Joseph Edwards, Psy.D. PLLC
Child, Adolescent & Family Psychology
Licensed Psychologist

The following are forms that will be emailed to you in an electronic fillable format prior to the initial appointment.

The following forms are in a pdf (portable document format) file here so that you can view the forms if you wish.

Forms to be completed at the start of treatment and/or evaluation:

- Consent for Treatment or Evaluation
- Acceptance of Financial Responsibility
- HIPPA Privacy Notice (required by federal law)
- Outpatient Treatment Contract (office policies/patient responsibilities)
- Telepsychology Informed Consent
- In-person Informed Consent during the pandemic
- Signature form for all consent forms

1300 Clear Springs Trace, Suite 7 ▪ Louisville, KY 40223-3868 ▪ 502.425.5422 ▪ Fax 502.425.5424

Joseph F. Edwards, Psy.D. PLLC
Child, Adolescent & Family Psychology
Licensed Psychologist

Consent for Treatment and/or Evaluation

I affirm that I have sole, or temporary sole, custody or I am the guardian of this minor child and the authority to authorize psychological services for my child (or self, if an adult. I give permission for Joseph F. Edwards, Psy.D. to render treatment and/or service to:

_____ including evaluation, psychotherapy, psychological assessment and/or consultation.
(Patient Name)

_____
Signature of Parent/Guardian
Or adult (18 or older)

_____
Signature of Parent/Guardian
Or adult (18 or older)

_____
Date

_____
Date

_____
Witness

_____
Witness

1300 Clear Springs Trace, Suite 7 ■ Louisville, KY 40223-3868 ■ 502.425.5422 ■ Fax 502.425.542

Joseph F. Edwards, Psy.D. PLLC
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Acceptance of Financial Responsibility

I understand that, after paying for the visit I may ask Dr. Edwards' for an insurance form (HCFA form), with the proper billing and diagnostic codes, so I may file my insurance. I understand even in using "out-of-network benefits" that in using health insurance to cover part of the cost of services rendered by Dr. Edwards, that he will likely have to disclose varying amounts of clinical information (frequently including but not limited to: demographic information, a diagnosis, treatment plan, prognosis, information about family history and participation, and updates regarding the patient's symptoms and gains or regression). I understand that payment for services rendered is expected by Dr. Edwards at the time of service. Payments are expected at the time of service, unless special arrangements are made in writing with Dr. Edwards.

Please be aware, that after repeated statements and notices have been issued (a 90 day notice, a 120 day notice and a Final notice—regarding balances for services exceeding 120 days) and a balance remains on an account that Dr. Edwards has the right to and will likely use a collection agency or attorney in order to receive reimbursement for services rendered. All necessary information will be sent to the collection agency and/or attorney including but not limited to information about responsible party—*name, address, work, and home telephone numbers, name of employer, etc.* and financial information—*about the type of service (*e.g., individual or family session, consultation charge or testing related charges), *dates of service, payments and charges.*

Notice of Privacy Policies and Practices

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

I. Uses and Disclosures for Treatment, Payment, and Health Care Operations

I may *use* or *disclose* your *protected health information* (*PHI*), for *treatment, payment, and health care operations* purposes. To help clarify these terms, here are some definitions:

- "You or your" refers to the child, parent(s), sibling(s), grandparent(s) or legal guardian involved in evaluation and/or treatment by Dr. Edwards.
- "*PHI*" refers to information in your health record that could identify you.
- *"Treatment, Payment, and Health Care Operations"*
  - *Treatment* is when I provide, coordinate or manage your health care and other services related to your health care.
  - *Payment* is when I obtain reimbursement for your healthcare. Examples of payment are when I disclose your PHI to your health insurer to obtain reimbursement for your health care or to determine eligibility or coverage.
  - *Health Care Operations* are activities that relate to the performance and operation of my practice. Examples of health care operations are quality assessment and improvement activities, business-related matters, such as audits and administrative services, and case management and care coordination.
- "*Use*" applies only to activities within my office, such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.
- "*Disclosure*" applies to activities outside of my office, such as releasing, transferring, or providing access to information about you to other parties.

