the intended recipient of information, specific information sought, for what purposes, and for what duration the release is valid. This ROI is signed by the patient and is frequently required by third parties prior to sharing any information about a patient. _____ Initial

While not a provision of confidentiality typically covered under standard disclosure caveats, Dr. Rosholt reserves the right to involve local law enforcement for the purposes of public safety. Accordingly, patients arriving to sessions visibly under the influence of intoxicating substances and who intend to operate a vehicle upon completion of our meeting will be strongly encouraged to arrange for other transportation. For any patient who refuses and proceeds to attempt / operate a vehicle in an inebriated state, local law enforcement will be contacted. _____ Initial

In order to ensure that you are being provided with the best psychotherapy experience, Dr. Rosholt participates in confidential case consultation and supervision. Any presented cases will be free of any identifying information to obscure the identity of the individual. Additionally, should clinical _____ Initial

If you are seeking insurance reimbursement, I will be required to acknowledge that you are my patient, and some information including diagnosis, if that is required may be given to your insurance company. If you plan to request a written receipt to submit to your insurance company for reimbursement, discuss this with me at the outset of treatment. Be aware that submitting a mental health invoice for reimbursement carries a certain amount of risk to confidentiality, privacy or future eligibility to obtain health or life insurance. _____Initial

While it is my hope that third parties will observe standards in place regarding protected health information, once information has been disseminated, it is up to the individual providers to ensure confidentiality. As such, be aware of the delicate nature of health information, and the potential consequences that may occur as a result of appropriate or accidental disclosure. Often, many third parties archive clinical information, potentially for future reference. _____ Initial

3) What are therapy and psychological assessment?

While it would be helpful to have a standard answer to this question, often the answer varies depending on the reasons one initially considers seeking therapy / assessment. This is true, as well, for the duration and frequency of therapy, unless a pre-set number of sessions limits our work together.

First and foremost, therapy and psychological assessment are voluntary and should be free from undue influence of anyone other than the patient receiving services. At any time prior to engaging in services or after psychological services begin, you have the right to terminate therapy. It is my hope that we can discuss your decision prior to doing so. Additionally, in the event of mandated treatment or assessment, these rights also apply, but may have more contingent consequences that may need to be thoroughly considered prior to terminating treatment. Therapy and psychological assessment are most effective when both the therapist and patient maintain an active role in the therapeutic process.

Psychotherapy can have benefits, risks and can be best described as a process through which the patient and therapist try to first clarify the concern(s) encountered by the patient. Much like two people on separate sides of a piece of art see different things and observe from their individual perspective, so too can a therapist and patient. Therapy has also been described as a process by which the therapist holds a mirror for the patient to reflect and consider various concerns and issues. Often times, the therapist and patient work to solve tangible problems encountered in the patient's life. Other times, the therapist and patient work to allow greater self-understanding for the patient. Additional benefits may include better relationships, solutions to specific problems, improved coping skills, and significant reduction in distress. This frequently occurs through talking sessions, by which the therapist will listen a great deal as well ask some specific and challenging questions the patient may not have previously considered. This has the potential to cause considerable distress with patient, meaning things can often become uncomfortable and emotionally stressful, leaving the patient to question how helpful therapy may truly be. Furthermore, changes and insight gained through therapy may leave those close to the patient questioning, disliking, or even resenting changes that have occurred. Alternatives to therapy do exist, and may be equally effective for the patient to pursue – i.e. medication, time. Those seeking therapy would be best served examining alternatives to therapy, ensuring awareness of viable options. Finally, results or outcomes from therapy cannot be guaranteed.

The therapeutic relationship developed between you and Dr. Rosholt is one that is based on objectivity and the ability to provide unbiased perspective. As such Dr. Rosholt will refrain from dual relationships, or playing multiple roles in the lives of her patients, i.e. serving as your therapist and employer, professor, tennis partner, etc. Please understand this boundary is not reflective of a lack of interest in your life or desire to not be a part of it, but more about

maintaining the clear boundaries not observed in most casual relationships / friendships. If a dual relationship is unavoidable, Dr. Rosholt will discuss it extensively with you, providing appropriate referrals, if necessary.

