Robert Reiser, Ph.D.
Licensed Psychologist (PSY 9327)

TREATMENT AGEEMENT AND CONSENT TO PSYCHOLOGICAL TREATMENT

1. **CONFIDENTIALITY:** All information disclosed within your psychotherapy sessions and the written records pertaining to those sessions are confidential and may not be revealed to anyone without your written permission, except when disclosure is required by law. Most of the provisions explaining when the law requires disclosure are described in the "Notice of Privacy Practices" that you received with this form.

2. **WHEN DISCLOSURE IS REQUIRED BY LAW:** Some of the circumstances where disclosure is required by law are (1) where there is a reasonable suspicion of child, dependent or elder abuse or neglect; and, (2) where a client presents a danger to self to others, to property, or (3) is gravely disabled (for more details see also "Notice of Privacy Practices" form).

3. **WHEN DISCLOSURE MAY BE REQUIRED:** Disclosure may be required pursuant to a legal proceeding. If you place your mental status at issue in litigation initiated by you, the defendant may have the right to obtain the psychotherapy records and/or testimony by you. In couple, family therapy, or group treatment or when different family members are seen individually, confidentiality and privilege do not apply between the couple, group or among family members. I will use my clinical judgment when revealing such information. I will not release records to any outside party unless he is authorized to do so by all adult family members who were part of the treatment.

4. **CONFIDENTIALITY OF MEDICAL INFORMATION WHEN TREATING A MINOR CHILD**: Parents and legal guardians have the legal right to access confidential medical information pertaining to a minor child with a few exceptions based on state and Federal law. However, in the interests of developing trust, rapport and a good therapeutic relationship, when seeing a minor child, I prefer to use my clinical judgment in determining what types of communication should be made to parents or legal guardians. In general, I may choose to restrict releasing clinical information to parents to the following (1) general information and psychoeducation about the nature of the problem and treatment being considered, (2) discussions of immediate safety and health concerns that may jeopardize the well being of the minor, including significant risk of suicidality, dangerousness to others, or other behavior that is an immediate risk to health or safety, (3) any other information that will be beneficial to the treatment of the child.

5. **EMERGENCIES:** If there is an emergency during our work together, or in the future after termination, where I become concerned about your personal safety, the possibility of you injuring someone else, or about you receiving proper psychiatric care, I will do whatever I can within the limits of the law, to prevent you from injuring yourself or others and to ensure that you receive the proper medical care. For this purpose, I may also contact the police, hospital or the person whose name you have provided as an emergency contact or other persons previously identified by you.

6. **HEALTH INSURANCE AND CONFIDENTIALITY OF RECORDS:** Disclosure of confidential information may be required by your health insurance carrier in order to process claims. Only the minimum necessary information will be communicated to the carrier. I have no control over what insurance companies do with the information or who has access to this information. You

must be aware that submitting a mental health invoice for reimbursement carries a certain amount of risk to confidentiality, privacy, or to future eligibility to obtain health or life insurance. The risk stems from the fact that mental health information is entered into insurance companies' computers and computers are inherently vulnerable to break-ins and unauthorized access.

7. **CONFIDENTIALITY OF E-MAIL, CELL PHONE AND OTHER COMMUNICATIONS:** E-mail and cell phone communication can be accessed by unauthorized people and, hence, the privacy and confidentiality of such communication can be compromised. E-mails, in particular, are vulnerable to such unauthorized access due to the fact that servers have unlimited and direct access to all e-mails that go through them. Please notify me at the beginning of treatment if you decide to avoid or limit in any way the use of any or all of the above-mentioned communication methods. I can provide a secure, encrypted email service (Virtru) that is HIPAA compliant. Please never use e-mail or faxes to communicate with me in emergency situations.

8. **LITIGATION LIMITATION:** Due to the nature of the therapeutic process and the fact that it often involves making a full disclosure with regard to many matters which may be of a confidential nature, it is agreed that should there be legal proceedings (such as, but not limited to divorce and custody disputes, injuries, lawsuits, etc.), neither you nor your attorney, nor anyone else acting on your behalf will call on me to testify in court or at any other proceeding, nor will a disclosure of the psychotherapy records be requested.

9. **SESSION RECORDINGS AND CONSULTATION:** I routinely make recordings of my sessions and consult regularly with other professionals regarding my clients for training, supervision, and other purposes; however, your name or your identifying information is never mentioned.

