Lynn Stoffers, L.P.C.
Mailing Address: 6501 E. Greenway Pkwy. #103-493
Scottsdale, AZ 85254
Phone: 602-354-2577

CONFIDENTIALITY, OFFICE POLICIES AND INFORMED CONSENT

This statement contains information about my philosophy of therapy and business policies. Please read it carefully and discuss any questions that might help to make your counseling experience as satisfying as possible. When you sign this document, it will represent an agreement between us.

Philosophy: I believe that therapy is a co-creative process in which the client(s) and therapist work together to define goals, assess progress, plan termination and provide referrals. I enter into this process with respect for individuals and have expectations of the same in return. The therapeutic process has challenges and benefits. As part of the process you may experience unexpected and uncomfortable feelings, however, the benefits of therapy can include significant reduction in feelings of distress, improved relationships with others, and resolutions of specific problems. Although therapy typically has a positive outcome, there are no guarantees and each individual is unique. Together we will develop an individual treatment plan that outlines the major issues you wish to address and the approach that will be used to reach these goals. When you have reached these goals, I ask that you participate in a closing session to review your accomplishments and allow me to assist you in identifying any supports available to help maintain your growth. I encourage your to discuss any question you have about our relationship, since the success of the therapeutic process requires a "good fit" between the therapist and client.

Appointments: The frequency and duration of our meetings will depend on your treatment goals. **Your therapy session is reserved for you. Please give 24 hours notice of cancellation. Failure to do so without good cause will make it necessary for you to pay for the missed appointment.**

You can leave all messages on my confidential voice mail. I retrieve these messages periodically throughout the workday. I will make every effort to return your call as soon as possible. If the message is urgent, pleases indicate so. In the event of a life threatening emergency, please call 911, your family physician, the nearest emergency room and ask for the psychologist or psychiatrist on call or any of these other agencies: EMPACT/Suicide Crises Hotline (480) 784-1500; TERROS (602) 685-6000; Child Protective Services (888) 767-2445; or National Domestic Violence Hotline (800) 799-7233.

Fees: The cost of service is your responsibility. Payment is expected at the time of service. My private fee is $160.00 for a 50-minute psychotherapy session. A 75-minute psychotherapy session is $240.00. An extended psychotherapy session (100 minutes) is $320.00. In addition to weekly appointments, I charge this amount for other processional services you may need including: report writing, telephone conversations lasting longer than 10 minutes, attendance at meetings with

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other professionals you have authorized, preparation of records or treatment summaries, and the time spend performing any other service you may request of me. If 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 another party calls me to testify. Due to the difficulty of legal involvement, I charge $250.00 per hour for preparation and attendance at any legal proceeding.
Checks returned for insufficient funds will be charged at an additional $35.00.

Insurance Billing and Payments: If you have insurance, this office will file the claim for you as a courtesy. If you are using your insurance coverage, it may be a requirement that a clinical diagnosis, a treatment plan or summary of your treatment be furnished to them in order to receive payment. If is your responsibility for paying the portion that is not reimbursed by your insurance company. If your insurance company does not respond within 60 days from the filing date, it will be your responsibility to pay for the services in full and seek reimbursement from your insurance company. BALANCES 60 DAYS PAST DUE WILL BE SUBJECT TO A 15%INTEREST CHARGE PER-MONTH ON THE UNPAID BALANCE. UNPAID BALANCES OVER 90 DAYS WILL BE REFERRED TO THE CREDIT BUREAU.

If you are utilizing insurance please read and sign the following authorization:
Authorization to Release Information and Pay Benefits to Therapist: I hereby authorize payment of all benefits to Lynn Stoffers, L.P.C., otherwise payable to me, relative to the services reported. I understand that I am financially responsible for the charges not covered by this authorization:

_____
Signature of Client or Parent/Guardian Date

I understand that by signing below I waive my right to confidentiality in the collection of any fees and in any dispute which might result for services rendered.
I have read and understand my responsibilities regarding fees, payments, no shows, collection procedures and costs. I give consent to the provider to begin treatment as discussed.

_____
Signature of Client or Parent/Guardian Date

Private Pay: I have chosen to waive the use of my insurance, or do not have insurance that will cover the cost of therapy. I am choosing to pay privately to cover my therapy sessions.
Signature-Private Pay Clients:_____ Date:_____

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Minors: If you are under eighteen years of age, please be aware that while the specifics of our communication may remain confidential, your parents do have a right to receive your medical records. It is my policy to request agreement from parents that they consent to give up access to your records. If they agree, I will provide them with only general information about our work together unless I feel that there are safety concerns, particularly if there is a high risk that you will seriously harm yourself or another, in-which case I will notify them of my concern. I will also provide them with a verbal summary of your treatment when it is complete, if they wish. Before giving them any information, I will discuss the matter with you, if possible, and will do the best I can to resolve any objections you may have about what I am prepared to discuss.