Additionally, therapy should have clear goals and treatment plans that are more meaningful when both you and Dr. Rosholt are able to construct these together. By the conclusion of our fourth (4^{th}) session together, Dr. Rosholt and you will develop short, intermediate, and long-term treatment goals (when appropriate – given duration of treatment and presenting concerns) as well as treatment plans aimed at meeting these goals. As stated, Dr. Rosholt will employ a variety of effective treatment approaches to do so, including, but not limited to: psychological assessment, cognitive- behavioral treatment, motivational interviewing, behavioral interventions, psychodynamic approaches, solution-focused therapy, psycho-education, and developmental psychology. Additionally, you will be provided with a diagnosis based on the Diagnostic and Statistical Manual, Fifth Edition (DSM-5) of the American Psychiatric Association. Diagnoses are tools by which therapists are able to able to communicate and understand a patient's presenting concerns, symptoms, and identify proven interventions.

No single therapist can serve all populations and treat all problems brought to therapy. In some instances, Dr. Rosholt may seek consultation and supervision from colleagues when addressing a particular case or issue, while at the same time maintaining confidentiality of the patient. However, Dr. Rosholt will also provide up to three referrals to any patient or treatment issue that is outside her ability to provide competent services. Additionally, in the event of direct threats to Dr. Rosholt's physical safety, she reserves the right to terminate therapy, providing up to three appropriate referrals.

4) Telehealth / Teletherapy

Following the COVID-19 pandemic in March 2020, the field of psychology expanded to include teletherapy. Teletherapy refers to the provision of mental health services via technological mediums rather in in-person / in-office meetings. These may include telephonic communication, visual / web- based video streams providing a face-to-face option via a secured internet connection. The use of teletherapy has its own benefits and risks and will require specific agreements between you and your therapist and clarification of the risks assumed. Please refer to the *"INFORMED CONSENT FOR TELEHEALTH SERVICES"* if this applies to your work with Dr. Rosholt.

5) Fees for Services

Therapy and Psychological Assessments are services that you are contracting with Dr. Rosholt to receive. The cost for Dr. Rosholt's services is $200.00 per 60-minute hour for therapy, or 60-minute hour for psychological assessment. The fees cover Dr. Rosholt's professional time, but also go towards the cost of running the office and amenities (air conditioning, heating, lighting), office supplies, assessment measures used (if applicable), and liability and professional insurance costs. Adjunct services (ex. writing letters, completing forms, etc.) requiring greater than 15 minutes outside of scheduled appointments will be billed according to Dr. Rosholt's hourly rate of $200.00 unless other arrangements have previously been made. _____ Initial

Payment is due at the time of services, unless other arrangements have been made. Dr. Rosholt accepts cash, money order, personal check, cashier's check, or VISA/MasterCard debit cards, and VISA/MasterCard/Discover/American Express credit cards. There will be a returned check fee of $50.00 assessed for any insufficient funds (NSF) checks. Following one insufficient funds check, only cash, debit, or credit payments will be accepted. _____ Initial

If you would like me to bill your insurance, it is important to understand that most insurance agreements require you to authorize me to provide a clinical diagnosis, and occasionally additional information regarding treatment plans, prognosis, a summary, or copies of your record. Prior to releasing any of these, you and I will receive a written request from the insurance company outlining the information sought, the purpose of the disclosure, and what will be done with the information once they are through with it. In these situations, I will only release the minimum information necessary to receive reimbursement and meet insurance provider policies.

