Spectrum Psychology and Wellness, LLC
Boston Professional Village
1772 E. Boston Street Ste 105 | Gilbert, AZ 85295-6242
o: 480.621.7257 | f: 480.584.5825 | http://www.SpectrumWellnessAZ.com

Treating Doctor: ☐ ***Rachel Loftis, Ph.D. (Please use other forms if seeing a different provider)***

1) Patient Information

First Name________________________Middle Initial______Last Name__________________________Social Security #___________________Date_______________

Date of Birth_________________________Age____________ Gender___________Ethnicity____________________________Marital Status_________________________

Mailing
Address:____

Home Phone #: ____ Work Phone #: ____

Cell Phone # (for appointment reminders):____Email____

Reason for initial appointment:____

Please check if we may leave a message at the numbers above: ☐ *Home #* ☐ *Work #* ☐ Cell #

Employment Status: ☐ Employed ☐ Full-Time Student ☐ Part-time Student ☐ Retired ☐ Other

Occupation____Employer_______________________________________Highest Education Level_________________________

____
Emergency Contact Phone # Relationship

2) Appointment Reminders and Online Appointment Scheduling (Disregard if you registered online)

You can receive an appointment reminder to your email address, your cell phone (via a text message), or your home phone (via a computer generated voice message) the day before your scheduled appointments. You can also enjoy the convenience of online scheduling at any time. Once your account is established, you simply visit www.SpectrumWellnessAZ.com to schedule or reschedule your appointments. Appointment information is considered to be "Protected Health Information" under HIPAA. By your signature below, you are waiving your right to keep this information completely private, and requesting that it be handled as you have noted below.

Requested login name: |__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|
(letters or numbers only)

Requested password: |__|__|__|__|__|__|__|__|__|__|__|
(letters or numbers only)

Where would you like to receive appointment reminders? (check **ONLY** one) *Note, in the best of circumstances it is impossible to guarantee a 100% delivery rate, due to factors outside our control (i.e., bad phone numbers or email addresses, or reminders being misclassified as "spam"). It is always best to view reminders as a "courtesy" rather than a "certainty." Missed appointment fees will still apply.

☐ Via an email message to the address listed above
☐ Via an automated telephone message to my home phone
☐ Via a text message on my cell phone (normal text message rates will apply)
☐ None. I'll remember my appointments on my own. (Missed appointment fees will still apply)

Appointment Cancellation Policy: Because of the extended length of appointments, it may be difficult to reschedule on short notice. If you need to cancel or reschedule, please give 24 hour advance notice. ***Charges will apply for missed appointments, late cancelations and/or arriving 15+ min. past your scheduled appointment time.***

3) Referral, Authorization and Policy Information

How did you hear about us? ☐ Google Search/Google Maps ☐ Doctor's Referral ☐ Word-of-Mouth Referral ☐ Psychology Today Therapist Directory

Who may we thank for your referral to our office?
Name:____

Spectrum Psychology and Wellness, LLC
Acknowledgement of Office Policies and Clinical Conditions of Evaluation and Treatment

_________ I acknowledge having scheduled a voluntary Psychological evaluation for diagnostic and treatment
Initial purposes with a practitioner at Spectrum Psychology and Wellness, LLC (SP&W). I acknowledge understanding that after completion of the initial evaluation session, a decision can be made by either party to establish, or not to establish, a practitioner-patient relationship. In this event, we will be happy to provide you the name of at least 3 local mental health professionals for a second opinion.

_________I acknowledge that SP&W does not provide Emergency Psychological or Continuous Crisis Management
Initial services, and agree to contact the emergency room at the nearest hospital and ask for the psychologist or psychiatrist on call, dial 911, or call the EMPACT crisis hotline at 480-784-1500 for assistance. I also recognize that my practitioner's schedule is filled in advance and may not allow for patients to be seen on an urgent basis unless there is a cancellation.

_________I acknowledge understanding that SP&W's policy regarding **treatment of minors** requires that if legal
Initial documents exist regarding custodial agreements it is required that a copy be on file with our office. I also acknowledge understanding that in the event of a parental separation or divorce, both parents MUST consent, in writing, to this assessment. Similarly, if one parent retains sole legal custody, this parent MUST provide legal documentation of this in order for assessment to proceed. In the case of joint custody, both parents MUST consent to the assessment. I understand that both parents, regardless of custody, have a legal right to records (see Arizona Revised Statute 25-403.06)

_________I acknowledge receiving a copy of the Psychologist-Patient Agreement packet and that I have reviewed and
Initial agreed to the fees listed under "Professional Fees."

_________I understand that I will be able to provide payment of my choice at each time of service. I also understand
Initial that a credit/debit card **OR** cash deposit of $100 is ***REQUIRED*** to be on file for any remaining balance after my account has been processed (e.g., self-pay fees, no-show/late cancel fees).

_________I acknowledge understanding and agreeing to the following policy: **SP&W *requires at least 24 hours'***
Initial ***notice prior to canceling an appointment. Because we offer appointment reminders and commonly have a waiting list, missed appointments that were not canceled with 24 hours' notice will incur a charge to your credit/debit card on file at the rate of $100. Late cancelations and/or arriving 15+ min. past your scheduled appointment time will incur a charge at the rate of $80. Additionally, in the best of circumstances it is impossible to guarantee a 100% delivery rate of appointment reminders, due to factors outside our control (i.e., bad phone numbers or email addresses, or reminders being misclassified as "spam"). It is always best to view reminders as a "courtesy" rather than a "certainty." Missed appointment fees will still apply. The benefit of reserving your therapist's time specifically for your session is that you rarely have any significant wait time. However, if you fail to keep your appointment, or fail to cancel more than 24 hours prior to the session, this block of time is no longer available to others and will still be billed to you.***

Your signature below acknowledges that you have read, understand, and agree to these policies:

____ ____________________
Patient/Legal Guardian Signature Date

Spectrum Psychology and Wellness, LLC
Agreement and Acknowledgement of Private Payment Conditions

Dr. Rachel Loftis does not accept insurance as payment from new patients. This notice is to inform all new patients that insurance-accepted appointments are not currently available.

Please initial each line to accept these conditions:

_______ I understand that Dr. Loftis is not currently accepting new appointments that leverage insurance as payment.
Initial Any appointments scheduled will be billed to the patient/responsible party at the private payment rates. Claims will not be submitted to insurance by Spectrum Psychology and Wellness or Dr. Rachel Loftis. The initial appointment fee is $225. Subsequent appointments have a fee of $195 per appointment.

_______ Payment in full is due at each time of service.
Initial

_______ Private payment rates will apply regardless of what insurance the patient has and regardless of what the
Initial patient's standard payment/copay/deductible payment is.

_______ Spectrum Psychology and Wellness can provide a superbill for each appointment at the request of each
Initial patient or responsible party. The patient/responsible party can submit the superbill to insurance for consideration but should not expect to receive full appointment costs as reimbursement.

_______ Knowledge of the patient's insurance policy and benefits is the responsibility of the patient/policy holder.
Initial Spectrum Psychology and Wellness cannot discuss or confirm any insurance benefits for patients submitting their claims via superbill. Spectrum Psychology and Wellness cannot discuss or confirm any out-of-network benefits.

By signing below, you acknowledge the above information and agree to pay the private payment rates as noted.

