POLICIES, PROCEDURES AND PATIENT CONSENT

This information is required by Utah Code 58-61-502
I am licensed as a psychologist under the name Christopher K. Wehl, Ph.D., Utah Psychologist license 115392-2501. My qualifications (educational history, professional experience) can be found at https://chriswehl.com/curriculum-vitae/. I complete continuing education of at least 48 hours during a two-year licensing cycle.

In accordance with the Psychologists Ethical Code, I will strive to:

- provide you benefits and take care to do no harm
- establish a relationship of trust and uphold professional standards of conduct
- promote accuracy, honesty, and truthfulness in the science, teaching, and practice of psychology
- exercise reasonable judgment and take precautions to ensure that my potential biases do not lead to or condone unjust practices
- respect the dignity and worth of all people, and the rights of individuals to privacy, confidentiality, and self-determination.

As such I will not

- engage in unfair discrimination based on age, gender, gender identity, race, ethnicity, culture, national origin, religion, sexual orientation, disability, socioeconomic status, or any basis proscribed by law.
- engage in sexual harassment (sexual solicitation, physical advances, or verbal or nonverbal conduct that is sexual in nature), that occurs in connection with my professional activities or roles as a psychologist.
- engage in a multiple relationship if it could reasonably be expected to impair the my objectivity, competence, or effectiveness in performing my functions as a psychologist, or otherwise risks exploitation or harm to the person with whom the professional relationship exists.
- exploit persons over whom I have supervisory, evaluative or other authority such as clients/patients, students, supervisees, research participants, and employees.
- engage in sexual intimacies with current therapy patients, or with individuals I know to be close relatives, guardians, or significant others of current patients, nor will I terminate therapy to circumvent this standard. I will not engage in sexual intimacies with former clients/patients for at least two years after cessation or termination of therapy, and then only in very exceptional circumstances.
- I will not accept as therapy patients persons with whom they have engaged in sexual intimacies.
- I will terminate therapy when it becomes reasonably clear that the patient no longer needs the service, is not likely to benefit, or is being harmed by continued service. As a patient, you are free to terminate therapy at any time, for any reason, though I prefer to have a discussion in advance. You should feel free to ask for additional information or seek a second opinion about any suggested course of treatment.

If you think I or any behavioral health provider has done any of these things, you should consider reporting it to https://services.dopl.utah.gov/s/

I comply with the APA Ethics code https://www.apa.org/ethics/code, and the Utah Psychologist Licensing Act https://le.utah.gov/xcode/Title58/Chapter61/58-61-P5.html

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.

Meetings
I typically will schedule you for one session per week. The first session is a diagnostic interview, and will usually be about 60 minutes. I will ask questions about your concerns and other questions that will allow me to determine the issues relevant to your treatment. Subsequent sessions will be between 45 and 60 minutes in length, depending on your needs. Couples and family therapy sessions are at least 60 minutes in length. 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. It is important to note that insurance companies do not provide reimbursement for missed or cancelled sessions.

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.

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. I recommend using my secure/encrypted email https://hushforms.com/chriswehl507, which is also available on my website.

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:

- 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 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 agreements with Amy Lambert Billing (for billing), Docutrac, UHIN, and Gateway EDI (for purposes of electronic billing), Zoom Pro (secure video), Doxy.Me (secure video), Hushmail (secure email), Google for G-Suite products (including secure cloud backup), Bonneville Collections (for collecting on delinquent accounts), and Columbus Secure Shredding (shedding PHI). These agreements require these outside entities to maintain the security and confidentiality of the data shared with them, 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.

- Disclosures required by health insurers or to collect overdue fees are discussed elsewhere in this Agreement.

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 licensing board 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, but include the following.

- **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. 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

To enhance the protection of your personal information, if you are using an insurance plan to partially pay for your services, I keep two types of records on you. Your ***clinical record*** contains information such as treatment plans sent to insurance companies and progress notes, along with records of consultations and signed releases of information. This record is available for your review. The other record contains my ***psychotherapy notes***. These notes often contain more sensitive information we discuss and are for my own use in your treatment. These are not available to you or to insurance companies, or anyone else without your written, signed authorization.