_____ Initial

Understand that once I release information, I cannot control how third parties store, disclose, or destroy PHI. Also, you should be aware that diagnostic information provided to an insurance company may be stored, potentially electronically, and become part of the insurance company's files. _____ Initial

6) Cancellation Policy

Scheduled appointments are blocks of time reserved specifically for you. Should you need to reschedule or cancel an appointment, we request 24 hours' notice. Dr. Rosholt will attempt to reschedule appointments prior to assessing the late cancellation fee of $200.00. Please note: Most insurance companies will not pay for missed / cancelled appointments, and this becomes the responsibility of the patient. _____ Initial

7) Contact Information

Outside of scheduled appointments, Dr. Rosholt is available via telephone, Monday through Friday, 9:00 AM to 5:00 PM. In the event that you need to contact Dr. Rosholt, please use the office contact number of (760) 269-8289. Should you reach voicemail, please leave a message as directed. Every effort will be made to return messages within one business day, Monday through Friday. Messages left when Dr. Rosholt is out of the office will be returned on the next business day. Alternatively, Dr. Rosholt can be reached via email at julia@juliarosholtpsyd.com.

In the event of a psychiatric emergency when Dr. Rosholt is unavailable, please contact the San Diego County Access and Crisis Line at 1-888-724-7240, contact 911, or proceed to the nearest hospital emergency room. _____ Initial

Fax, email, text messages, and cellular phones provide many opportunities for communication to occur quickly and conveniently. However, each of these can, at times, be less than secure, less

reliable, or difficult to access. As such, please use only the office phone number to communicate with Dr. Rosholt's office, unless other arrangements have previously been made with Dr. Rosholt. Electronic communication will only be used for scheduling and administrative purposes (billing, cancellation of session, inclement weather, etc.). Clinical issues will not be addressed via email, text, or another electronic medium. _____ Initial

Additionally, despite living in a major metropolitan area, there may be an occasion in which you and Dr. Rosholt run into each other in a social context, i.e. grocery store, restaurant, performance, shopping mall, etc. In the event this occurs, Dr. Rosholt will not initiate any interaction so as to maintain patient confidentiality and comfort. It will always be at your discretion how to handle such occurrences.

8) Interruptions to Treatment / Assessment

In the event that Dr. Rosholt succumbs to injury, disability, or death, preventing her from communicating or beginning, continuing, or providing treatment services, an individual identified in Dr. Rosholt's professional will shall contact the patient and provide appropriate referrals, continued care, and access to relevant clinical information. This person is also a licensed psychologist and is bound to the confidentiality and ethical guidelines outlined in this document.

When extended absences from treatment are known in advance (extended vacation, sabbatical, traveling, medical leave), Dr. Rosholt will provide contact information and facilitate communication with another competent therapist for continued treatment during Dr. Rosholt's absence. Again, this is voluntary and you may opt instead to resume therapy upon Dr. Rosholt's return. Additionally, should fire, national disaster, inclement weather, or other unavoidable circumstance interrupt treatment services, Dr. Rosholt will make all reasonable arrangements and accommodations to maintain continued treatment.

9) Grievance Policy

On occasion, patients leave therapy feeling as if they were not served ethically and quite possibly were the victim of a violation of codes and laws designed to protect those seeking psychological services, due to illegal, irresponsible, or negligent acts. In the event that this occurs, all concerns and complaints are handled by the California Board of Psychology. Complaints can be filed:

- Online at: http://www.psychboard.ca.gov/consumers/filecomplaint.shtml
- Via US Mail: By printing / completing the Consumer Complaint Form available at http://www.psychboard.ca.gov/formspubs/form.pdf and mailing to:

  Board Of Psychology
  1626 North Market Blvd; Suite N-215 Sacramento CA 95834

- Via Phone at: 1-866-503-3221
  A complaint must be made in writing. No one may retaliate against you for filing a

complaint or for exercising your rights as described in this notice. You also may file a complaint with:

Regional Manager, Office for Civil Rights
U.S. Department of Health and Human Services 90 7th Street, Suite 4-1000
San Francisco, CA 94103.

Should a dispute or grievance arise as a result of our work together, Dr. Rosholt and the patient will work informally to resolve any conflict or dispute. However, in the event that informal means are unsuccessful or either party is unwilling to resolve the conflict informally, a neutral, third party mediator, agreed upon by both parties, will be employed. The costs for this mediator will be equally shared by Dr. Rosholt and the patient. Should mediation fail to resolve the conflict or dispute, the issue will be submitted and addressed via binding arbitration in San Diego County, California, according to the rules of the American Arbitration Association current at the time of filing.

