

CO-PARENTING THERAPY POLICIES, PROCEDURES AND PATIENT CONSENT

Psychological Services

Psychotherapy is not easily described in general statements. It varies depending on the personalities of the psychologist and patient, and the particular problems you are experiencing. There are many different methods I may use to deal with the problems that you hope to address. Psychotherapy is not like a medical doctor visit. Instead, it calls for a very active effort on your part. In order for the therapy to be most successful, you will have to work on things we talk about both during our sessions and at home.

Psychotherapy can have benefits and risks. Since therapy often involves discussing unpleasant aspects of your life, you may experience uncomfortable feelings like sadness, guilt, anger, frustration, loneliness, and helplessness. On the other hand, psychotherapy has also been shown to have many benefits. Therapy often leads to better relationships, solutions to specific problems, and significant reductions in feelings of distress. But there are no guarantees of what you will experience.

Co-parenting therapy is intended to improve the quality of communication and effective collaboration of divorced parents for the benefit of their children. Divorced parents often have difficulty working together, for obvious reasons. Yet, parental conflict is well known to create poorer outcomes for children, while cooperative co-parenting leads to child outcomes indistinguishable from children in intact families (see <https://chriswehl.com/high-conflict-divorce-services/parenting-after-divorce/>). I typically begin by meeting individually with each parent, to understand the issues from their perspective. I will usually meet with parties jointly, with some side communications about problem behaviors. We will discuss issues of dispute, but the focus will be on how the problems are discussed, as much as whether you can agree on a solution.

Co-parenting therapy is for co-parents who want to

- learn to discuss their children and parenting in a collaborative, respectful way,
- can avoid discussing personal grievances from the past and focus on the needs of the children,
- want to learn about parenting and co-parenting “best practices,”
- want to discuss and resolve outstanding issues, such as scheduling, school concerns, behavioral concerns,
- recognize and accept the importance of both parents in the children's lives,
- can accept that this process is about your child, not you.

If you cannot answer yes to each of these, you are not a good candidate for co-parenting therapy. You may need to do some work in individual therapy first, to get to this point. Both parents must be able to endorse these goals to begin co-parenting therapy with me.

Meetings

I typically will schedule you for sessions that meet the needs of the circumstances. 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. Co-parenting therapy sessions are at least 60 minutes in length. Joint sessions are usually uncomfortable, at first, but usually feel less stressful as sessions progress. Insurance will not cover co-parenting therapy, because it is not treating a mental disorder.

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. If you are unable to reach me and feel that you can't wait for me to return your call, call the University Neuropsychiatric Institute (801) 587-3000 and ask for the crisis service. They can reach me if I am in town. 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.

I use **secure email and texting**, to protect your privacy. This link (<https://hushforms.com/chriswehl507>) will allow you to send me secure email and attach documents. Regular Email communication is not secure, and could be read by others as messages are stored on remote servers. If you choose to contact me via 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. 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. Since co-parent therapy is about helping the co-parents, I will share information between the parties without specific consent. 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:

- I may occasionally find it helpful to consult other health and mental health professionals about a case. During a consultation, I discuss the matter anonymously, and make every effort to avoid revealing the identity of my patient. The other professionals are also legally bound to keep the information confidential. If you don't object, I will not tell you about these consultations unless I feel that it is important to our work together. I will note all consultations in your Clinical Record (which is called "PHI" in my Notice of Psychologist's Policies and Practices to Protect the Privacy of Your Health Information).
- 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 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 the permission of a professional staff member.
- 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 you are involved in a court proceeding and a request is made for information concerning the professional services I provided to you, such information is protected by the psychologist-patient privilege law. I cannot provide any information without your (or your legal representative's) written authorization, or a court order. If you are involved in or contemplating litigation, you should consult with your attorney to determine whether a court would be likely to order me to disclose information.
- If a government agency is requesting the information for health oversight activities, I am required to provide it for them.
- 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.

Professional Fees¹

For co-parenting 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.

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

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.

The fee for co-parenting 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 at least 24 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 **\$225** 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 co-parenting therapy, as it is not 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 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 charged interest of 1.5% per month on any balance over 30 days that is owed. You will be

¹ My fees change infrequently, usually every few years, and by a small percentage, but as you may be a patient for many years, this will keep fees the same for all patients. When fees change on my website, they will change on your account. My current fees can be found on the consent forms for co-parenting therapy services at www.chriswehl.com/forms.

charged \$35 for checks returned unpaid by your bank in addition to the actual fee charged by my bank. Scheduled appointments not cancelled at least 24 hour in advance will be charged to you (full fee at Dr. Wehl's discretion) and will not be billed to your insurance. Any refund of over-payment made by credit card or other means that incurs a merchant charge, will be refunded, less the merchant charge.

I have read and understand the procedures for emergencies, confidentiality, billing, payment and insurance, and I consent to co-parenting 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 # _____ 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 monthly for the amount you owe, including replenishing the retainer? If you check this option I will send you an itemized statement.

Yes No Do you want to receive statements by secure email?

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

Client Signature Date

Legal Guardian Date
(if client is a minor)

Financially Responsible Party Date
(if different)

PATIENT

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: Home _____ Work: _____ Mobile: _____

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

Person to contact in case of emergency: _____ Phone: _____

Physician: _____ Phone: _____

RESPONSIBLE PARTY IF DIFFERENT THAN PATIENT (Statements will be sent to)

This must be the person signing fee agreement as responsible party

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: Home _____ Work: _____ Mobile: _____ Email: _____

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)