II. Uses and Disclosures Requiring Authorization

I may use or disclose PHI for purposes outside of treatment, payment, or health care operations when your appropriate authorization is obtained or if a disclosure required by law as discussed below. An "*authorization*" is written permission above and beyond the general consent that permits only specific disclosures. In those instances when I am asked for information for purposes outside of treatment, payment or health care operations, I will obtain an authorization from you before releasing this information. I will also need to obtain an authorization before releasing your psychotherapy notes. *"Psychotherapy notes"* are notes I have made about our conversation during a private, group, joint, or family counseling session, which I have kept separate from the rest of your medical record. These notes are given a greater degree of protection than PHI.

You may revoke all such authorizations (of PHI or psychotherapy notes) at any time, provided each revocation is in writing. You may not revoke an authorization to the extent that (1) I have relied on that authorization; or (2) if the authorization was obtained as a condition of obtaining insurance coverage, and the law provides the insurer the right to contest the claim under the policy.

III. Uses and Disclosures with Neither Consent nor Authorization

I may use or disclose PHI without your consent or authorization in the following circumstances:

- **Child Abuse**: If I have reasonable cause to believe that a child is dependent, neglected or abused, I must report this belief to the appropriate authorities, which may include the Kentucky Cabinet for Families and

Children or its designated representative; the commonwealth's attorney or the county attorney; or local law enforcement agency or the Kentucky state police.

"*Dependent child*" means any child, other than an abused or neglected child, who is under improper care, custody, control, or guardianship that is not due to an intentional act of the parent, guardian, or person exercising custodial control or supervision of the child.

- **Adult and Domestic Abuse**: If I have reasonable cause to believe that an adult has suffered abuse, neglect, or exploitation, I must report this belief to the Kentucky Cabinet for Families and Children.

- **Health Oversight Activities**: The Kentucky Board of Examiners of Psychology may subpoena records from me relevant to its disciplinary proceedings and investigations. I may share your Protected Health Information to health oversight agencies such as federal and state Departments of Health and Human Services, Medicare/Medicaid Peer Review Organizations and/or your insurance company, for activities such as audits, investigations and inspections, compliance with civil rights laws.

- **Judicial and Administrative Proceedings**: If you are involved in a court proceeding and a request is made for information about your diagnosis and treatment and records thereof, such information is privileged under state law, and I will not release information without the written authorization of you or your personal or legally- appointed representative, or a court order. The privilege does not apply when you are being evaluated for a third party or where the evaluation is court-ordered. You will be informed in advance if this is the case.

- **Serious Threat to Health or Safety**: If you, or any family member, communicate to me an actual threat of physical violence against a clearly identified or reasonably identifiable victim or an actual threat of some specific violent act, I have a duty to notify the victim and law enforcement authorities.

- **Workers' Compensation**: If you file a claim for workers' compensation, you waive the psychotherapist-patient privilege and consent to disclosure of your health information reasonably related to your injury or disease to your employer, workers' compensation insurer, special fund, uninsured employers' fund or the administrative law judge.

- **Emergencies**: I may use or share your protected health information in an emergency treatment situation. If this happens, I will try to obtain your consent as soon as reasonably practicable. Finally, I may use or share your protected health information to an authorized public or private entity to assist in disaster relief efforts and to coordinate uses and disclosures to family or other individuals involved in your health care.

IV. Other Permitted And Required Uses and Sharing That May Be Made Without Your Consent, Authorization Or Opportunity To Object (Except as prohibited by 42CFR Part 2,Confidentiality of Alcohol and Drug Abuse Patient Records)

I may use and share your Protected Health Information. It will be limited to the requirements of the law including but not limited to the following instances:

- **Public Health**: As required by law, I may disclose your Protected Health Information to state and federal public health, or legal authorities charged with preventing or controlling disease, injury, or disability. I may share your Protected Health Information, if authorized by law, to a person who may have been exposed to a communicable disease or may be at risk of getting or spreading the disease or condition. Information will be released to avert a serious threat to health or safety. Any disclosure, however, would only be to someone authorized to receive that information pursuant to law.

- **Coroners, Funeral Directors, and Organ Donation**: I may disclose Protected Health Information to a coroner or medical examiner for identification purposes, determining cause of death or for the coroner or medical examiner to perform other duties authorized by law. I may also disclose relevant Protected Health Information to a funeral director, as authorized by law in order to permit the funeral director to carry out their duties. I may disclose such information in reasonable anticipation of death. Protected health information may be used and disclosed for cadaveric organ, eye or tissue donation purposes.