10) Data Records and Storage

Dr. Rosholt maintains copies for all active patient files. The State of California requires that all patient files be kept for a minimum of seven (7) years after the completion of services. In the event that a patient is a minor, all patient files will be maintained for seven (7) years after reaching the age of 18 (until the patient is 25 years old). Active and archived patient files are kept in secure, locked, and fire-resistant filing cabinets on premises, or electronically and securely according to guidelines set forth by HIPAA. After seven (7) years, patient files will be destroyed according to standards set forth in the California Business and Professions Code. While Dr. Rosholt may store or input patient information via personal computer, any protected health information (PHI) will be done so using password protected, firewalled, and encrypted programming expectations set forth by HIPAA, to limit unintended dissemination, access to protected information, and detrimental computer viruses.

The information contained in clinical files is the property of you, the patient, and is available to you at your request. Should you desire access to this information, please submit in writing your request to Dr. Rosholt. PLEASE NOTE: A charge of $0.25 per page will be assessed for any photocopies made as a result of such a request.

11) Notice of Office Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION* ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

*Protected Health Information (PHI)

Privacy
Julia R. Rosholt, Psy.D. is required by state and federal law to maintain the privacy of your protected health information (PHI). PHI includes any identifiable information about your physical or mental health, the health care you receive, and the payment for your health care.

Dr. Rosholt is required by law to provide you with this notice to tell you how she may use and disclose your PHI and to inform you of your privacy rights. Dr. Rosholt must follow the privacy practices as set forth in her most current Notice of Privacy Practices.

This notice refers only to the use/disclosure of PHI. It does not change existing law, regulations and policies regarding informed consent for treatment.

Changes to this Notice
Dr. Rosholt may change her privacy practices and the terms of this notice at any time. Changes will apply to PHI that Dr. Rosholt already has as well as PHI that Dr. Rosholt receives in the future. The most current privacy notice will be on file in Dr. Rosholt's office and will be available on request. Every privacy notice will be dated.

How Does Dr. Rosholt Use and Disclose PHI?
Dr. Rosholt may use/disclose your PHI for treatment, payment and health care operations without your authorization. Otherwise, your written authorization is needed unless an exception listed in this notice applies.

Uses/Disclosures Relating to Treatment, Payment and Health Care Operations
The following examples describe some, but not all, of the uses/disclosures that are made for treatment, payment and health care operations.

For treatment - Consistent with regulations and policies, Dr. Rosholt may use/disclose PHI to doctors, nurses, service providers and other personnel (e.g., interpreters) in her office, who are involved in delivering your health care and related services. Your PHI will be used to help inform Dr. Rosholt's services, to assist in developing your treatment and/or service plan and to conduct periodic reviews and assessments. PHI may be shared with other health care professionals and providers to obtain prescriptions, lab work, consultations and other items needed for your care. PHI will be shared with service providers for the purposes of referring you for services and then for coordinating and providing the services you receive, provided a signed and written release is in place identifying outside providers. An exception to this may be in the event that coordination of care is imminent or an emergency.

To obtain payment - Consistent with the restrictions set forth in regulations and policies, Dr. Rosholt may use/disclose your PHI to bill and collect payment for your health care services. Dr. Rosholt may release portions of your PHI to the Medicaid or Medicare program or a third-party payor to determine if they will make payment, to get prior approval and to support any claim or bill.

For health care operations - Dr. Rosholt may use/disclose PHI to support activities such as program planning, management and administrative activities, quality assurance, receiving and responding to complaints, compliance programs (e.g., Medicare, California Board of

Psychology), audits, training and credentialing of health care professionals, and certification and accreditation (e.g., The Joint Commission).

Appointment Reminders

Dr. Rosholt may use PHI to remind you of an appointment or to provide you with information about treatment alternatives or other health related benefits and services that may be of interest to you.