10. **USE OF ONLINE TOOLS, MOBILE APPS AND VIDEOCONFERENCING**: Dr. Reiser may suggest that you use an online tool or a mobile application to record assessment related information related to your treatment. Under certain circumstances, he may suggest a meeting via video. He uses a professional version of Zoom designed to safeguard your confidentiality and to meet HIPAA security standards (e.g., encrypted data transmission). However, if you do use one of these tools, confidentiality cannot be completely guaranteed, and you agree to accept the risk that a breach of confidentiality may occur. It is also possible that that Dr. Reiser may be less helpful than usual because he will have less information than when you and he are in the same room; and, video meetings are vulnerable to interruptions and technical difficulties.

11. **TELEPHONE CONTACT & EMERGENCY PROCEDURES:** If you need to contact me between sessions, please leave a message on his business cell phone 415-297-1016 and your call will be returned as soon as possible. I check my messages a few times a day (but never during the night time). I check my messages less frequently on weekends and holidays. If an emergency situation arises, please indicate it clearly in your message. I will not be able to handle immediate emergencies that may arise during the course of treatment. If you need to talk to someone right away, you can call the Marin County Crisis Line at 499-1100, or 415 473-6666 for the 24-hour Psychiatric Emergency Service for Marin County. In Santa Clara County for the Suicide and Crisis Hotline call 1-855-278-4204 or call 911 for any life-threatening emergency.

12. **PAYMENTS AND INSURANCE REIMBURSEMENT:** Clients are expected to pay the standard

fee of $195 per 45 minute session at the beginning of each session. For our extended 90 minute initial assessment session you will be charged $390. You may make payments by check or credit card. A minimum of 72-hour notice is required for re-scheduling or canceling an appointment**.** You will be charged the full appointment fee if you cancel or reschedule without 72 hours' notice. **By signing this agreement, you also agree to provide me with an authorization to charge your credit card for any missed or cancelled appointments.** Telephone conversations, site visits, report writing and reading, consultation with other professionals, release of information, reading records, longer sessions, travel time, etc. may be charged at the same rate, unless indicated and agreed otherwise. Please let me know right away if any problem arises during the course of therapy regarding your ability to make timely payments. Clients who carry insurance should remember that professional services are rendered and charged to the client and not to the insurance company. It is your responsibility to verify the specifics of your coverage. Upon request, I will provide you with a monthly statement of services provided, which you can then submit to your insurance company for reimbursement if you so choose. Not all issues/conditions/problems, which are the focus of psychotherapy, are reimbursed by insurance companies.

13. **MEDIATION AND ARBITRATION:** All disputes arising out of or in relation to this agreement to provide psychotherapy services shall first be referred to mediation, before, and as a pre-condition of the initiation of arbitration. The mediator shall be a neutral third party chosen by mutual agreement of Dr. Reiser and his client(s). The cost of such mediation, if any, shall be split equally, unless otherwise agreed. In the event that mediation is unsuccessful, any unresolved controversy related to this agreement should be submitted to and settled by binding arbitration in Marin County in accordance with the rules of the American Arbitration Association which are in effect at the time the demand for arbitration is filed. Notwithstanding the foregoing, in the event that your account is overdue (unpaid) and there is no agreement on a payment plan, I can use legal means (court, collection agency, etc.) to obtain payment. The prevailing party in arbitration or collection proceedings shall be entitled to recover a reasonable sum for attorneys' fees. In the case of arbitration, the arbitrator will determine that sum.

14. **THE PROCESS OF THERAPY/EVALUATION:** Participation in therapy can result in a number of benefits to you, including improving interpersonal relationships and resolution of the specific concerns that led you to seek therapy. Working toward these benefits, however, requires effort on your part. Psychotherapy requires very active involvement, honesty, and openness in order to change your thoughts, feelings and/or behavior, I will ask for your feedback and views on your therapy, its progress, and other aspects of the therapy and will expect you to respond openly and honestly.

    During evaluation or therapy, remembering or talking about unpleasant events, feelings, or thoughts can result in your experiencing considerable discomfort or strong feelings of anger, sadness, worry, fear, etc. or experiencing anxiety, depression, insomnia, etc. may challenge some of your assumptions or perceptions or propose different ways of looking at, thinking about, or handling situations that can cause you to feel very upset, angry, depressed, challenged, or disappointed. Attempting to resolve issues that brought you to therapy in the first place, such as personal or interpersonal relationships, may result in changes that were not originally intended. Psychotherapy may result in decisions about changing behaviors, employment, substance use, schooling, housing, or relationships. Sometimes a decision that is positive for one family member

is viewed quite negatively by another family member. Change will sometimes be easy and swift, but more often it can be slow and even frustrating. There is no guarantee that psychotherapy will yield positive or intended results. During the course of therapy, I am likely to draw on various psychological approaches according to the problem that is being treated and his assessment of what will best benefit you. These approaches include cognitive-behavioral, behavioral, system/family, or other psycho-educational interventions.