- **Law Enforcement/Legal Proceedings**: I may disclose mental health records for law enforcement purposes as required by law or in response to a valid subpoena, discovery request or other lawful process. These law enforcement purposes include (1) legal processes and otherwise required by law; (2) limited information requests for identification and location purposes; (3) pertaining to victims of a crime; (4) suspicion that death has occurred as a result of criminal conduct; (5) in the event that a crime occurs on the premises of my office; and (6) medical emergency and it is likely that a crime has occurred. Also, I may disclose information to government for national security and intelligence reasons. For example, during an FBI investigation I may release information in response to a lawful subpoena or order of the court.

- **Correctional Institution**: Should you be an inmate of a correctional institution, I may disclose to the Corrections Cabinet health information necessary for your health and the health and safety of other individuals.

- **Others Involved in your Healthcare**: Unless you object, I may disclose to a member of your family, a relative, a close friend or any other person you identify, your protected health information that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We may use or disclose protected health information to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care of your location, general condition or death.

V. Patient's Rights and Psychologist's Duties

Patient's Rights:

- *Right to Request Restrictions* –You have the right to request restrictions on certain uses and disclosures of protected health information. However, I am not required to agree to a restriction you request.

- *Right to Receive Confidential Communications by Alternative Means and at Alternative Locations* – You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations. (For example, you may not want a family member to know that you are seeing me. On your request, I will send your bills to another address.)

- *Right to Inspect and Copy* – You have the right to inspect or obtain a copy (or both) of PHI in my mental health and billing records used to make decisions about you for as long as the PHI is maintained in the record. I may deny your access to PHI under certain circumstances, but in some cases, you may have this decision reviewed. On your request, I will discuss with you the details of the request and denial process.

- *Right to Amend* – You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. I may deny your request. On your request, I will discuss with you the details of the amendment process.

- *Right to an Accounting* – You generally have the right to receive an accounting of disclosures of PHI. On your request, I will discuss with you the details of the accounting process.

- *Right to a Paper Copy* – You have the right to obtain a paper copy of the notice from me upon request, even if you have agreed to receive the notice electronically.

Psychologist's Duties:

- I am required by law to maintain the privacy of PHI and to provide you with a notice of my legal duties and privacy practices with respect to PHI.

- I reserve the right to change the privacy policies and practices described in this notice. Unless I notify you of such changes, however, I am required to abide by the terms currently in effect.

- If I revise my policies and procedures, I will provide you a copy of the revised policies and procedures directly or by mail.

- I reserve the right to change the terms of this notice and to make the new notice provisions effective for all PHI that I maintain. I will provide you with a revised notice by giving you a copy directly or by mail.

VI. Questions and Complaints

If you have questions about this notice, disagree with a decision I make about access to your records, or have other concerns about your privacy rights, you may contact
Joseph F. Edwards, Psy.D. by telephone at 502-587-7117 for further information.

If you have questions and would like additional information, you may contact:

Division of Mental Retardation: Phone # (502) 564-7700
Division of Mental Health: Phone # (502) 564-4448
Division of Substance Abuse: Phone # (502) 564-2880
Division of Administration & Financial Management: Phone # (502) 564-4860

If you believe your privacy rights have been violated, you can file a written complaint with Joseph F. Edwards, Psy.D. 101 E. Kentucky St., Louisville, KY 40203 or fax it to my attention at 502-587-7047 or with the Office of Civil Rights; US Department of Health and Human Services; 200 Independence Avenue, SW; Room 509F, HHH Building; Washington, DC 20201; or OCR Hotlines-Voice: 1-800-368-1019. There will be no retaliation for filing a complaint.

VII. Notice of Privacy Practices Availability and Effective Date

This notice will be prominently posted in my waiting room. You will be provided a hard copy at the initiation of evaluation and/or treatment.

This notice will go into effect on April 14, 2003.

Outpatient Treatment Contract

with

Joseph F. Edwards, Psy.D. PLLC

Licensed Psychologist and Health Service Provider

There are several important components to a successful treatment relationship, particularly if the experience is to be helpful. A clear understanding of what is expected, ongoing communication throughout the relationship, and adherence to treatment recommendations are *essential.* It is also important for anyone in treatment to feel informed, to be involved in decision-making, and to be an *active* participant in the process of treatment. This contract represents your acknowledgment of your commitment to this approach to treatment and an opportunity for me to overview my treatment philosophy. I request that you carefully read through this treatment contract, asking questions when you have them. If you are in agreement with this approach, acknowledge your understanding and commitment to treatment by signing the last page of this contract. I ask that you keep the first three pages of this document for future reference.