____ _______________

Patient/Legal Guardian Signature Date

WE REQUIRE A CREDIT CARD TO BE ON FILE FOR ANY ACCOUNT BALANCES

Credit/Debit Card/Deposit Authorization Form
All information will remain secured and confidential.

You will be able to provide payment of your choice at each time of service. However, a credit/debit card OR $100 cash deposit is ***REQUIRED*** to be on file. This credit/debit card or cash deposit will be used for any remaining balance after any fees have been processed (e.g., self-pay fees, no-show/late cancel fees). If your credit/debit card is declined at the time of collection, you will be required to leave a cash deposit for any future transactions. If your cash deposit is depleted to cover any charges on your account, you will be required to re-establish this deposit to be held for any future fees that are not paid in advance. If a balance remains on your account, it will be refunded.

SP&W *requires at least 24 hours' notice prior to canceling an appointment. Because we offer appointment reminders and commonly have a waiting list, missed appointments that were not canceled with 24 hours' notice will incur a charge to your credit/debit card on file at the rate of $100. Late cancelations and/or arriving 15+ min. past your scheduled appointment time will incur a charge at the rate of $80.*

Additionally, in the best of circumstances it is impossible to guarantee a 100% delivery rate of appointment reminders, due to factors outside our control (i.e., bad phone numbers or email addresses, or reminders being misclassified as "spam"). It is always best to view reminders as a "courtesy" rather than a "certainty." Missed appointment fees will still apply. The benefit of reserving your therapist's time specifically for your session is that you rarely have any significant wait time. However, if you fail to keep your appointment, or fail to cancel more than 24 hours prior to the session, this block of time is no longer available to others and will still be billed to you. For additional information about fees, please refer to the Psychologist-Patient Agreement under "Professional Fees."

I am authorizing Spectrum Psychology and Wellness, LLC to charge my credit/debit card for any balance due on my account from any services related to my treatment at Spectrum Psychology and Wellness, LLC.

__________ ***If credit card on file is in someone else's name, patient acknowledges that Spectrum Psychology and Wellness, LLC reserves the right to discuss billing related questions or concerns directly with the card holder.***
Initial

Cardholder/Depositors Printed Name:____ __

Billing Address:____

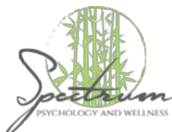
Credit Card Type: _____Visa _____MasterCard **__NOT ACCEPTED AT THIS OFFICE__**AMEX

____ HSA Card _____ DEBIT CARD

Credit/Debit Card Number:____

Expiration Date:___________________ CVV/CVC # (Three digits on back of card):____________

______________________________________ _______________
Cardholder/Depositors Signature Date



Spectrum Psychology and Wellness, LLC
Boston Professional Village
1772 E. Boston Street Ste 105 | Gilbert, AZ 85295-6242
o: 480.621.7257 | f: 480.584.5825 | http://www.SpectrumWellnessAZ.com

General contact with Spectrum Psychology and Wellness:

Spectrum Psychology and Wellness is a reception-less office.

What this means is that there is not a front office staff member that sits in the lobby at our offices.

Our office manager and support staff do not work on site but can be reached by leaving a message at our main number, 480-621-7257, and selecting option #1. The phone will not be answered directly and you will be instructed to leave a message that should be returned within a 24-hour period.

All scheduling (cancelations within the allowed period and rescheduling) is done by you, the patient, on the patient portal that you registered on at http://www.SpectrumWellnessAZ.com.

New Patient Initial Visit Procedure:

As mentioned above, Spectrum Psychology and Wellness is a reception-less office. When you arrive for your first visit with us, please locate the light switch panel under the TV in the lobby. Please flip up and leave on the light switch for your provider so they know you have arrived.

For directions to our office, please see map on last page of forms.

Psychologist-Patient Agreement
Please read and sign, and return only the last page

Welcome to our practice. This document (the Agreement) contains important information about our professional services and business policies. It also contains summary information about the Health Insurance Portability and Accountability Act (HIPAA), a new federal law that provides new privacy protections and new patient rights with regards to the use and disclosure of your Protected Health Information (PHI) used for the purpose of treatment, payment, and health care operations. HIPAA requires that we provide you with a Privacy Practices (the Notice) for use and disclosure of PHI for treatment, payment, and health care operations. The Notice, which is attached to this Agreement, explains HIPAA and its application to your personal health information in greater detail. The law requires that we obtain your signature acknowledging that we have provided you with this information. Although these documents are long and sometimes complex, it is very important that you read them carefully. You and your practitioner can discuss any questions you have about procedures. When you sign this document, it will represent an agreement between us. You may revoke this Agreement in writing at any time. That revocation will be binding unless action has been taken in reliance on it; if there are obligations imposed on us by your health insurer in order to process or substantiate claims made under your policy; or if you have not satisfied any financial obligations you have incurred.

PSYCHOLOGICAL SERVICES

Psychotherapy is not easily described in general statements. It varies depending on the personalities of the psychologist and the patient, and the particular problems you are experiencing. Psychotherapy as we practice it is a relationship focused, respectful, and goal oriented discussion process designed to help you address particular problems you are experiencing. There are different methods and treatment approaches your practitioner may use to deal with the problems you hope to address. In order for psychotherapy to be effective, it calls for a very active effort on your part. The more honest, truthful, and genuine you are with your practitioner about what you believe, think, say or do, in your daily life outside this office, and with your practitioner in this office, the more likely it is that you will really understand yourself, your practitioner will really understand you, and you and your practitioner can work together to help you heal. In the same way, your practitioner will be honest with you. At times, your practitioner may ask you to work on assignments in between sessions; this often speeds the therapeutic process and makes it more effective. Your first sessions will involve an evaluation of your treatment needs. By the end of the evaluation, your practitioner will be able to offer you their clinical impressions of what our work will include and a treatment plan to follow. Please consider this information along with your own opinions of whether you feel comfortable working with your practitioner. Therapy involves a commitment of time, money and energy, so please be careful about the practitioner you select. If you ever have questions about your practitioner's treatment approach, they will be glad to discuss their methods and techniques with you. Similarly, after completion of the initial evaluation session, a decision can be made by either party to establish, or not to establish, a practitioner-patient relationship. In this event, we will be happy to provide you the name of at least 3 local mental health professionals for a second opinion.

Psychotherapy can have risks and benefits. Many individuals and families who participate in psychotherapy benefit from the process. Therapy can facilitate self-discovery, emotional expression of difficult and painful feelings, coping skills, as well as strengthen interpersonal relationships. Furthermore, the process of therapy provides opportunities to uncover novel solutions to difficult and painful problems. However, a "cure" is not guaranteed, and participating in psychotherapy can yield risks as well. The process of talking about problems can elicit painful feelings and interpersonal conflict. Although this can be uncomfortable, it is often a natural and normal occurrence within the change process.

