PARENT-CHILD REUNIFICATION THERAPY
POLICIES, PROCEDURES AND PATIENT CONSENT

Parent-child Reunification Therapy

Reunification therapy is to restore a relationship between a parent and child who resists or refuses participating in scheduled parent-time. It is not a health care service; it is not treating a diagnosable condition, and cannot be billed to health care insurance. The purpose of reunification therapy is to discuss and resolve the conflicts, issues, and disputes that underlie the avoidance so that regular visits and a healthy parent-child relationship can be restored.

Reunification therapy can have benefits and risks. The resist/refuse dynamic is a strategy of problem-solving by avoidance, and reunification requires resolving problems without avoidance. It requires meetings where conflicts are discussed, and can be uncomfortable. The consequences of allowing the resist/refuse dynamic to persist are well documented in research and include a loss of family and emotional support, loss of financial support, and the development of relationship skills that are associated with poor adult relationship functioning. Successful parent-child reunification restores the severed relationship and relieves the problems between the parent and child.

In order to facilitate the reunification process, the estranged children and parent must exercise parent-time. I require that I have sole authority to determine the amount and timing of parent-time visits, not to exceed that allowed by the Court Order.

Meetings

I typically begin by collecting background information about the estrangement. I do this by meeting separately with the estranged parent, the other parent, and the estranged children. Then, visits are scheduled for me to meet with the children and the estranged parent. These meetings will recur weekly until regular parent-time is restored and all parties are satisfied with the quality of the shared time. Since this is not treatment for mental illness, I do not do diagnostic evaluations, though I will gather information to understand the interpersonal and individual issues. Reunification therapy sessions are at least 60 minutes in length. Joint sessions are usually uncomfortable, at first, but usually feel less stressful as sessions progress. Once an appointment hour is scheduled, you agree to pay for it unless you provide at least 24 hours advance notice of cancellation, unless we both agree that you were unable to attend due to circumstances beyond your control.

Meetings may be by video conference. These are video sessions, via a HIPAA compliant, secure and encrypted platform. I use several platforms, and will send you a link before your appointment. You will need a computer with high-speed internet access and a webcam, and (preferably) either the Firefox or the Chrome browser. Smart phones and devices like iPads work, too. Be sure you can be in a private space where others cannot overhear either side of the discussion.

Please look over **www.apa.org/practice/guidelines/telepsychology** to learn about risks and benefits of telepsychology, and sign my telepsychology consent form before your next visit at **https://hushforms.com/chriswehl703** .

Contacting me

Due to my work schedule, I am often not immediately available by telephone. When I am unavailable, my telephone is answered by voice mail where you can leave a confidential message. I will return your call as soon as possible. If you are difficult to reach, please inform me of some times when you will be available. In the event of a mental health crisis, call the University Neuropsychiatric Institute Crisis Line at (801) 587-3000 or call 911. If I will be unavailable for an extended time, I will leave the name and phone number of a colleague who is providing coverage on my voice mail message.

Regular email is not secure as messages are stored on remote servers, so it is prudent to avoid using regular email to send any information you would not want to reveal in public. I use **secure email and texting,** to protect your privacy. This link (**https://hushforms.com/chriswehl507) which is also available on my website** will allow you to send me secure email and attach documents. If you choose to contact me via non-secure email (see letterhead or website) you are accepting those privacy risks, and accepting email as an acceptable medium for my responses, unless or until you notify me otherwise.

Text messages are useful for scheduling and other brief communications, and particularly to get my attention more quickly than email or phone calls. I use **Signal** for private and secure texting. It is free and works on iPhones and Android devices **https://signal.org**. After installed, you can text me from within Signal at 801-350-0115.

Confidentiality

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

It is often necessary to talk to the non-estranged parent in the course of reunification therapy. Your agreement for such contact is required for participating in reunification therapy, and understood by your consent below.

If attorneys or the court are involved, I will need to communicate with them, at my discretion. I may occasionally find it helpful to consult other health and mental health professionals about a case. During a consultation, I make every effort to avoid revealing the identity of the parties. The other professionals are also legally bound to keep the information confidential. I will not notify you about these anonymous consultations unless I feel that it is important to our work together.

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

I also have formal business associate contracts with Amy Lambert Billing (for billing), Office Ally (for electronic billing), Doxy.Me (secure video), ClockTree (secure video), Hushmail (secure email), Signal (secure texting), Google G Suite, Gateway EDI (for purposes of electronic billing) and with Bonneville Collections (for collecting on delinquent accounts). These contracts require business associates to maintain the confidentiality of these data except as specifically allowed in the contract or otherwise required by law. If you wish, I can provide you with a model copy of my business associate contract.