As a clinical child psychologist, I provide diagnostic evaluations, individual and family psychotherapy, psychological testing, consultation, and liaison with other professionals (providing recommendations for treatment and making referrals as indicated). I also am involved in a peer consultation group that meets on a monthly basis, which is a vehicle, in which I grow professionally, for your benefit and mine. I am a solo practitioner and not in a group practice. I do the scheduling of my own patient appointments, collecting of fees for services, and billing for my services. I earned a doctorate in clinical psychology, a doctor of psychology degree, Psy.D., from Spalding University. In addition, I completed a one-year predoctoral internship program at *McLean Hospital,* an affiliate of Harvard Medical School, and completed a one-year post-doctoral fellowship in Clinical Child/Pediatric Health Psychology at the *University of Louisville School of Medicine.* I am a *licensed clinical psychologist* with a specialty in child/adolescent psychology and a *health service provider* both in the Commonwealth of Kentucky and the State of Indiana. I am listed as a registrant on the National Register of Health Service Providers in Psychology, a member of the American Psychological Association (APA) and several divisions related to clinical, child psychology and state leadership within APA, and the Kentucky Psychological Association (KPA). As a member of these organizations, I make a strong effort to adhere to the ethical standards and practice guidelines of these organizations.

Confidentiality and Informed Consent

In general, information disclosed/communicated during the course of treatment is both confidential and protected by law. However, there are a few important exceptions, including: 1) when you (or the legal guardian of a minor) has signed an appropriate consent for the release of information; 2) if a judge issues a specific order requiring my testimony (this may occur in a child custody/visitation dispute, divorce or adoption proceeding, or in a lawsuit where mental condition is felt to be an issue; 3) statute-mandated reporting of any suspected abuse (of a child, significant other, spouse, or elder); and 4) when there is a reported or perceived threat to harm self or others; potential harm to others also requires by law that steps be taken to notify the potential victim, as well as, the police. The overall message is that I have a clear *moral, ethical and legal responsibility to prevent people from being harmed when, to the best of my professional judgment, such danger appears to exist.*

I may occasionally consult with colleagues about the service that I provide for you. The most common manner in which this would occur would be through presenting your case (without identifying information) to my peer consultation group. These mental health professionals are bound by the same laws regarding confidentiality as I am. Further, I am required to keep appropriate records for clinical and legal purposes. If you utilize third party reimbursement (insurance) I will need to provide the insurer with a clinical diagnosis and summary of treatment (some of which ask questions about treatment compliance, involvement of family members, and if other family members are receiving treatment). Some insurance companies require more detailed information than other companies require. Upon your request, I will provide you with the information that your company requires. If you have concerns about the information required, please voice your concern with me so that we can determine what information will actually be released. Upon your request, I will provide you with a treatment plan form (of your specific insurance company), which is used to gather information about the

treatment I am providing for you (so that your insurance company can review and further authorize continued sessions).

It is my professional belief that children and adolescents are entitled to confidentiality regarding the specific content of their therapy/treatment contact-this represents an important component in the development of trust and a therapeutic alliance. It is also important for parents to receive general information on how treatment is proceeding. If substantial concerns arise about a family member, I recommend that the concern(s) be addressed and resolved in the context of a family therapy session. If a parent (or family member) calls to provide me with information about the patient, please be aware that in the next therapy session, I will acknowledge that I received the phone call so that the patient is aware of the call. The exceptions to confidentiality previously described apply to children and adolescents as well.

It is important for both a child/adolescent and their parents to feel informed about the treatment process at every level, which includes therapy recommendations, diagnostic issues, education, medication issues, treatment goals and expectations, as well as prognosis. Part of this process includes discussing alternative approaches, the associated risks/benefits of treatment (or alternative treatments), an understanding that a desired treatment outcome is not guaranteed, and having an opportunity to ask questions. This supports positive communication, teamwork, improves treatment focus, minimizes confusion and helps avoid treatment disruption.

Treatment & Financial Issues

My approach to treatment involves considering a multidimensional nature of any psychological or behavioral distress. In other words, there rarely is one "reason" that explains mental, emotional or behavioral struggle. Given this, treatment frequently involves use of several different interventions and therapy formats (which may include: individual and family therapy, group therapy, parenting work, support groups, medication, use of community resources, and academic interventions). Focus on family, social, personal, school and interpersonal functioning is critical.