Uses/Disclosures Requiring Authorization

Dr. Rosholt is required to have a written authorization from you or your personal representative with the legal authority to make health care decisions on your behalf for uses/disclosures beyond treatment, payment and health care operations unless an exception listed below applies. You may cancel an authorization at any time, if you do so in writing. A cancellation will stop future uses/disclosures except to the extent Dr. Rosholt has already acted based upon your authorization.

Exceptions

- For guardianship or commitment proceedings when Dr. Rosholt is a party
- For judicial proceedings if certain criteria are met
- For protection of victims of abuse or neglect
- For research purposes, following strict internal review
- To correctional institutions, if you are an inmate
- For federal and state oversight activities such as fraud investigations, usual incident reporting, and protection and advocacy activities
- If required by law, or for law enforcement or national security
- To avoid a serious and imminent threat to public health or safety

Your Rights

You, or a personal representative with legal authority to make health care decisions on your behalf, have the right to:

- Request that Dr. Rosholt use a specific address or telephone number to contact you.*
- Obtain, upon request, a paper copy of this notice or any revision of this notice, even if you agreed to receive it electronically. *
- Inspect and copy PHI that may be used to make decisions about your care. Access to your records may be restricted in limited circumstances. If you are denied access, in certain circumstances, you may request that the denial be reviewed. Fees may be charged for copying and mailing. *
- Request additions or corrections to your PHI. Dr. Rosholt is not required to comply with a request. If she does not comply with your request, you have certain rights. *
- Receive a list of individuals who received your PHI from Dr. Rosholt (excluding disclosures that you authorized or approved, disclosures made for treatment, payment and healthcare operations and some required disclosures).*

- Ask that Dr. Rosholt restrict how she uses or discloses your PHI. Dr. Rosholt is not required to agree to a restriction. *
  * These requests must be made in writing

Record Retention

Your individual records relating to Dr. Rosholt provided care and services will be retained at a minimum for seven (7) years from the date you are discharged from her care, or to the age of 25 if the patient is a minor (under 18 years old). After that time, your records may be destroyed.

Consent to Treatment

I have read the above Informed Consent to Therapy and Office Procedures document and had the opportunity to address any questions or concerns I may have and have them answered to my satisfaction. I understand this document represents a contract to treatment and agree to the conditions and stipulations included herein. I have read this document and hereby consent to treatment services provided by Julia Rosholt, Psy.D. My signature below indicates that I have read this agreement and agree to its terms and acknowledge that I have received a copy of the Privacy Policy, as required by law.

Name (printed): _____DOB _____

Signature: _____ Date _____

Release of Information Authorization

By signing this form and designating the type of information and to whom this information is released, you are allowing me to exchange protected information from your (or if the patient is a minor / dependent, their) clinical file to the designated person.

I, _____ (Patient Name & DOB), hereby authorize Julia Rosholt, Psy.D. to release / exchange the following: (Please Initial)

____ Diagnosis ____ Psych Assessment ____ Discharge Summary

____ Treatment History ____ Treatment Planning ____ Medication History

____ Medical History ____ Progress Notes. ____ Entire Record

Other:
_____

This information is to only be released to / exchanged with:
_____

For the Purposes of:
_____

Subject to the following limitations: _____

Unless otherwise stipulated, this release of information is valid for twelve (12) months from the date signed below or upon termination of therapy. I understand I may revoke this authorization, at my discretion, upon request in writing. Julia Rosholt, Psy.D. is hereby released from liability arising as a result of requesting, releasing, or receiving the above information.

I understand that Dr. Rosholt generally cannot condition psychological services upon my signing an authorization that would allow a disclosure of PHI that is not yet permitted as described in the Informed Consent, or a disclosure that is otherwise not permitted by law. I understand that even if the authorization would not involve impermissible disclosures, Dr. Rosholt cannot condition treatment upon my signing a release unless: 1) My treatment is related to research and the authorization is to allow the use of disclosure of PHI for that research; or 2) the psychological services provided for the purpose of creating health information for a 3rd party.

I understand that the information used or disclosed pursuant to this authorization may be subject to re- disclosure by the recipient of my information and may no longer be protected by the HIPAA privacy rule.

Client / Representative Signature*: _____

Date: _____ * Signature of parent/guardian if client is a minor or dependent adult.