MEETINGS

The initial assessment occupies the bulk of the first session. During this time, you can both decide if your practitioner is the best person to provide the services you need in order to meet your treatment goals. If psychotherapy is begun, one 50-minute session (one appointment hour of 50 minutes duration) is usually scheduled per week at a time agree on, although some sessions may be longer or more frequent depending on the issues that arise or scheduling constraints. The frequency of sessions typically decreases as progress is being achieved. **If you need to cancel an appointment, please do so with at least 24 hours advance notice. Missed appointments, late cancelations or arriving 15+ min. past your scheduled appointment time will incur a charge.**

PROFESSIONAL FEES

All fees are due at the time of service. The fee for the initial diagnostic consultation is $225 and each subsequent appointment is $195 per session. There is a $75 fee for each additional 30 min. increment beyond the usual session time in crisis or emergency services. Fees for psychological testing and report writing are $225/hr. A full test battery may range from 7-10 hours. Records review for diagnostic purposes will be charged at a $50 fee per 15 min. increment. There is a $30 fee per 15 min. increment for any special reports, clinical letters, forms or any other written document, including those related to FMLA, short or long-term disability, Social Security Disability or chronic health condition exemption forms. Please note, we do not write letters for emotional support animals. A returned check fee for insufficient funds (per occurrence) is $25. Copies mailed over 15 pages (16th+) will be charged at a rate of $0.50/page + postage. A records fee for printed copies is $0.07 per page. Fees for other as needed services will vary by service and administration time required. The fee for legal proceedings/meetings (charged portal to portal) is $250/hr, + $1000 retainer for services requiring more than four hours (charged and collected before the date of the trial or meeting). Other services may include telephone conversations lasting longer than ten minutes, consultations with other agencies/professionals (with your permission), etc. **Please provide at least 24 hours' notice prior to canceling an appointment. Because we offer appointment reminders and commonly have a waiting list, missed appointments that were not canceled with 24 hours' notice will incur a charge to your credit/debit card on file at the rate of $100. Late cancelations and/or arriving 15+ min. past your scheduled appointment time will incur a charge at the rate of $80. Additionally, in the best of circumstances it is impossible to guarantee a 100% delivery rate of appointment reminders, due to factors outside our control (i.e., bad phone numbers or email addresses, or reminders being misclassified as "spam"). It is always best to view reminders as a "courtesy" rather than a "certainty." Missed appointment fees will still apply. The benefit of reserving your therapist's**

time specifically for your session is that you rarely have any significant wait time. However, if you fail to keep your appointment, or fail to cancel more than 24 hours prior to the session, this block of time is no longer available to others and will still be billed to you.

CONTACTING US

Due to work schedule constraints, your practitioner is often not immediately available by telephone. When they are unavailable, the telephone is answered by a trusted Spectrum Psychology and Wellness, LLC, an Arizona limited liability company (the Practice) employee or a confidential voicemail system. Please leave your message and we will make every effort to return your call promptly. The confidential voicemail system works 24 hours a day, seven days a week. Please leave your call back number with your message as your practitioner may be away from the office when they receive your message, and therefore be unable to consult your chart for your telephone-contact information. The practice does not provide Emergency Psychological or Continuous Crisis Management services. If you are unable to reach your practitioner and feel you cannot wait for them to return your call, contact the emergency room at the nearest hospital and ask for the psychologist or psychiatrist on call, dial 911, or call the EMPACT crisis hotline at 480-784-1500 for assistance. In the event that a practitioner will be out of the office for an extended period of time, the voicemail greeting will provide the name(s) of the psychologist(s) covering for them, along with their contact information. Please note that your practitioner's schedule is filled in advance and may not allow for patients to be seen on an urgent basis unless there is a cancellation.

SOCIAL MEDIA POLICY

This policy outlines our office practices related to use of Social Media. Please read it to understand how we conduct ourselves on the Internet as mental health professionals and how you can expect the Practice to respond to various interactions that may occur between us on the Internet. If you have any questions about anything in this document, we encourage you to bring them up when you meet with your practitioner.

FRIENDING

The Practice and its employees do not accept friend or contact requests from current or former patients on any social networking site (Facebook, LinkedIn, Plaxo, etc). We believe that adding patients as friends or contacts on these sites can compromise your confidentiality and our respective privacy. It may also blur the boundaries of the therapeutic relationship.

FOLLOWING

The Practice and its employees may publish a blog on our website or post psychology news on Twitter. We have no expectation that you as a patient will want to follow our blog or Twitter stream. However, if you use an easily recognizable name on Twitter and we happen to notice that you've followed us there, we may briefly discuss it and its potential impact on our working relationship. Our primary concern is your privacy. If you share this concern, there are more private ways to follow us on Twitter (such as using an RSS feed or a locked Twitter list), which would eliminate your having a public link to our content. You are welcome to use your own discretion in choosing whether to follow us. Note that we will not follow you back, as we do not follow current or former patients on blogs or Twitter. Our reasoning is that we believe casual viewing of patients' online content outside of the therapy hour can create confusion in regard to whether it's being done as a part of your treatment or to satisfy our personal curiosity. In addition, viewing your online activities without your consent and without our explicit arrangement towards a specific purpose could potentially have a negative influence on our working relationship. If there are things from your online life that you wish to share with your practitioner, please bring them into your sessions where you and your practitioner can view and explore them together, during the therapy hour.

INTERACTING

Please do not use SMS (mobile phone text messaging) or messaging on Social Networking sites such as Twitter, Facebook, Plaxo or LinkedIn to contact the Practice. These sites are not secure and messages may not be read in a timely fashion. Do not use Wall postings, @replies, or other means of engaging with the Practice in public online if we have an already established patient/practitioner relationship. Engaging with the Practice in this way could compromise your confidentiality. It may also create the possibility that these exchanges become a part of your legal medical record and will need to be documented and archived in your chart. If you need to contact our office between sessions, the best way to do so is by phone. Direct email at Admin [at] SpectrumWellnessAZ [dot com] is second best for quick, administrative issues such as changing appointment times. See the email section below for more information regarding email interactions.

USE OF SEARCH ENGINES

It is NOT a regular part of our practice to search for patients on Google or Facebook or other search engines. Extremely rare exceptions *may* be made during times of crisis. If the Practice has a reason to suspect that you are in danger and you have not been in touch with us via usual means (coming to appointments, phone, or email) there *might* be an instance in which using a search engine (to find you, find someone close to you, or to check on your recent status updates) becomes necessary as part of ensuring your welfare. These are unusual situations and if the Practice ever resorts to such means, it will be fully documented and discussed with you when you and your practitioner next meet.

GOOGLE READER

The Practice or its employees do not follow current or former patients on Google Reader and do not use Google Reader to share articles. If there are things you want to share with the Practice that you feel are relevant to your treatment whether they are news items or things you have created, we encourage you to bring these items of interest into your sessions.

BUSINESS REVIEW SITES

You may find our psychology and wellness practice on sites such as Yelp, Healthgrades, Yahoo Local, Bing, Kudzu, or other places which list businesses. Some of these sites include forums in which users rate their providers and add reviews. Many of these sites comb search engines for business listings and automatically add listings regardless of whether the business has added itself to the site. If you should find the Practice on any of these sites, please know that our listing is NOT a request for a testimonial, rating, or endorsement from you as our patient.

The American Psychological Association's Ethics Code states under Principle 5.05 that it is unethical for psychologists to solicit testimonials: "Psychologists do not solicit testimonials from current therapy patients or other persons who because of their particular circumstances are vulnerable to undue influence." Of course, you have the right to express yourself on any site you wish. But due to confidentiality, the Practice cannot respond to any review on any of these sites whether it is positive or negative. We urge you to take your own privacy as seriously as we take our commitment of confidentiality to you. You should be aware that if you are using these sites to communicate indirectly with the Practice about your feelings about our work, there is a possibility that we may never see it.