Your commitment to the treatment process is an essential part of good treatment and involves:

1) attending scheduled appointments consistently;
2) notifying the office in a timely fashion if you unavoidably must cancel an appointment;
3) communicating with me (and the other healthcare providers who work with you) regarding:
-any suicidal/homicidal threats or gestures, evidence of hallucinations or changes in thought processing, aggressive or self-abusive behavior, substance abuse concerns, the development of concerning *risk-taking* behavior (e.g., run away behavior), concern about possible abuse, non-adherence to treatment recommendations, misuse of medication, school suspensions, legal difficulties, or runaway behavior, a major decline in home, school, occupational, or personal functioning, a substantial change within the family (or family stressor);
4) communication about billing and insurance information, and the making of regular payments on your account as you have agreed; I reserve the right to utilize a collection agency when a balance occurs and you do not adhere to the payment plan that you agreed to;
5) inform me as quickly as possible if and when there are changes in insurance coverage (otherwise, in this day and age of managed care, sessions which go *unauthorized* will be unlikely to be reimbursed to you by your insurance company); it is the members responsibility to know if their plan requires pre-authorization and obtain such from the insurance company;
6) if you are a member of an insurance company for which I am NOT a participating provider, I ask that you pay me for the services I render and that you ask your health insurance company to reimburse you. As a courtesy, an initial claim will be filed on your behalf, and the insurance company instructed to send any reimbursement directly to you. If there is a problem with an insurance claim, I can provide you with a copy of the HCFA form so you can re-file a claim;
7) if you are a Humana member, you will be expected to make your Humana specialist co-payment at the time of service. If you have a high deductible plan, you will be expected to pay the full negotiated Humana rate at the time of service. All necessary claims will be filed on your behalf with Humana;
8) if you bring a child for treatment and sign the financial responsibility form, you are ultimately responsible for paying the charges in a timely manner (even if you are divorced and the court has mandated that your ex-spouse be responsible for the full, or a portion, of medical bills---you will need to pay for the service(s) and, then pursue reimbursement from your former spouse);

9) monitoring and/or utilizing medication as prescribed by a physician and keeping me up to date on prescription changes;
10) actively participating in the treatment involves completing homework assignments, applying new skills and insights gained through therapy sessions, openly discussing any "complications" that affect treatment, as well as, any unforeseen side-effects of treatment.

Attendance at scheduled appointments is extremely important, not only for successful treatment outcome, but also in terms of consideration of others who may have the desire to schedule appointments. Because of this, I ask that you call to reschedule appointments with as much in advance as possible. *Appointments canceled with less than 48 hours notice* will be charged ($90) which is one-half the regular hourly fee. Appointments missed ***without notification*** will be charged **full fee** ($175). After two canceled or missed appointments, discussion about this pattern will be part of the next therapy session; a pattern of such incidents will result in a review of these treatment contract expectations, and may lead to a termination of treatment, due to non-compliance. I will, however, provide you with information pertaining to other treatment options/referrals, and in the interim, should you experience a crisis, will be available to offer emergency care.

Special Fees

It is expected that payment for the session be made at the time of each session, unless special arrangements have been made in advance. If a balance accumulates, it is expected that the regular payments be made. If you encounter some special financial limitations, it is your responsibility to inform me, or my office manager, promptly so that a payment plan can be developed (this will avoid the utilization of collection procedures including an attorney and/or a collection agency). Please refer to the Fee Schedule of a listing of all my professional fees. Please be aware there is a special fee of $25 per occurrence associated with a "bad check" (to help offset additional expenses such as bank fees). Further, if a patient requests that clinical records be mailed (upon signing the appropriate release of information form) there is a 25-cent per page charge (if 15 pages or more are requested), and this will be a digital copy of the file. Special fees are charged for attending school meetings or observations ($150 per hour), and for preparing for and giving legal depositions, as well as preparation for, travel time and testimony time in legal proceedings ($450/hr). From time to time, a parent will ask that I write a special letter for an attorney, daycare, etc., there are special charges for letters of $150/letter. I do not charge for writing routine letters to pediatricians or family physicians or other doctors involved in providing care to the patient. Further, while I do not charge for routine phone calls, I do bill at my therapy rate for extended phone calls and you would be informed of such a charge and there would be mutual agreement for such a consultation.