15. **DISCUSSION OF YOUR TREATMENT PLAN:** Within a reasonable period of time after beginning treatment, I will discuss with you my working understanding of the problem, treatment plan, therapeutic objectives, and my view of the possible outcomes of treatment. If you have any unanswered questions about any of the procedures used in the course of your therapy, their possible risks and benefits, my expertise in employing them, or about the treatment plan, please feel free to ask additional questions. I will make every effort to respond to your concerns fully. You also have the right to ask about other treatments for your condition and their risks and benefits. If you could benefit from any treatment that I do not provide, I have an ethical obligation to assist you in obtaining those treatments.
16. **EVALUATION OF YOUR TREATMENT:** I am committed to evaluating the outcomes of treatment with you, and for this purpose, will ask you to complete a number of assessments of problems or symptoms at the beginning of treatment, periodically and at the end of treatment. I use a HIPAA compliant service called PsychSurveys that sends you an email notice to complete surveys to the email address you have given me. To complete these surveys you will be asked to log in to the PsychSurvey website. These surveys will be sent periodically to help me evaluate the progress of our work together.
17. **TERMINATION:** After a series of initial meetings, I will make an assessment as to whether I can be of benefit to you**.** I do not accept clients who, in my opinion, I cannot help. In such a case, I will give you a number of referrals that you can contact. If at any point during psychotherapy, I believe that I am not being effective in helping you reach your therapeutic goals, I will discuss this concern with you and, if appropriate, we may decide to terminate your treatment. I will give you referrals that may be of help to you. If at any time you want another professional's opinion or wish to consult with another therapist. You have the right to terminate therapy at any time. If you choose to do so, I will offer to provide you with names of other qualified professionals whose services you might prefer.
18. **CANCELLATION: A minimum of 72-hour notice is required for re-scheduling or canceling an appointment.** The full fee of $195 for a 45-minute session will be charged for sessions missed without such notification. Most insurance companies do not reimburse for missed sessions.

I have read the above agreement about office policies and information about psychological treatment carefully and agree.

_____

Client name (print) **Date** **Signature**

_____

Client name (print) **Date** **Signature**
(or Legal Guardian if Minor)

_____

Therapist **Date** **Signature**

POLICIES AND PRACTICES TO PROTECT THE PRIVACY OF YOUR HEALTH INFORMATION

Protecting the privacy and confidentiality of what is discussed in your meetings with me is extremely important in order for psychological treatment to be effective. This notice describes how psychological and medical information about you may be used and disclosed and how you can obtain access to this information. Please review this notice carefully and feel free to ask any questions.

Under the Health Insurance Portability and Accountability Act ("HIPAA"), which is a federal law, I am required to maintain the privacy of your protected health information and provide you with notice of our legal duties and privacy practices with respect to such protected health information.

How I May Use or Disclose Your Health Information

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

Protected Health Information refers to information in your health record that could identify you.

Treatment is when I provide, coordinate or manage your health care and other services related to your health care. An example of treatment would be when I consult with another health care provider, such as your family physician or another psychologist or psychiatrist.

Payment is when I obtain reimbursement for your health care. Examples of payment are when I disclose your protected health information 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 my activities such as 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.

The following categories describe different ways that I may use and disclose protected health information. Not every use or disclosure in a category will be listed. However, all of the ways I am permitted to use and disclose information will fall within one of these categories.

For treatment. I may use or disclose your protected health information to provide, coordinate or manage health care and treatment. An example of this would be when I consult with another health care provider, such as your family physician, or another psychologist or psychiatrist regarding your care. With your written authorization, I may also disclose information about you to other people who may be involved in your care, such as family members.

For payment. I may need to disclose protected health information about you so that treatment and services you receive from me may be billed and payment may be collected from you, an insurance company, or a third party. For example, I may need to disclose information about the services you receive from me so your health plan will pay me or reimburse you for the services. Your health plan provider may be told about a treatment you are going to receive to determine whether your plan will cover the treatment. Again, I will obtain written authorization to disclose this information.

For health care operations. I may use and disclose protected health information about you for office operations. These uses and disclosures are necessary to run my office and make sure that all clients receive quality care. For example, I may use protected health information to review its treatment and services and to evaluate the performance of the my staff in caring for you. I may combine the information with information from other clients to see where improvements can be made in the care and services I offer. In these cases, I will remove information that identifies you from this set of medical information.