If we are working together, we hope that you will bring your feelings and reactions to our work directly into the therapy process. This can be an important part of therapy, even if you decide you and your practitioner are not a good fit. None of this is meant to keep you from sharing that you are in therapy with the Practice wherever and with whomever you like. Confidentiality means that we cannot tell people that you are our patient and our Ethics Code prohibits us from requesting testimonials. But you are more than welcome to tell anyone you wish that the Practice provides you therapy or how you feel about the treatment provided to you, in any forum of your choosing.

If you do choose to write something on a business review site, we hope you will keep in mind that you may be sharing personally revealing information in a public forum. We urge you to create a pseudonym that is not linked to your regular email address or friend networks for your own privacy and protection. If you feel the Practice have done something harmful or unethical and you do not feel comfortable discussing it with your practitioner, you can always contact the Ethics Committee at the Arizona Psychological Association, or the Arizona Board of Psychologist Examiners, which oversees licensing.

LOCATION-BASED SERVICES

If you use location-based services on your mobile phone, you may wish to be aware of the privacy issues related to using these services. We do not place our practice as a check-in location on various sites such as Foursquare, Gowalla, Loopt, Facebook, etc. However, if you have GPS tracking enabled on your device, it is possible that others may surmise that you are a therapy patient due to regular check-ins at our office. Please be aware of this risk if you are intentionally "checking-in," from our office or if you have a passive LBS app enabled on your phone.

EMAIL

The Practice or its employees prefer using email only to arrange or modify appointments. Please do not email the Practice content related to your therapy sessions, as email is not completely secure or confidential. If you choose to communicate with us by email, be aware that all emails are retained in the logs of your and our Internet service providers. While it is unlikely that someone will be looking at these logs, they are, in theory, available to be read by the system administrator(s) of the Internet service provider. You should also know that any emails the Practice receive from you and any responses that we send to you become a part of your legal record.

LIMITS ON CONFIDENTIALITY

The law protects the privacy of all communications between a patient and a psychologist. In most situations, we can release information about your treatment to others only if you sign a written Authorization form that meets certain legal requirements imposed by HIPAA. There are other situations that require only that you provide written, advanced consent. Your signature on this Agreement provides consent for those activities, as follows:

- Your practitioner may occasionally find it helpful to consult with other health and mental health professionals about a case. During a consultation, your practitioner will make every effort to avoid revealing the identity of their patients. The other professionals are also legally bound to keep information confidential. If you do not object, your practitioner will not tell you about these consultations unless they feel it is important to your work together. They will note all consultations in your clinical record (which is called "PHI" in our Notice of Psychologist's policies and Practices to Protect the Privacy of Your Health Information).
- You should be aware that the Practice practices with other mental health professionals and that they may employ administrative staff. In most cases, your practitioner needs to share protected information with these individuals for both clinical and administrative purposes, such as scheduling, billing and quality assurance. All of the mental health professionals are bound by the same rules of confidentiality. All staff members are trained about protecting your privacy and have agreed not to release any information outside of the practice without the permission of a professional staff member.
- The Practice or its employees also have contacts with skilled nursing facilities and hospitals. As required by HIPAA, we have formal business associate contracts with these business, in which they promise to maintain the confidentiality of this data except as specifically allowed in the contract or otherwise required by law. If you wish, we can provide you with the names of these organizations and/or a blank copy of this contract.
- If a patient threatens to harm himself/herself, the Practice may be obligated to seek hospitalization for him/her, or to contact family members or others who can help provide protection.

There are some situations where the Practice is permitted or required to disclose information without either your consent or authorization:

- If you are in a court proceeding and a request is made for information concerning the professional services we provided you, such information is protected by the psychologist-patient privilege law.
- Any information disclosed during the course of the professional services we provide you is protected by the psychologist-patient privilege law.

In each of the above situations, the Practice cannot provide any information without your or your legal representative's written authorization, or a court order. If you are involved in or contemplating rules of confidentiality. All staff members are trained about protecting your privacy and have agreed not to release any information outside of the practice without the permission of a professional staff member.

- If a patient files a complaint or lawsuit against the Practice, we may disclose relevant information regarding that patient in order to defend ourselves.
- If a governmental agency is requesting the information for health oversight activities, the Practice may be required to provide information for it.
- If a patient files a worker's compensation claim, and the Practice is providing services related to that claim, we must, upon appropriate request, provide appropriate reports to the Workers Compensation Commission or the insurer.

There are some situations in which the Practice is legally obligated to take actions, which we believe necessary to attempt to protect others from harm, and we may have to reveal some information about a patient's treatment.

- Your practitioner is required by law to report any suspicions of child abuse to the Office of Child Protective Services.
- Your practitioner is required by law to report any suspicions of elder abuse.
- If a patient communicates an explicit threat of imminent serious physical harm to a clearly identifiable victim, and your practitioner believes that the patient has the intent and ability to carry out such a threat, they must take protective actions that may include notifying the potential victim, contacting the police, or seeking hospitalization for the patient.

If such a situation arises, your practitioner will make every effort to discuss it with you fully before taking any action, and will limit their disclosure to what is necessary. If you have any questions about the exceptions to confidentiality, please ask and we can discuss and clarify these issues.

PROFESSIONAL RECORDS

The laws and standards of our profession require that we keep Protected Health Information about you in your clinical recorded. Except in unusual circumstances that involve danger to yourself and/or others or where information has been supplied to the Practice confidentially by others, you may examine and/or receive a copy of your clinical record if you request it in writing. Because these are professional records, they can be misinterpreted an/or upsetting to untrained readers. For this reason, we recommend that you initially review them in your practitioner's presence, or have them forwarded to another mental health professional so you can discuss the content.

In addition, your practitioner may also keep a set of Psychotherapy Notes. These notes are for your practitioners own use and are designed to assist them in providing you with the best treatment. While the contents of Psychotherapy Notes vary from patient to patient, they can include the contents of your conversations during sessions as well as your practitioner clinical impressions. These notes also contain particularly sensitive information that you may reveal to your practitioner that is not required to be included in your clinical record. These Psychotherapy Notes are kept separate from your clinical record. While insurance companies can request and receive a copy of your clinical record, they cannot receive a copy of your Psychotherapy Notes without your written, signed authorization. Insurance companies cannot require your authorization as a condition of coverage nor penalize you in any way for your refusal. You may examine and/or receive a copy of your Psychotherapy Notes, thought we recommend you discuss such notes together with your practitioner.

If you are not seen at our office for a period of 90 days, your file will be closed as inactive, but you may contact us at any time if the need arises. Your treatment records and/or testing materials are maintained for a minimum of three years past a minor's 18th birthday OR for at least seven years from the date of the last visit (adult or minor), whichever is longer (See Arizona Revised Statute 12-2297). In the untimely event of death or incapacity, or the termination or selling of the practice, patient records of those who are actively receiving services (e.g. seen within the last month) will be given to one or more local behavioral health professional(s) to facilitate the continuation of treatment. In such situation, you have the right to continue treatment with this professional, discontinue treatment, or ask for referral. Records for inactive patients will be handled by a "records custodian," which may be an individual or company. The custodian will be responsible for satisfying records requests and destroying records when the legal time frames for records retention have been satisfied. Please refer to ARS 32-3211 for more information.

AUDIO TAPED RECORDS

There are times during the assessment portion of a psychological, psychoeducational, or neuropsychological evaluation where your responses may be audio recorded to assist with the accuracy of your responses and for accurate scoring of your performance on the assessments. You have the right to decline consent for this at any point. The contents of the audiotape will not be shared and will remain part of the confidential patient record that will be protected in the same manner as all other confidential records. Similarly, the storage of the audiotape will abide and adhere to the Ethical Code standards, along with appropriate statute regarding storage of patient files.