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 unless I decide that such access is likely to injure the child, or we agree otherwise. Parental involvement in a child's therapy is important, as is a child's freedom to talk about sensitive issues without concern that the information will be shared with their parents. **It is my policy to share general information about the progress of the child's treatment and his/her attendance at scheduled sessions.** Any other communication will require the child's verbal authorization, unless I feel that the child is in imminent danger to self or other, in which case, I will notify the parents of my concern. I do not consider drug use, sexual activity, illegal activity, truancy, etc., to constitute imminent danger. Before giving parents any information beyond general progress and attendance, I will discuss the matter with the child, if possible, and do my best to handle any objections he/she may have.

Professional Fees

My fees are as follows[1]:

- Diagnostic interview (90791) is $200.
- 45 minute psychotherapy (90834) is $125.
- 60 minute psychotherapy (90837) is $165.
- 60 minute couple or family therapy session (90847) is $165.

I charge this prorated amount for other professional services you may need. Other services include letter or report writing, telephone conversations with you or on your behalf, consulting with other professionals, preparation of records or treatment summaries, and the time spent performing any other service you may request of me. If you become involved in legal proceedings that require my participation, you will be expected to pay for all of my professional time, including preparation and transportation costs, even if I am called to testify by another party. Because of the difficulty of legal involvement, I charge $225 per hour for preparation and attendance at any legal proceeding, payable with the request to appear.

Insurance Reimbursement

If you have a health insurance policy, it will usually provide some coverage for mental health treatment if you have a psychiatric diagnosis covered by the insurer.[2] I will submit claims to your primary health plan, if you provide me with the necessary information; however, you (not your insurance company) are responsible for full payment of my fees. If you have a secondary health plan, you will be responsible to collect from them. **It is very important that**

[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 psychotherapy services at www.chriswehl.com/forms.

[2] Court related therapy (e.g., co-parent therapy, reunification therapy) cannot be billed to health insurance.

you find out exactly what mental health services your insurance policy covers, and comply with any requirements of your plan (e.g., getting preauthorization, physician referral, determining that I am on your plan's provider list, notifying me of changes in your health coverage). Be aware that some services may be deemed "non-covered" services because of diagnosis, modality of treatment, or for other reasons. **You will be responsible for payment whether or not your health plan allows the service.**

You should carefully read the section in your insurance coverage booklet that describes mental health services. If you have questions about the coverage, call your plan administrator. Of course, I will provide you with whatever information I can based on my experience and will be happy to help you in understanding the information you receive from your insurance company.

You should also be aware that your contract with your health insurance company requires that I provide it with information relevant to the services that I provide to you. I am required to provide a clinical diagnosis, dates of service, type of service, and length of service. Sometimes I am required to provide additional clinical information such as treatment plans or summaries, or copies of your entire clinical record. In such situations, I will make every effort to release only the minimum information about you that is necessary for the purpose requested. 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, I have no control over how they handle this sensitive information once it is in their hands. In some cases, they may share the information with a national medical information databank. I will provide you with a copy of any report I submit, if you request it. **By providing billing information for your health plan and signing this Agreement, you agree that I can provide requested information to your health insurance plan.**

Billing and Payments

I accept cash, check, MasterCard, Visa, Discover, American Express and the Cash app. **I require a credit card on file to guarantee payment.**

- I will send billing statements in the first or second week of the month for services provided the previous month.
- If you intend to use health insurance to partially pay for my services, we will bill you for what we expect you will owe in unmet deductibles and copayments. Once we receive payment from your insurer, we will make any adjustments based on their actual explanation of benefits. If you choose to use your health insurance, you agree to pay any amounts not covered by your health plan (e.g., copayments, unpaid deductibles, missed appointment fees, charges for non-covered services such as writing letters, completing forms, or charges for diagnoses or services not covered by your health plan).
- If you do not have health insurance or do not want me to bill your insurance I will provide you an annual **Good Faith Estimate** of the expected costs of your treatment for the remainder of the calendar year.
- Payment will be expected within 15 days of the date I mail (or securely email) a statement to you. Your credit card will be charged for amounts owed by you that are not paid within 20 days of mailing your statement.