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

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

There are situations in which I am legally obligated to take action to protect others from harm, even without your permission. If I believe a child, an elderly or disabled person is being abused, I am required to file a report to the appropriate agency. In the event that I believe a client is threatening serious harm to another, I am required to either notify the potential victim, the police or seek the client's hospitalization. If the threat of harm is to oneself, I may seek hospitalization or contact family members or others who can help provide protection.

I have a moral, ethical and legal responsibility to prevent people from being harmed when to the best of my professional judgment, such danger exists. Fortunately, these situations rarely arise in my practice, but if they do it is my policy to fully discuss these matters with you before taking any action if at all possible.

Miscellaneous: I occasionally find it helpful to consult other professionals about a case. The consultant is legally bound to keep this information confidential. Every effort is made to maintain your privacy and anonymity. Your signature below indicates you have read the information in this document and agree to abide by its terms during our professional relationship. IF YOU HAVE ANY QUESTIONS, PLEASE ASK.

Client Signature: _____ Date: _____

Parent/Guardian (if client is under 18) _____ Date: _____

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NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CN GET ACCESS TO THIS INFORMATION PLEASE REVIEW CAREFULLY

My Duty to Safeguard your Protected Health Information: Individually identifiable information maintained in your case file, about your past, present, or future health or condition, the provision of health care services to you, or payment for the health care services is considered "Protected Health Information" (PHI). I may change my policies at any time. However before I make a material revision to my policies, I will change my notice of information practices and deliver the revised notice as require by law. The revised notice will be effective for all Protected Health information that I maintain at that time. except when require by law, immaterial change to any term of the notice may not be implemented prior to the effective date of the notice in which such material change ifs reflected. Yo can also request a copy of my notice at any item by call ing the office and requesting that revised copy be sent to you in the mail.

How I may Use and Disclose your Protected Health Information: I may use or disclose PHI for a variety to reasons. I have a limited right to use or disclose your PHI for purposes of treatment, payment and behavioral health care operations. For uses or disclosures, I must have your written authorization unless the law permits or requires me to make the use or disclosure without your authorization. You also have the right to revoke your authorization. If I disclose your PHI to a business associate in order for that entity to perform a function on your behalf, I must have in place an agreement from the business associate that it will extend the same degree of privacy protection to your information that I must apply to your PHI. However, the law provides that I am permitted to make some uses or disclosures without your consent or authorization. The following offers more description and some examples of my potential uses or disclosures of your PHI.

Uses and Disclosures Relating to Treatment, Payment, or Health Care Services: Generally, I may use or disclose your PHI as follows:

For Treatment: I may use or disclose your PHI to provide, coordinate or manage your healthcare and any related services. I may disclose your PHI to physicians, psychiatrists, psychologists, and other licensed health care providers who provide you with health care services or are otherwise involved in your care. For example, if a psychiatrist is treating you, I may disclose you PHI to him/her in order to coordinate your care.

For Payment: I may use and disclose your PHI to bill and collect payment for the treatment and services I provide you. Example: I might send your PHI to your insurance company or health plan in order to get payment for the health care services that I have provided you. I could also provide your PHI to businesses associates, such as billing companies, claims processing companies, and others that process health care claims for my office.

For Health Care Services: I may disclose your PHI to facilitate the efficient and correct operation my my practice. Example: Quality control-I might use your PHI in the evaluation of the quality of services that you have received or to evaluate the performance of the health care professionals who provided you with these services. I may also provide your PHI to my attorney, accountant, consultants, and others to make sure that I am in compliance with applicable laws.

When Required By Law: I may disclose PHI as required by state and federal law. Examples include information about suspected abuse, neglect or domestic violence , or relating to suspected criminal activity, or in response to a court order or other legal process, judicial and administrative proceedings, and certain other law enforcement situations, to personal representatives and workers compensation. I must also disclose PHI to authorities that monitor compliance with these privacy requirements.

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I, _____, hereby authorize Lynn Stoffers, L.P.C., to use or disclose protected health information about me to carry out treatment, payment or health care operation. I acknowledge that I have read a copy of her Notice of Privacy Practices. This notice describes how Lynn Stoffers, L.P.C., may use and disclose my protected health information, certain restrictions on the use and disclosure of my healthcare information, and rights I may have regarding my protected healthcare information.