PATIENT RIGHTS

HIPAA provides you with several new or expanded rights with regard to your clinical record and disclosures of protected health information. These rights include requesting that your practitioner amend your record; requesting restrictions on what information from your clinical record is disclosed to others; requesting an accounting of most disclosures of protected health information that you have neither consented to nor authorized; determining the location to which protected health information disclosures are sent; having any complaints you make about the Practice's policies and procedures recorded in your records; and the right to a paper copy of the Agreement, the attached notice form, and our privacy policies and procedures. We are happy to discuss any of these rights with you.

MINORS AND PARENTS

Patients under 18 years of age who are not emancipated, and their parents, should be aware that the law may allow parents to examine their child's treatment records and/or testing materials. Because privacy in psychotherapy is often crucial to successful progress, particularly with teenagers, we typically request that parents respect their children's privacy. We typically provide parents with general information about the progress of the

child's treatment and general issues being addressed. Since we often conduct collateral individual and family meetings, we maintain the child's privacy during collateral family sessions as well. In situations where your practitioner hears information that leads them to suspect the child's safety is in danger, the child's confidentiality is breached and your practitioner informs the parent(s) of their concern.
As children are part of a family system, decisions about psychological, medical, and/or educational care, etc. must be made by the child's legal guardian(s), who must be physically present to provide consent, have an opportunity to be fully informed of the assessment process, be provided with an opportunity to ask questions, and in order for identity to be verified. In the event of a parental separation or divorce, both parents MUST consent, in writing, to this assessment. Both parents are invited and encouraged (as they are able) to participate in the process of assessment and treatment planning. If one parent retains sole legal custody, this parent MUST provide legal documentation of this in order for assessment to proceed. In the case of joint custody, both parents MUST consent to the assessment. Both parents, regardless of custody, have a legal right to records (see Arizona Revised Statute 25-403.06)

BILLING AND PAYMENTS

You will be able to provide payment of your choice at each time of service. However, a credit/debit card is REQUIRED to be on file for any remaining balance after your account has been processed (e.g., self-pay fees, no-show/late cancel fees). You will be expected to pay for each session at the time it is held, unless we agree otherwise. Payment schedules for other professional services will be agreed to when they are requested. In circumstances of unusual financial hardship, the Practice may be willing to negotiate a fee adjustment or payment installment plan. If your account has not been paid for more than 60 days and arrangements for payment have not been agreed upon, the Practice has the option of using legal means to secure payment. This may involve hiring a collection agency or going through small claims court which will require the Practice to disclose otherwise confidential information. In most circumstances, the information released regarding a patient's treatment is his/her name, the nature of services provided, and the amount due. If such legal action is necessary, its costs will be included in the claim.

INSURANCE REIMBURSEMENT

In order for us to set realistic treatment goals and priorities, it is important to evaluate what resources you have available to pay for your treatment. If you have a health insurance policy, it will usually provide some coverage for mental health treatment. However, Dr. Rachel Loftis does not accept insurance as payment from new patients, as she is not accepting new appointments that leverage insurance as payment. Any appointments scheduled will be billed to the patient/responsible party at the private payment rates. Claims will not be submitted to insurance by Spectrum Psychology and Wellness or Dr. Rachel Loftis for her services. The initial appointment fee is $225. Subsequent appointments have a fee of $195 per appointment. Patients are financially responsible for the entire bill, and the fees are due at the time of service. We require all patients pay at the beginning of their appointment for services scheduled.

Private payment rates will apply regardless of what insurance the patient has and regardless of what the patient's standard payment/copay/deductible payment is. Spectrum Psychology and Wellness can provide a superbill for each appointment at the request of each patient or responsible party. The patient/responsible party can submit the superbill to insurance for consideration but should not expect to receive full appointment costs as reimbursement. This information will become part of the insurance company files and will probably be stored in a computer. Though all insurance companies claim to keep such information confidential, the Practice has no control over what they do with it once it is in their hands. In some cases, they may share the information with a national medical information databank.

Knowledge of the patient's insurance policy and benefits is the responsibility of the patient/policy holder. Spectrum Psychology and Wellness cannot discuss or confirm any insurance benefits for patients submitting their claims via superbill. Spectrum Psychology and Wellness cannot discuss or confirm any out-of-network benefits.

NOTICE OF PRIVACY PRACTICES

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

Your Rights
You have the right to:
- Get a copy of your paper or electronic medical record
- Correct your paper or electronic medical record
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

Your Choices
You have some choices in the way that we use and share information as we:
- Tell family and friends about your condition
- Provide disaster relief
- Include you in a hospital directory
- Provide mental health care
- Market our services and sell your information
- Raise funds

Our Uses and Disclosures
We may use and share your information as we:
- Treat you
- Run our organization
- Bill for your services
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests
- Work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

Your Rights
When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record
- You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct your medical record
- You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications
- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will say "yes" to all reasonable requests.

Ask us to limit what we use or share
- You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.

Get a list of those with whom we've shared information
- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice
You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you
- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated
- You can complain if you feel we have violated your rights by contacting us at Spectrum Psychology and Wellness, LLC 1772 E. Boston Street Ste 105 Gilbert, AZ 85295-6242, calling 480-621-7257, or emailing at Admin [at] SpectrumWellnessAZ [dot com]. You may also contact the Ethics Committee of the Arizona Psychological Association (AzPA) for further information.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.**
- We will not retaliate against you for filing a complaint.

Your Choices
For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:
- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation
- Include your information in a hospital directory

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we never share your information unless you give us written permission:
- Marketing purposes
- Sale of your information
- Most sharing of psychotherapy notes

In the case of fundraising:
- We may contact you for fundraising efforts, but you can tell us not to contact you again.

Our Uses and Disclosures

How do we typically use or share your health information?
We typically use or share your health information in the following ways.

Treat you
We can use your health information and share it with other professionals who are treating you.
Example: A doctor treating you for an injury asks another doctor about your overall health condition.

Run our organization
We can use and share your health information to run our practice, improve your care, and contact you when necessary.
Example: We use health information about you to manage your treatment and services.

Bill for your services
We can use and share your health information to bill and get payment from health plans or other entities.
Example: We give information about you to your health insurance plan so it will pay for your services.

How else can we use or share your health information?
We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

Help with public health and safety issues
We can share health information about you for certain situations such as:
- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Do research
We can use or share your information for health research.

Comply with the law
We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests
We can share health information about you with organ procurement organizations.

Work with a medical examiner or funeral director
We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests
We can use or share health information about you:
- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions
We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities
- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

Changes to the Terms of this Notice
We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

This notice originally went into effect on August 1, 2010. Revised on September 23, 2013.

Please sign and return after reading the Psychologist-Patient Agreement and the HIPPA Notice above. Pages 5-12 are yours to keep for your reference.