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 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, this signed consent agreement, and the amount due. If such legal action or collections agency is necessary, you will be charged a collection fee of 50%, 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 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 overpayment 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 treatment under the conditions described. I authorize the release of information to my insurance company (if I supplied insurance billing information or a copy of my insurance card). I understand that I am ultimately responsible for the balance due, regardless of how my health insurer may respond to claims. 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 if I do not pay by another means at the time of service. I also authorize Dr. Wehl to validate this card by making a nominal charge which will be credited to my account.

Visa Mastercard Amex # _____ Expiration date _____
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? 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 (if client is a minor) **Date**

_____ _____
Financially Responsible Party (if different) **Date**

INFORMED CONSENT FOR TELEPSYCHOLOGICAL SERVICES

All services are being provided by telepsychology, so prior to starting video-conferencing services, you need to know and agree to the following:

- There are potential benefits and risks of video-conferencing, that differ from in-person sessions. People may overhear your side of the conversation. Technical problems may hamper the quality of the connection, requiring rescheduling.
- Confidentiality still applies for telepsychology services, and nobody will record the session without the permission from the others person(s).
- We agree to use the video-conferencing platform selected for our virtual sessions, and Dr. Wehl will explain how to use it. I currently use the Zoom Pro platform that is HIPAA compliant. If you haven't used Zoom on your device before, log in a few minutes early to register and install their app. This is the permanent link https://us02web.zoom.us/j/2746654454?pwd=S3c5YXRBdlFoQ3J0YURTdE1Kb25wZz09 If you lose track of it, you can always find it in the first sentence on my website, www.chriswehl.com. My website address is always in my email signature line.
- You will need to have high-speed internet and use a computer with a webcam (modern laptops have these) or a smartphone during the session.
- It is important to be in a quiet, private space that is free of distractions (including cell phone or other devices) during the session. We cannot have a session while you are the driver or passenger in a car.
- It is important to use a secure internet connection rather than public/free WIFi.
- It is important to be on time. If you need to cancel or change your tele-appointment, you must notify me in advance by phone, text or email.
- We need a back-up plan (e.g., phone number where you can be reached) to restart the session or to reschedule it, in the event of technical problems.
- We need a safety plan that includes at least one emergency contact and the closest ER to your location, in the event of a crisis situation.

- If you are not an adult, we need the permission of your parent or legal guardian (and their contact information) for you to participate in telepsychology sessions.

You should confirm with your insurance company that the video sessions will be reimbursed; if they are not reimbursed, you are responsible for full payment.

Third parties that are known to cover telepsychology visits include:

- HMHI (UNI) Behavioral Health Network
- PEHP
- Medicare
- Federal BCBS
- Most Regence plans, but you should confirm that your plan has this benefit

As your psychologist, I may determine that due to certain circumstances, telepsychology is no longer appropriate.

_____

Print Name of patient

_____ _____

Signature of patient or legal guardian **Date**

_____

Phone number to reach you in case of technical issues

_____

Name of emergency contact

_____

Phone number for emergency contact

_____

Address(s) where you will be located during telepsychology sessions

_____

Name of closest Emergency Dept to where you will be located during sessions

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:_____

INSURANCE INFORMATION **(complete only if you wish to use your health plan to help with payment)**

Primary Insurance/Health Plan: _____

Insurance Card #: _____

Health plan Address: _____

City:_____ State:_____ Zip:_____ Phone: ( )_____

Subscriber's Name _____Birth date: _____ Employer: _____

Subscriber's relationship to patient (e.g., spouse, child):_____

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 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 or Parent if minor)

_____
(Printed name of Patient)