INFORMED CONSENT FOR TELEHEALTH SERVICES

Julia Rosholt, Psy.D. may provide therapy by Telehealth, the practice of mental health care delivery, diagnosis, consultation, treatment, transfer of medical data, and education using interactive real time synchronous audio and video technology where the patient and provider are at separate locations. Telehealth is beneficial to some clients as it can provide greater flexibility and decreased travel time.

There are some risks and consequences related to Telehealth that you should consider before agreeing to therapy via Telehealth. Despite reasonable efforts on the part of your psychotherapist, there is always the possibility that the transmission of personal information could be disrupted or distorted by technical failures. The transmission of personal information could be interrupted by unauthorized persons. The electronic storage of personal information could be unintentionally lost or accessed by unauthorized persons. When conducting psychotherapy via Telehealth, the ability of both the psychotherapist and the patient to assess non-verbal cues, body language and facial expressions may be limited. Telehealth may not be the most effective form of treatment for certain individuals or presenting problems. If Telehealth is appropriate for you, you have the following rights:

1. The laws that protect the confidentiality of your personal information also apply to Telehealth. The information disclosed by you during the course of your sessions is confidential. However, there are both mandatory and permissive exceptions to confidentiality, including, mandatory reporting of child, elder, and dependent adult abuse and when a client presents a serious danger of physical violence to another person or when a client is dangerous to him or herself.
2. Personally identifiable images or other information from the Telehealth interaction will not be disseminated to other entities without your written consent. In addition, all existing laws regarding confidentiality, privilege, patient access to medical information, and copies of medical records apply.
3. You have the right to withhold or withdraw consent to the use of Telehealth in the course of your care at any time, without affecting your right to future care or treatment.
4. If you would be better served by another form of intervention (e.g., face-to-face), you may be encouraged to use this medium or be referred to another provider. Despite your efforts and the efforts of your therapist, your condition may not improve, and in some cases may even get worse. No therapy can be guaranteed or assured.
5. Certain situations, including emergencies and crises, are inappropriate for audio-video-computer-based therapy services. If you are in crisis or in an emergency, you should immediately call 9-1-1 or seek help from a hospital or crisis-oriented health care facility in your immediate area.

PATIENT CONSENT TO THE USE OF TELEHEALTH:

I have read and understand the information provided above regarding Telehealth, have discussed it with my therapist, and all of my questions have been answered to my satisfaction. I have read this document carefully and understand the risks and benefits related to the use of Telehealth services and have had my questions regarding the procedure explained. By executing this document, I hereby give my informed consent to participate in the use of Telehealth services for treatment under the terms described herein.

Name: _____ Signature: _____

Date: _____ Witness: _____

Assumption of the Risk and Waiver of Liability Relating to Coronavirus / COVID-19

The novel coronavirus, COVID-19, has been declared a worldwide pandemic by the World Health Organization. COVID-19 is extremely contagious and is believed to spread primarily from person-to-person contact, though it can also be spread by touching contaminated surfaces. As a result, local, state, and federal governing bodies as well as health officials and agencies have strongly recommended social distancing policies to reduce the spread of the virus. As of Mid-March 2020, the State of California issued an executive order (Executive Order N-33-20) requiring all individuals to stay at home as a response to COVID-19 with the exception of essential businesses, which may continue their work because of the importance to Californians' health and wellbeing.

The office of Julia Rosholt, Psy.D. falls under the essential business category outlined by the Executive Order issued by the State of California. This order allows health care providers, including psychologists and assistants to continue to offer, services if remote delivery of services is not practical. The office of Julia Rosholt, Psy.D. and all staff have implemented social distancing policies and are conducting business via telehealth/remote procedures wherever possible. However, some aspects of psychological and neuropsychological testing cannot be conducted via telehealth procedures. Therefore, some services and aspects of an evaluation may only be delivered via in-person administration.

You have the option to participate in an evaluation that is conducted completely using telehealth procedures and without in-person meetings. However, should measures require in-person administration due to nature of the testing materials, these scores cannot be included, and the validity of the evaluation may be limited. You also have the option to complete any assessment requiring in-person administration upon lifting of the stay-at-home order within the State of California.