1) Consent for Treatment:

- I have freely chosen to receive psychotherapy or assessment services and understand that you are free to terminate services at any time.
- I understand that during the course of diagnostic assessment or therapy that at times it is necessary to discuss material that may be upsetting in order to receive help.
- I understand that records and/or testing materials or information collected about you will be held or released in accordance with the state laws regarding confidentiality of such records.
- I understand that state and local laws require that practitioners report all cases in which there is a danger to self or others as well as any information that might be related to child or elder abuse.
- I understand that you have the following patient rights:
  - The right to be informed about various steps and activities involved in receiving treatment.
  - The right to be informed about the limits of confidentiality under federal and state laws related to the receipt of services.
  - The right to be given information in order to make informed decisions about whether to accept or refuse treatment.
  - The right to be informed in advance of charges for services.
  - The right to all available services without discrimination of race, color, sex, creed, age, handicap, marital status, or origin.
  - The right to referrals as appropriate for other behavioral health providers or other services.
  - The right to humane treatment that affords reasonable protection from harm, freedom from verbal or physical abuse, and appropriate privacy.

TREATMENT OF A MINOR

If you are consenting to receive services **for your minor child**, please select the custodial arrangement that applies to your current situation. If legal documents exist regarding custodial agreements it is required that a copy be on file with our office. ***Please bring a copy of Custody Decree to your first appointment.**

☐ Biological parents residing together.

-Consent for treatment form may be signed by one biological parent.

☐ Biological parents not residing together - - sole custody arrangement.
-*Consent for treatment form must be signed by the parent with sole custody.

☐ Biological parents not residing together - - joint custody arrangement.
-*Consent for treatment form MUST be signed by BOTH biological parents.

____ ____

Custodial Parent/Legal Guardian Signature Date Custodial Parent Signature Date

2) HIPAA Privacy Acknowledgement:

- I have received the HIPAA Privacy Notice regarding the uses and disclosures of your Protected Health Information and understand my rights and responsibilities with respect to my medical records.
- I hereby authorize Spectrum Psychology and Wellness, LLC (SP&W) to release any medical or incidental information to my referring physician or any other physicians who have been or may become involved with my care.
- I also authorize the release of information that may be necessary in the processing of any insurance claims I submit on my own.
- I also authorize the release of medical records to Spectrum Psychology and Wellness, LLC upon request.
- When expedient, I authorize the transmittal of my records by FAX. I understand that transmission by FAX, by its very nature, is not confidential.

PERSONAL REPRESENTATIVES (family members, attorneys, etc.): I hereby authorize SP&W and its Employees permission to discuss, send and/or receive medical information to/with the following individuals:

____ ____

Name Relationship to Patient Name Relationship to Patient

3) Coordination of Care:

We offer coordination of treatment as applicable with other behavioral health practitioners, primary care physicians (PCPs), and other appropriate medical practitioners involved in a member's care.

____ ____

Name of other practitioner/PCP involved in your care Phone/Fax number

☐ I hereby freely, voluntarily and without coercion, authorize SP&W to facilitate continuity and coordination of treatment with the individual listed above. I understand no medical records will be requested through this consent.

☐ I do <u>not</u> want to have information shared with my PCP/other medical or behavioral health practitioner

YOUR SIGNATURE BELOW INDICATES THAT YOU HAVE READ THIS PSYCHOLOGIST-PATIENT AGREEMENT AND YOU AGREE TO ITS TERMS AND ALSO SERVES AS AN ACKNOWLEDGEMENT THAT YOU HAVE RECEIVED THE HIPAA NOTICE FORM DESCRIBED ABOVE.

____ ____

Patient Name (please print) Patient/Custodial Parent Signature Date

1772 E Boston St #105

1772 E Boston St #105, Gilbert, AZ 85295

Directions

Save

View larger map

1772 E Boston St #105

©2016 Google - Map data ©2016 Google Terms of Use Report a map error

Spectrum Psychology and Wellness, LLC.
1772 East Boston Street, #105
Gilbert, AZ 85295

Telephone:+1 480 621 7257
FAX:+1 480 584 5825
E-mail: Admin@SpectrumWellnessAZ.com

Spectrum Psychology and Wellness, LLC
Boston Professional Village
1772 E. Boston Street Ste 105 | Gilbert, AZ 85295-6242
o: 480.621.7257 | f: 480.584.5825 | http://www.SpectrumWellnessAZ.com

TELEMEDICINE INFORMED CONSENT FORM

I ______________________________ [name of patient] hereby consent to engaging in telemedicine with ________________ [name of provider] at Spectrum Psychology and Wellness (SPW), as part of my psychotherapy. I understand that "telemedicine" includes the practice of health care delivery, diagnosis, consultation, treatment, transfer of medical data, and education using interactive audio, video, or data communications. I also understand that I will be required to verify my identity before each psychological service if the telemedicine does not involve video.

I understand that I have the following rights with respect to telemedicine: (1) I have the right to withhold or withdraw consent at any time without affecting my right to future care or treatment. (2) The laws that protect the confidentiality of my medical information also apply to telemedicine. As such, I understand that the information disclosed by me during the course of my therapy is generally confidential. However, there are both mandatory and permissive exceptions to confidentiality, including, but not limited to reporting child, elder, and dependent adult abuse; expressed threats of violence towards an ascertainable victim; and where I make my mental or emotional state an issue in a legal proceeding. (3) I understand that my healthcare information may be shared with other individuals for scheduling and billing purposes. I understand that telemedicine services will be treated with the same privacy and confidentiality as I would be afforded in a face-to-face office setting, and that should any additional persons be present during any telemedicine services other than my provider, I will be informed of their presence and thus will have the right to request the following: (A) omit specific details of my health history that are personally sensitive to me; (B) ask additional persons to leave the telehealth session; and/or (C) terminate the session at any time. (4) I understand that there are inherent confidentiality and technological risks and consequences from telemedicine, including, but not limited to, the possibility, despite reasonable efforts on the part of my psychotherapist, that: the transmission of my medical information could be disrupted or distorted by technical failures; the transmission of my medical 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 telemedicine-based services and care may not be as complete as face-to-face services. I also understand that if my psychotherapist believes I would be better served by another form of psychotherapeutic services (e.g. face-to-face services) I will be referred to a psychotherapist who can provide such services in my area. Finally, 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 psychotherapist, my condition may not improve, and in some cases may even get worse. (5) I understand that I may benefit from telemedicine, but that results cannot be guaranteed or assured. (6) I understand that I have a right to access my medical information and copies of medical records in accordance with Arizona state law. (7) I understand that any dispute arriving from telemedicine with my provider will be resolved in Arizona, and that Arizona law shall apply to all disputes.

I understand that assessing and evaluating threats and other emergencies can be more difficult when conducting telemedicine than in traditional in-person therapy. To address some of these difficulties, I understand that an emergency plan will be created before engaging in telemedicine services. I will be asked to verify the identity of the emergency contact person provided in my patient chart upon intake, who is near my location and who will be contacted in the event of a crisis or emergency to assist in addressing the situation. I understand that by listing this individual as my emergency contact, I am allowing SPW to contact them as needed during such a crisis or emergency. If the session is interrupted for any reason, such as the technological connection fails, and I am having an emergency, do not call the therapist back; instead,

call 911, the EMPACT Crisis Hotline at 480-784-1500, or go to my nearest emergency room. Call the SPW office back at 480-621-7257 after I have called or obtained emergency services. If the session is interrupted and I am not having an emergency, disconnect from the session and SPW will wait two (2) minutes and then re-contact me via the telemedicine platform on which we agreed to conduct therapy. If I am not re-contacted within two (2) minutes, then the office will attempt to reach me by the phone number I have on file.