There are some situations where I am permitted or required to disclose information without either your consent or Authorization:

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

If a patient threatens to harm himself/herself, I may be obligated to seek hospitalization for him/her or to contact family members or others who can help provide protection.

If a patient files a worker's compensation claim, I must, upon appropriate request, provide a copy of the patient's record to the appropriate parties, the patient's employer, the workers' compensation insurance carrier or the Labor Commission.

There are some situations in which I am legally obligated to take actions, which I believe are necessary to attempt to protect others from harm and I may have to reveal some information about a patient's treatment. These situations are uncommon in my practice.

- **Child Abuse**: If I have reason to believe that a child has been or is likely to be subjected to incest, molestation, sexual exploitation (which includes the viewing of child pornography), sexual abuse, physical abuse, or neglect, the law requires that I immediately notify the Division of Child and Family Services or an appropriate law enforcement agency. Once such a report is filed, I may be required to provide additional information.

- **Abuse of Vulnerable Adult**: If I have reason to believe that any vulnerable adult has been the subject of abuse, neglect, abandonment or exploitation, I am required to immediately notify Adult Protective Services intake. Once such a report is filed, I may be required to provide additional information.

- **Harm to others:** If a patient communicates an actual threat of physical violence against an identifiable victim, I am required to take protective actions. These actions may include notifying the potential victim and contacting the police, and/or seeking hospitalization for the patient.

- **Communicable Disease:** If I have reason to believe that you are suspected of having or are suffering from a disease that is communicable, I am required by law to report this to the local health department.

Professional Records
I will keep notes of your visits. Since most contacts will be joint, both parties will have to agree to obtain the records.

Minors and Parents
Reunification therapy usually involves minor children. Consent for their participation is given by the parents (by signing this document), and it is understood that they often would not consent to participate if they were asked. It is common in court-involved cases for the non-estranged parent to be required to see that the minor children attend scheduled meetings.

Professional Fees
For reunification therapy, I require payment of a replenishing retainer of **$1000**, paid in proportion to the order's payment provisions. The retainer will need to be replenished at billing cycles. Any remaining balance will be returned at the conclusion of the case.

You will need to pay the amount you owe (including maintaining the retainer balance) within 15 days of receiving a statement. Dr. Wehl will charge your credit card for this amount if he has not received full payment 20 days after mailing you a statement. You agree to pay a finance charge of 18% per annum (1.5% per month) on the 30 day unpaid balance. You agree to pay $35 for checks returned unpaid by your bank or credit card charge-backs, in addition to the actual fee charged by Dr. Wehl's bank.

Work on the case will only progress when the retainer is replenished at billing cycles.

The fee for reunification therapy is **$180** per hour, and is billed, prorated, by time spent for all activities necessary to the process, including individual and joint sessions; communicating with parties by phone, email, text message, in person, or video conference; communicating with the parties' attorneys, or guardian ad litem; scheduling; reviewing records; writing requested letters or reports, consulting with other professionals and in unusual circumstances, appearing at depositions or court, including travel and waiting time. If out-of-town travel is involved, actual expenses will be added. Copying of file documents is done at 50 cents per page. Once an appointment hour is scheduled, you agree to pay for it unless you provide <u>at least 24</u> hours advance notice of cancellation unless we both agree that you were unable to attend due to circumstances beyond your control.

If you request my appearance or I am subpoenaed to testify in a hearing or deposition in this matter, you agree to pay all of my related professional time, including preparation and transportation costs, even if I am called to testify by another party. As a party, you can request the court reapportion the charges to the party who subpoenaed me. I charge **$<u>225</u>** per hour for preparation and attendance at any legal proceeding, payable in advance with the request to appear.

Insurance Reimbursement
Insurance cannot be billed for reunification therapy, as it is not a healthcare service or the treatment of a mental disorder.

Billing and Payments
I require a valid credit card on file to guarantee payment. You will be billed periodically (usually monthly) for your charges and to replenish the retainer, by the method you elect, below (e.g., mailed statement, emailed statement,

automatic charge of the credit card on file for your balance). I accept cash, check, MasterCard, Visa, Discover, American Express and the Cash app. 20 days after statements are mailed, unpaid amounts will be charged to your credit card. If both parents are splitting the costs, I will need a credit card authorization on file for each party. If a payment is not made or a credit card charge is declined, I may suspend my services. I will accept payment on behalf of a delinquent party from any source (including the other parent) to continue services. I will account for the source of payments but will not collect payments for a delinquent party if payment is made by another party. Payments can be made at https://chriswehl.com/payment/.