This office has put into effect preventative policies and procedures to reduce the spread of COVID-19 including sanitizing all instruments, furniture, and other office items before and after each individual patient; reducing and minimizing the number of individuals in the office at any given time; requiring all staff and patients to wear protective face covering; requiring all staff and patients to sanitize hands frequently, including but not limited to before and after each appointment; and requiring all staff and patients abide by social distancing policies and maintain at least a 6 foot distance from others wherever possible. Additional personal protective equipment (PPE) may be employed by staff (e.g., gloves, face shields).

My signature or Parent/Guardian's initials and signature(s) below indicates that I understand and agree to the following:

I understand that I have opted to come into the office of Julia Rosholt, PsyD by choice and have been made aware of alternative options and/or limitations to my psychological evaluation, diagnosis, and treatment recommendations if I prefer not to attend an in-person meeting. **Initial ____**

I understand that my decision to attend this appointment is voluntary. **Initial ____**

I understand that if upon screening or through observation, I exhibit or endorsed publicly identified symptoms associated with the COVID-19 virus, I will be asked to reschedule the assessment in the interest of public health. **Initial ____**

I understand that by attending an in-person appointment at this office even with preventative policies and procedures in place, I may become exposed to or infected with COVID-19. **Initial ____**

I understand the current risks involved with COVID-19 exposure or infection, which may result in personal injury, illness, permanent disability, and/ or death. **Initial _____**

I agree to follow all social distancing and sanitation procedures listed in this form during my appointment and at the office of Julia Rosholt, Psy.D. **Initial _____**

I voluntarily assume this risk and accept sole responsibility for any injury to myself, my child, or any other person I choose to accompany me to this appointment. **Initial _____**

I hereby release any liability and hold harmless the office of Julia Rosholt, Psy.D., associated staff, and employees, of and from claims, including all liabilities damages, costs, or expenses of any kind arising out of or relating thereto. **Initial _____**

Signed: _____ Date: _____

Name (printed): _____ Relationship: _____

Patient Name: _____ DOB: _____

Witness: _____ Date: _____

FINANCIAL SERVICES AGREEMENT

FEES: Fees are due at the time of service. My fee for service is $200 per individual 50-minute session. Checks should be made out to Dr. Julia Rosholt. Debit / credit cards (Visa, MasterCard, American Express, Discover) are accepted for your convenience. Fees are subject to change.

ADDITIONAL TIME: Occasionally, patients will require additional time and attention to address issues related to therapy or psychological assessments, both in and out of the office. In the event that Dr. Rosholt is asked to prepare reports, place calls on the patient's behalf, copy documents, review documents, render opinions, or provide consultation, an additional fee of $25 per 15-minute increments will be due to account for Dr. Rosholt's time. This fee does not apply to brief phone calls related to scheduling, absences, or confirming plans / agreements made in session.

INSURANCE: Dr. Rosholt is a contracted, in-network provider with Cigna insurance company. If a patient would like to utilize insurance benefits for mental health services for an out-of-network insurance provider, Dr. Rosholt will provide patients with a statement (a Superbill), which patients can submit to the third-party of his/her choice to seek reimbursement of fees already paid.

NO SHOW OR NO CALL: Your session time has been specifically reserved for you. If you are unable to keep the appointment, please contact us 24 hours in advance unless there is an emergency. All no show/no call appointments, barring an emergency, will be billed at a rate of $100.00.

COURT APPEARANCE: Should Dr. Rosholt need to, be requested, or subpoenaed to appear in court on your behalf for any reason, the cost for my services in court is $800 per half day, or $1600 for full day. Additional travel expenses (e.g. mileage, airfare, lodging) may also apply to the aforementioned day rates.

Please discuss any questions you may have. Dr. Rosholt wants to make sure your specific issues are addressed, and you receive the assistance and clarification you are looking for.

Name (printed): _____

Signature: _____

Date: _____

Witness: _____Date: _____