I have read and understand the information provided above. I understand that my emergency contact person will be contacted by SPW in the event of a crisis or emergency. I understand that SPW fee policies regarding late cancellation and no-show fees still apply to telehealth services. I have discussed it with my practitioner, and all of my questions have been answered to my satisfaction. My signature below indicates my informed and willful consent to treatment.

____ ____________
Patient Signature Date

____ ____________
Custodial Parent/Legal Guardian Signature Date

Spectrum Psychology and Wellness, LLC
Boston Professional Village
1772 E. Boston Street Ste 105 | Gilbert, AZ 85295-6242
o: 480.621.7257 | f: 480.584.5825 | http://www.SpectrumWellnessAZ.com

INFORMED CONSENT FOR IN-PERSON SERVICES DURING COVID-19 OR OTHER PUBLIC HEALTH CRISES

This document contains important information about our decision (yours and mine) to resume in-person services in light of the COVID-19 or other public health crises. Please read this carefully and let me know if you have any questions. When you sign this document, it will be an official agreement between us.

Decision to Meet Face-to-Face
We have agreed to meet in person for some or all future sessions. If there is a resurgence of the pandemic or if other health concerns arise, however, I may require that we meet via telehealth. If you have concerns about meeting through telehealth, we will talk about it first and try to address any issues. You understand that, if I believe it is necessary, I may determine that we return or begin to utilize telehealth for everyone's well-being.

If you decide at any time that you would feel safer staying with, or returning to, telehealth services, I will respect that decision, as long as it is feasible and clinically appropriate. Reimbursement for telehealth services, however, is also determined by the insurance companies and applicable law, so that is an issue we may also need to discuss.

Risks of Opting for In-Person Services
You understand that by coming to the office, you are assuming the risk of exposure to the coronavirus (or other public health risk). This risk may increase if you travel by public transportation, cab, or ridesharing service.

Your Responsibility to Minimize Your Exposure
To obtain services in person, you agree to take certain precautions which will help keep everyone (you, me, and our families, [our other staff] and other patients) safer from exposure, sickness and possible death. If you do not adhere to these safeguards, it may result in our starting / returning to a telehealth arrangement.

Initial each to indicate that you understand and agree to these actions:

- You will only keep your in-person appointment if you are symptom free. ___
- You will take your temperature before coming to each appointment. If it is elevated (100 Fahrenheit or more), or if you have other symptoms of the coronavirus, you agree to cancel the appointment or proceed using telehealth. If you wish to late cancel for this reason ONLY, we won't charge you our normal late cancellation fee. However, a late cancel due to symptoms will require that any future appointments must be by telehealth until either 14 days have passed, or you are able to produce a negative COVID-19 test. ___
- You will wait in your car or outside [or in a designated safer waiting area] until no earlier than 5 minutes before our appointment time. ___
- You will wash your hands or use your personal alcohol-based hand sanitizer when you enter the building. ___
- You may use a tissue provided or other non-direct hand contact method of your choice to flip up the light switch notifying your doctor you have arrived. ___
- You will adhere to the safe distancing precautions we have set up in the waiting room and therapy room. For example, you won't move chairs or furniture.___
- It is voluntary for you and/or for your provider to wear a mask. ___
- If you choose to take off your mask at any time you understand your risk of exposure and will not hold SPW in any way responsible. ___
- You will keep a distance of 6 feet and there will be no physical contact (e.g. no shaking hands) with me [or staff]. ___
- You will try not to touch your face or eyes with your hands. If you do, you will immediately wash or sanitize your hands. ___
- If you are bringing your child, you will make sure that your child follows all of these sanitation and distancing protocols. ___
- During the course of child/adolescent therapy board games are sometimes played and drawing materials are sometimes used. Your provider will do their best to disinfect materials between uses, but the materials may not be thoroughly sanitized. If you do not want your child using these shared materials please notify your

provider. Your provider will let you know if bringing your own materials from home is appropriate to your child's treatment plan. ___

- You will take steps between appointments to minimize your exposure to COVID-19. ___
- If you have a job that exposes you to other people who are infected, you will immediately let me [and our staff] know. ___
- If your commute or other responsibilities or activities put you in close contact with others (beyond your family), you will let me [and our staff] know. ___
- If a resident of your home tests positive for the infection, you will immediately let me [and our staff] know and we will then [begin] resume treatment via telehealth.___

I may change the above precautions if additional local, state or federal orders or guidelines are published. If that happens, we will talk about any necessary changes.

Our Commitment to Minimize Exposure

Our practice has taken steps to reduce the risk of spreading the coronavirus within the office and we have posted our efforts on our website and in the office. Please let me know if you have questions about these efforts.

If You or I Are Sick

You understand that I am committed to keeping you, me, [our staff] and all of our families safe from the spread of this virus. If you show up for an appointment and I [or our office staff] believe that you have a fever or other symptoms, or believe you have been exposed, I will have to require you to leave the office immediately. We can follow up with services by telehealth as appropriate.

If I [or our staff] test positive for the coronavirus, I will notify you so that you can take appropriate precautions.

Your Confidentiality in the Case of Infection

If you have tested positive for the coronavirus, I may be required to notify local health authorities that you have been in the office. If I have to report this, I will only provide the minimum information necessary for their data collection and will not go into any details about the reason(s) for our visits. By signing this form, you are agreeing that I may do so without an additional signed release.

Informed Consent

This agreement supplements the general informed consent/business agreement that we agreed to at the start of our work together.

Your signature below shows that you agree to these terms and conditions.

____ ________________

Patient Signature Date

____ ________________

Custodial Parent/Legal Guardian Signature Date

Spectrum Psychology and Wellness, LLC
Boston Professional Village
1772 E. Boston Street Ste 105 | Gilbert, AZ 85295-6242
o: 480.621.7257 | f: 480.584.5825 | http://www.SpectrumWellnessAZ.com

Developmental and Psychosocial History Form

Child's Name:___________________________ **Age:**______________________________

School:_________________________________ **Date of Birth:** ______________________

Grade:__________________________________ **Today's Date:**______________________

Your name:______________________________ **Relationship to Child:**_______________

The information you give here about your son or daughter is important to help us work together. Please answer honestly, but if there are some questions that you would prefer not to answer at this time, simply leave them blank. We will be able to go into further detail in our session together. We appreciate your time, effort, and honesty in filling out this form.

What are your primary concerns for your child at this time?

____

____

____

____

How long has this been an issue?____

If you have concerns about your child's learning or academic achievement, please explain:

____

____

____

Has your child or family recently experienced significant stress or change (e.g. recent move, significant conflict, death of a loved one, illness of a family member, birth of a sibling, etc.)? Please explain:

____

____

____

Please list the members of the child's current household:

Names: Relationship to Child: Age:

___

___

___

___

___

Please list other relatives not living the child, i.e., biological mother or father, stepsiblings, etc.

Names: Relationship to Child: Age:

___

___

___

Family History

Biological parent's name___ DOB___

Highest educational level achieved___

Current (and past) occupation(s)___

Ethnic background___

Biological parent's name___ DOB___

Highest educational level achieved___

Current (and past) occupation(s)___

Ethnic background___

What is the relationship status of the child's biological parents (i.e. married, separated, divorced, dating, partnered, single, never in a relationship)? Please include dates if relevant:

___

___

Other family members or individuals that have helped raise your child (e.g. step-parents, grandparents, aunts/uncles, etc.)