If your account has not been brought current for more than 60 days and arrangements for payment have not been agreed upon, I have 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 me to disclose minimal, but otherwise confidential information. In most collection situations, the only information I release regarding a patient's treatment is his/her name, the nature of services provided, and the amount due. If such legal action or collections agency is necessary, you will be charged a collection fee of 50% of the outstanding balance, plus any attorney's fees, court costs, and filing fees. You will be assessed a $15 statement fee for any month with no billable activity and an unpaid balance. You will be charged my bank fee plus $10 (currently $45) for checks returned unpaid by your bank. Scheduled appointments not cancelled at least 24 hour in advance will be charged to you (full fee at Dr. Wehl's discretion). Any refunds on funds paid via credit cards will have the credit card fees deducted from the refunded amount (currently 3%).

I have read and understand the procedures for emergencies, confidentiality, billing, payment and insurance, and I consent to reunification therapy under the conditions described. I agree to the above described terms regarding payment, charges to my credit card, interest, collections charges, charges for appointments missed or cancelled late, fees for checks returned unpaid, and payment of costs of collecting delinquent accounts.

Required credit card to be used to bring my account current and replenish the retainer if I do not pay by another means by 20 days after statements are sent. I also authorize Dr. Wehl to validate this card by making a nominal charge which will be credited to my account.

Visa Mastercard Amex Discover # _____ Exp: _____
card number

3 or 4 digit Card Security Code_____ Billing zip code for card: _____

Circle one

Yes No Do you want us to bill your credit card periodically for the amount you owe? This is the best way to keep your case progressing, as I have to stop working on your case from when I send statements until I receive payment. If you check this option I will send you an itemized statement.

Yes No Do you want to receive statements by email?

I HAVE READ THE INFORMATION IN THIS DOCUMENT AND CONSENT TO ABIDE BY ITS TERMS.

_____	_____
Client Signature	Date
_____	_____
Legal Guardian (if client is a minor)	Date
_____	_____
Financially Responsible Party (if different)	Date

ESTRANGED PARENT

Name:_____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: Mobile: _____ Email:_____

Sex:(M : F) Date of Birth: _____ Age: _____

ALIGNED PARENT

Name:_____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: Mobile: _____ Email:_____

Sex:(M : F) Date of Birth: _____ Age: _____

ESTRANGED CHILD 1

Name:_____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: Mobile: _____ Email:_____

Sex:(M : F) Date of Birth: _____ Age: _____

ESTRANGED CHILD 2

Name:_____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: Mobile: _____ Email:_____

Sex:(M : F) Date of Birth: _____ Age: _____

RESPONSIBLE PARTY IF DIFFERENT THAN ESTRANGED Parent (Statements will be sent to)
This must be the person signing fee agreement as responsible party

Name:_____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: Mobile: _____ Email:_____

Sex:(M : F) Date of Birth: _____ Age: _____

PATIENT NOTIFICATION OF PRIVACY RIGHTS

The Health Insurance Portability and Accountability Act (HIPAA) has created new patient protections surrounding the use of protected health information (PHI). Commonly referred to as the "medical records privacy law," HIPAA provides patient protections related to the electronic transmission of data (Transaction Rules), the keeping and use of patient records (Privacy Rules), and storage and access to health care records (Security Rules). HIPAA applies to all health care providers, including psychologists. Health care providers, health care agencies, and health insurance companies throughout the country are now required to provide patients a notification of their privacy rights as related to their health care records. You may have already received similar notices such as this one from your other health care providers.

As you might expect, HIPAA regulations are extremely complex and detailed. **My Notice of Psychologists' Policies and Practices to Protect the Privacy of Your Health Information** describes how mental health information about you may be used and disclosed, and how you may get access to this information. **My privacy policy is available online at www.ChrisWehl.com** at **https://chriswehl.com/hipaa-privacy-policy/**. **If you would prefer a paper document, please ask me for one.** Please read this document, as it is important for you to know what patient protections HIPAA affords you. If you have any questions about any of the matters discussed in this document, please do not hesitate to ask me for further clarification.

By law, I am required to secure your signature indicating you have received this Notice of Psychologists' Policies and Practices to Protect the Privacy of Your Health Information. Thank you for your thoughtful consideration of these matters.

I have been provided access to Dr. Wehl's Policies and Practices for protecting my health information online, or via a hard copy if so requested. I understand that it is my responsibility to read this document and to ask about anything that is unclear.

_____ Date _____

(Signature of Patient)

_____

(Printed name of Patient)