Patient Name/Representative: _____

Date: _____ Signature: _____

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I, _____ understand that Lynn Stoffers, L.P.C.,
(Client/Parent)

Licensed Professional Counselor, will provide Psychological Counseling for

myself/my child _____.
(circle one) (Name of Client)

I further understand that this provision of care does not include offering to give testimony in court, complying with attorney-generated subpoenas or any other form of voluntary waive of privilege. There is no expiration for this agreement.

I understand and agree to these terms by signing below.

_____ _____
(Client/Parent) (Date)

_____ _____
(Client/Parent) (Date)

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Initial Information Form

Name: _____ Date: _____

Address: _____

Birth Date: _____ Social Security #: _____

Phone: (home) _____ (cell) _____ (work) _____

May I contact and leave you a message at: Home _____ Cell _____ Work _____

Email Address: _____

Employer: _____ Occupation: _____

Household Members:

Name	Age	Relationship

Medical History:

Doctor(s) currently involved in your care? _____

Name of your primary care physician? _____

Health problems (include allergies): _____

Medications currently using; (if none, state none):

Medication	Dosage	Doctor	Reason

_____

Person Completing This Form Date

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Informed Consent for Teletherapy/Telehealth Therapy Sessions

I, _____, hereby consent to engage in teletherapy/telehealth with Lynn Stoffers, L.P.C. Teletherapy/telehealth has the same purpose or intention as psychotherapy or psychological treatment sessions that are conducted in person and are an alternative to accessing counseling services. However, due to the nature of the technology used, I understad there are differences between teletherapy/telehealth sessions and in-person sessions. I will discuss all of my concerns or questions with Lynn Stoffers and may do so at any time.

Client's Rights, Risks, and Responsibilities:

I, the client, have the right to withhold or withdraw consent at any time without affecting my right to future care or treatment.

I understand the potential risks to this technology, including interruptions, unauthorized access and technical difficulties. I understand that Lynn Stoffers or I may discontinue a telehealth/teletherapy session if either or both of us feel that the videoconferencing connections are not adequate for the situation. Lynn Stoffers agrees to inform me and obtain my consent if another person is present during the session for any reason. I agree to inform Lynn Stoffers if there is another person present during the session.

I understand that during this time of extra usage of the Internet system for people around the globe, there may be glitches or interruptions during telehealth/teletherapy sessions. These will be addressed as much as possible to ensure a clear and comfortable teletherapy/telehealth session. I understand that there are risks and consequences of participating in teletherapy/telehealth, including, but not limited to, the possibility, despite best efforts to ensure high encryption and secure technology on the part of my therapist, that: the transmission of my information could be disrupted or distorted by technical failure; the transmission of my information could be interrupted by unauthorized persons; and/or the electronic storage of my medical information could be accessed by unauthorized persons.

In addition, I understand that teletherapy based services and care may not be as complete as face-to-face services. I also understand that if my therapist believes I would be better served by another form of therapeutic services (e.g. face-to-face services), I will be referred to a professional who can provide such services in my area.

I understand that I may benefit from teletherapy, but that results cannot be guaranteed or assured. I understand that there are potential risks and benefits associated with any form of psychotherapy, and that despite my efforts and the efforts of my therapist, my condition may not improve, and in some cases, may get worse.

I accept that teletherapy does not provide emergency services. If I am experiencing an emergency situation, I understand that I can call 911or proceed to the nearest hospital emergency room for help. If I am having suicidal thoughts or making plans to harm myself, I can call the National Suicide Prevention Lifeline at 1-800-273-TALK (8255) for free 24-hour hotline support. Clients who are actively at risk of harm to self or others are not suitable for teletherapy services. If this is the case or becomes the case in the future, my therapist will recommend more appropriate services.

I understand the same confidentiality protections, limits to confidentiality and rules around my records apply as they would to an in-person sessions.

I understand that Face Time Sessions are not HIPAA compliant, but are approved by the Department of Health and Human Services Office for Civil Rights (OCR) for the duration of the COVID-19 Public Health Emergency. Zoom Conferencing is HIPAA Compliant, but also have the potential for unauthorized access due to the nature of Internet delivery.

Please be aware that if you choose to pay by Credit Card, I use "SQUARE", which electronically sends a receipt via text or email.

I have read, understand and agree to the information provided above regarding telehealth/teletherapy. I fully understand its contents including the risks and benefits of the procedures.

Client's Signature: _____ Date: _____

Therapist's Signature: _____ Date: _____