Doctor/Patient Contact

Another important aspect of any treatment relationship is your ability to make contact with your psychologist, either in the form of scheduling initial or follow-up appointments, or through phone contact if the need arises. I am available to see appointments on a scheduled basis. I schedule my own appointments, and if I am not available you may leave me a message on my answering machine with your contact information and I will return your call to schedule an appointment. My office has an answering machine available to receive phone calls *24 hours a day, seven day's a week.* Messages may be left on the answering machine at any hour. There is emergency contact information available as an option on the answering machine. There will be occasions when I am not personally available. In such circumstances, seek evaluation at a nearby emergency room for proper assessment and care. The national suicide prevention hotline number is 1-800-273-8255. My cell phone number currently is 502.541.2764, which you may call and I have voice mail should I not be available to immediate answer your call. **As a patient you have specific *rights and responsibilities*. A list of these basic rights and responsibilities is available at the waiting room.**

Telepsychology Informed Consent

As a client receiving psychological services through telepsychology methods, I understand:

1. This service is provided by technology (including but not limited to video, phone, text, and email) and may not involve direct, face to face, communication. There are benefits and limitations to this service. I will need access to, and familiarity with, the appropriate technology to participate in the service provided. Exchange of information will not be direct and any paperwork exchanged will likely be exchanged through electronic means or through postal delivery.

2. If a need for direct, **face to face services arises**, it is my responsibility to contact providers in my area places that offer such services include: ***U of L Health - Peace Hospital*** 2020 Newburg Road Louisville, KY 40205 Phone 502.451.3330 or the ***U of L Health-Peace 24-hour Help Line*** 502.451.3333 or 800.451.3637; or ***Norton Children's Hospital*** 231 E. Chestnut St. Louisville, KY 40202 (502) 629-6000; or ***Centerstone*** **Emergency Services for Children** can be accessed by calling (502) 589-8070. These centers may be contacted to arrange a face to face appointment. *I understand that an opening may not be immediately available.*

3. I may decline any telepsychology services at any time without jeopardizing my access to future care, services, and benefits.

4. **TECH ASPECTS**--These services rely on technology, which allows for greater convenience in service delivery. There are risks in transmitting information over the internet that include, but are not limited to, breaches of confidentiality, theft of personal information, and disruption of service due to technical difficulties. Therefore, it is important to use a **secure internet connection** rather than public/free Wi-Fi. We agree to use the **video-conferencing platform DOXY** (HIPPA Compliant) selected for our virtual sessions, and the psychologist will explain how to use it. You need to use a **webcam, I-Pad or 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. Dr. Edwards I will form time-to-time reassess the appropriateness of continuing to deliver services to me through the use of technology. As your psychologist, I may determine that due to certain circumstances, telepsychology is no longer appropriate and that we should resume in-person sessions.

5. We need a backup plan, in emergencies, in the event of disruption of service, or for routine or administrative reasons, it may be necessary to communicate by other means: in the following circumstances:
a. In emergency situations b. Should service be disrupted c. For other communication

6. So that my psychologist may utilize alternative means of communication in the above circumstances, I have provided my cellular number and email, or those of my parent/guardian/other. I have also provided an emergency contact name and phone number.

If the session is interrupted for any reason, and you are having an emergency, do not call me back; instead, call 911, call the **Centerstone hotline number: Adults call** (502) 589-4313 if a child call **Child** – (502) 589-8070 or go to your nearest emergency room. Call me back after you have called or obtained emergency services. . If you do not receive a call back within two (2) minutes, then call my cellular number 502-541-2764.

7. My psychologist will respond to communications and routine messages within 48 hours or sooner within regular business days.

8. It is my responsibility to maintain privacy on the client end of communication. Insurance companies, those authorized by the client, and those permitted by law may also have access to records or communications.

9. I will take precautions to ensure that my communications are directed only to my psychologist.

10. My communications exchanged with my psychologist will be stored in the following manner as a note in my patient file, telepsychology sessions are not recorded or stored.

11. The laws and professional standards that apply to in-person psychological services also apply to telepsychology services. This document does not replace other agreements, contracts, or documentation of informed consent.

12. The person who maintains financial responsibility should confirm with your insurance company that the telehealth sessions will be reimbursed; if they are not reimbursed, they are responsible for full payment. Fees for telepsychology are the same per hour as face-to-face sessions.