Family member's name____ DOB__________________________

Highest educational level achieved____

Current (and past) occupation(s)____

Ethnic background____

Family member's name________________________________ DOB__________________________

Highest educational level achieved____

Current (and past) occupation(s)____

Ethnic background____

What is the relationship status of the child's other caregivers?:

____

What, if any, is your family's religious or spiritual affiliation?____

To what extent are your spiritual and/or religious beliefs important to you?

____

Please provide any information about your family's religion or culture that you feel is important for us to know.

____

____

Do any immediate or extended family members (maternal/paternal grandparents, uncles, aunts, cousins) experience any of the following problems:

___ inattentiveness ___hyperactivity ___epilepsy or seizures

___ alcoholism ___ drug abuse ___ arrests or incarceration

___ developmental disabilities ___ anxiety ___ depression

___ schizophrenia ___ bipolar disorder ___ personality issues

___ learning disabilities ___ other:____

Early Developmental History

Were there any difficulties or medical concerns with mother's pregnancy? If yes, please explain.

____

Was mother experiencing significant stress during pregnancy? If yes, please explain.

____

Did mother use any medications or substances (alcohol, drugs) during pregnancy?

____

Was child wanted by parents?____

If adopted, at what age was the child adopted?_______________________________________

Does child know of adoption?____

Was the pregnancy full term?____________ Weeks at birth:___________ Birth weight:_____________

Were there any difficulties with the child's delivery? If yes, please explain.

____

Did your child have any medical problems as an infant? If yes, please explain.

____

Approximate age child said first words_______________ age of first phrase__________________________

Were parents or pediatrician concerned about slower than normal language development?_______________

Approximate age child first sat up alone_______________ walked_____________________________

Were parents or pediatrician concerned about slower than normal motor development?_________________

Rate of development overall: ____ slow   ___normal   ___fast

Did you have any concerns about your child's temperament, development, or behavior as a young child? If yes, please explain.

____

____

Child's temperament (first years of life):

Quiet and content	0	0	0	0	0	Colicky and irritable
Very easy to feed	0	0	0	0	0	Daily feeding problems
Slept well	0	0	0	0	0	Frequent sleeping problems
Usually relaxed	0	0	0	0	0	Often restless
Underactive	0	0	0	0	0	Overactive
Cuddly, easy to hold	0	0	0	0	0	Did not enjoy cuddling
Easily calmed down	0	0	0	0	0	Hard to calm down
Cautious and careful	0	0	0	0	0	Adventurous and impulsive
Coordinated	0	0	0	0	0	Uncoordinated/clumsy
Enjoyed eye contact	0	0	0	0	0	Avoided eye contact
Liked people	0	0	0	0	0	Disliked contact with people

*please indicate where on the continuum your child falls for each characteristic

Medical History

Does your child have any chronic illnesses? ___yes ___no

Please explain.____

Has your child had any major surgeries or head injuries? ___yes ___no

Please explain.____

Please list all medications your child is currently taking, including the dose and frequency.

____

____

____

Child's current health is: ___ poor ___fair ___good ___excellent

How well does your child sleep: ___ poor ___fair ___good ___excellent

Describe any nighttime issues or concerns about sleep:

____

____

____

Mental Health History

Has your child ever participated in any form of mental health services in the past (e.g. Counseling, family therapy, psychiatry, medications, etc.)? If yes, please list provider and dates.

Dates: Provider:

____

____

____

Has your child ever been diagnosed by a psychologist, physician, or other professional?

___ yes ___no

If yes, when and what was the diagnosis?____

Has your child ever been hospitalized for mental health reasons? _____yes _____no

Please describe any unusual, traumatic, or possibly stressful events in your child's life that you think may have had an impact on his or her development or current functioning. Include incident, child's age, and comments.

____

____

____

Has your child ever been bullied or abused (physically, emotionally, or sexually)? ___yes ___no

Has your child ever been arrested or involved in any criminal activity? ___yes ___no

Has your child ever used any alcohol or recreational drug ? ___yes ___no

Are there any concerns regarding sexual behavior? ___yes ___no

Does your family have any past or current involvement with CPS? ___yes ___no

Do you have any concerns about your child's use of technology or social media? ___yes ___no

If yes, please explain.

____

____

Educational History

Please list all schools attended:

Year Grade(s) School Name

____

____

____

____

____

Do you or your child's teacher have any concerns about her or his grades or behavior in school? If yes, please explain. ____

____

Is assignment or homework completion a problem for your child? If yes, please explain.

____

____

Has your child ever been suspended or expelled from school? ____yes ___no

Has your child received special education services currently or in the past? ___yes ___no

If yes, please describe (i.e. Title 1, speech/language therapy, occupational therapy, IEP, 504 plan).

____

____

Please describe how your child gets along with peers.

___ shy ___outgoing ___has many friends

___ very popular ___ wants to run things ___afraid peers will not like him/her

___poor loser at games ___ has trouble making friends ___ feelings hurt easily

___ does not compromise ___ picks on other children ___kind

___ other:____

Please check any traits that describe your child **now:**

___sad	___happy	___leader	___follower	___moody
___friendly	___quiet	___overactive	___independent	___dependent
___sensitive	___affectionate	___fearful	___cooperative	___defiant
___lethargic	___ too responsible	___trouble sleeping	___hard to discipline	___tantrums
___aggressive	___even tempered	___prefers to be alone	___anxious	___shy

___other:____

____

Please describe your child's strengths, special talents, skill areas.

____

____

____

Thank you for taking the time to complete this form. It will help us get to know you better and allows us to spend more time talking during our first session together. When you come to your first session we will be glad to answer any questions you may have. We look forward to meeting with you and your child.

Spectrum Psychology and Wellness, LLC
Boston Professional Village
1772 E. Boston Street Ste 105 | Gilbert, AZ 85295-6242
o: 480.621.7257 | f: 480.584.5825 | http://www.SpectrumWellnessAZ.com

Provisions for Treating Children

As psychologists we recognize that families come in many configurations, and that when families seek help for their children the family can be undergoing significant stress and states of change. When caretakers bring their children in for assessment and treatment for psychological difficulties, it is preferable that both parents consent for treatment knowing that the role of the psychologist in this practice is that of the family or child therapist and not as an expert witness.

When a family is confronted by parental separation, divorce, or changes in child custody, it can be hard on everyone, particularly on the children. Therefore, it is important that therapy present a safe environment for children in which they do not have to worry about what they say in therapy will be revealed in court or used against one of their parents. In order to protect that safety, it is preferred that everyone agree that either party will not call the treatment provider as an expert witness. As therapists it is unethical to offer opinions in court regarding custody or access of the children, for that is the realm of an expert witness, not a treating clinician.

It needs to be understood that a judge may not honor this agreement and the treating psychologist may be required to be a witness, although the provider will try to prevent that from happening. If the court appoints a professional to advise about child custody, the psychologist will provide information to him/her so that the best possible decision is made. However, this will only be done so if both parties sign a release of information and the psychologist will not make any recommendations about the final decision.

In signing this agreement, I acknowledge that my child's treating psychologist has discussed with me the difference between the roles of treating clinician and expert witness, and I agree not to subpoena the clinician, nor the clinician's records for the use in litigation. I understand the boundary between treating clinician and expert witness is necessary so that the treating clinician can maintain the integrity of the therapeutic relationship.

____
Signature of Parent/Guardian   Date

____
Printed Name

____
Signature of Parent/Guardian   Date

____
Printed Name

____
Psychologist   Date