13. **INFORMED TELEPSYCHOLOGICAL CONSENT:** This agreement is intended as a supplement to the general informed consent that we agreed to at the outset of our clinical work together and does not amend any of the terms of that agreement. Your signature indicates agreement with its terms and conditions.

Joseph Edwards, Psy.D. PLLC
Child, Adolescent & Family Psychology
Licensed Psychologist www.drjoeedwards.com

INFORMED CONSENT FOR IN-PERSON SERVICES DURING COVID-19 PUBLIC HEALTH CRISIS

This document contains important information about our decision (yours and mine) to resume in-person services in light of the COVID-19 public health crisis. 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 to 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, 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 cancel for this reason, I won't charge you our normal cancellation fee.
- You will wait in your car or outside until you receive a text to come in.
- You will wash your hands or use alcohol-based hand sanitizer when you enter the building.
- You will adhere to the safe distancing precautions we have set up in office—the kitchen is closed, only the restroom and testing/therapy rooms are open.
- You will wear a mask in all areas of the office (I [and my staff] will too).
- You will keep a distance of 6 feet and there will be no physical contact (e.g. no shaking hands) with me [or staff].

INFORMED CONSENT FOR IN-PERSON SERVICES DURING COVID-19 PUBLIC HEALTH CRISIS

- 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.
- You will take steps between appointments to minimize your exposure to COVID.
- If you have a job that exposes you to other people who are infected, you will immediately let me [and my 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 my staff] know.
- If a resident of your home tests positive for the infection, you will immediately let me [and my 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.

My Commitment to Minimize Exposure
My 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, [my staff] and all of our families safe from the spread of this virus. If you show up for an appointment and I [or my 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 my 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 or Parent of Minor Date

_____ _____
Psychologist Date

1300 Clear Springs Trace, Suite 7 ▪ Louisville, KY 40223-3868 ▪ 502.425.5422 ▪ Fax 502.425.5424

Office Safety Precautions in Effect during the Pandemic

My office is taking the following precautions to protect our patients and help slow the spread of the coronavirus.

- Office seating in the waiting room and in therapy/testing rooms has been arranged for appropriate physical distancing.
- My staff and I wear masks.
- My staff maintains safe distancing.
- Restroom soap dispensers are maintained and everyone is encouraged to wash their hands.
- Hand sanitizer that contains at least 60% alcohol is available in the therapy/testing rooms, the waiting room and at the reception counter.
- We schedule appointments at specific intervals to minimize the number of people in the waiting room.
- We ask all patients to wait in their cars until their appointment time.
- Credit card pads, pens and other areas that are commonly touched are thoroughly sanitized after each use.
- Physical contact is not permitted.
- Tissues and trash bins are easily accessed. Trash is disposed of on a frequent basis.
- Common areas are thoroughly disinfected at the end of each day.

Joseph Edwards, Psy.D. PLLC
Child, Adolescent & Family Psychology
Licensed Psychologist

Patient Name: _____ Date of Birth: _____

Parent/Legal Guardian Name: _____

Consent for Treatment

I affirm that I have sole, or temporary sole, custody or I am the guardian of this minor child and have the authority to authorize psychological services for my child (or self, if an adult). I give permission for Joseph F. Edwards, PsyD. to render treatment and/or services including evaluation, psychotherapy, psychological assessment and/or consultation.

_____ _____
Signature of Parent/Legal Guardian/Adult Date

_____ _____
Witness Date

I acknowledge receiving and reading a copy of each notice listed below. I have had an opportunity to ask questions, understand the information, and accept the guidelines/expectations that were presented in each.

Initial all (mandatory): **Privacy Practices/OT Contract/Financial Responsibility/Consent**

_____ Notice of Privacy Practices/HIPAA (Effective 4/2003)
Initial

_____ Outpatient Treatment Contract (Effective 05/2020)
Initial

_____ Acceptance of Financial Responsibility (Effective 01/2007)
Initial

Select one or both options (it is recommended you authorize both options whether you plan to take advantage of them, or not, to give more treatment flexibility):

_____ Consent for Telepsychology (Effective 03/2020)
Initial

_____ Consent for in-person sessions during the pandemic (05/2020)
Initial

_____ _____
Signature of Parent/Legal Guardian/Adult Date

_____ _____
Witness Date

1300 Clear Springs Trace, Suite 7 ▪ Louisville, KY 40223 ▪ 502.425.5422 ▪ Fax 502.425.5424