Appointment reminders. I may use and disclose medical information to contact you as a reminder that you have an appointment with me. For example, a receptionist may phone you the day before your appointment as a reminder. A message may be left on your answering machine. You have the right to be contacted by another method if you prefer. However, you must inform me in writing about your preference and I must agree to that request. If I agree to your request, I am bound to abide by it.

Additional Disclosures with Neither Consent nor Authorization

I may use or disclose information related to your care without your consent or authorization in the following circumstances:

Serious Threat to Health or Safety. I may disclose your confidential information to protect you or others from a serious threat of harm by you. I may communicate relevant

information concerning this to the potential victim, appropriate family members, or law enforcement or other appropriate authorities.

Child Abuse. If I know, or have reasonable cause to suspect, that a child is abused, abandoned, or neglected by a parent, legal custodian, caregiver or other person responsible for the child's welfare, the law requires that I report such knowledge or suspicion to Marin County Child Protective Services or to an appropriate law enforcement agency.

Adult and Domestic Abuse. If I know, or have reasonable cause to suspect, that a vulnerable adult (dependent or elderly) has been or is being abused, neglected, or exploited, I am required by law to immediately report such knowledge or suspicion to Marin County Adult Protective Services or to an appropriate law enforcement agency.

Health Oversight. The California Board of Psychology has the power, when necessary, to subpoena relevant records should I be the focus of an inquiry.

Judicial or Administrative Proceedings. If you are involved in a court proceeding, and a request is made for information about the professional services that I have provided you and/or the records thereof, such information is privileged under state law, and I must not release this information without your written authorization, or a court order. This 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.

Other uses and disclosures of protected health information not covered by this notice or applicable laws will be made only with your written permission. If you provide me permission to use or disclose medical information about you, you may revoke this permission, in writing, at any time. If you revoke your permission, I will no longer use or disclose medical information about you for the reasons covered by your written authorization. You understand that I am unable to take back any disclosures I have already made with your permission, and that I am required to retain our records of the care I provide to you.

Your Rights Related to HIPAA and Protected Health Information (PHI)

As my client, you have the following rights regarding protected health information that is maintained about you.

Right to Request Restrictions. You have the right to request restrictions on certain uses and disclosures of protected health information about you. However, I am not required to agree to a restriction you request.
To request restrictions, you must make your request in writing. In your request, you must tell me 1) what information you want to limit; 2) whether you want to limit our use, disclosure, or both; and 3) to whom you want the limits to apply, for example, disclosures to your spouse.

Right to Receive Confidential Communications by Alternative Means and at Alternative Locations. You have the right to request and receive confidential communications of protected health information by alternative means and at alternative locations. (For example, you may not want a family member to know that you are being seen by me. Upon your written and approved request, messages for you can be left by another method).
To request confidential communications, you must make your request in writing. I will not ask you the reason for your request. I will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

Right to inspect and copy.
You have the right to inspect and copy protected health information that may be used to make decisions about your care as long as this information is maintained in the record.
To inspect and copy information that may be used to make decisions about you, you must submit your request in writing. If you request a copy of the information, I may charge a fee for the cost of copying, mailing, or other supplies associated with your request. I may deny your request to inspect and copy in certain limited circumstances.

Right to Amend. You have the right to request an amendment of your protected health information for as long as this information is maintained in the record. On your request, I will discuss with you the details information of the amendment process.

Right to an Accounting. You generally have the right to receive an accounting of disclosures of your protected health information for which you have neither provided consent nor authorization. On your request, I will discuss with you the details of the accounting process.
Right to a paper copy of this notice. You have a right to a paper copy of this notice.

My Responsibilities Related to HIPAA and Psychological Records

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 as required by changes in state and federal law regarding PHI. If I revise my policies and procedures, I will provide you with a written update of this.

Uses and Disclosures Requiring Authorization

I may use or disclose information from your clinical record for purposes outside of treatment, insurance, and health care operations when your appropriate authorization is obtained. 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, insurance and health care operations, I will obtain an authorization from you before releasing this information. For example if you request that I discuss an employment issue that has been created or exacerbated by psychological issues with your supervisor I will have you fill out an authorization or consent prior to 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 conversations, which are kept separate from the rest of your medical record. These notes are given an even greater degree of protection than Protected Health Information.

You may revoke all such authorizations at any time, provided each revocation is in writing. You may not revoke an authorization to the extent that (1) I have relied or acted 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.

Complaints

If you are concerned that I has violated your privacy rights, or you disagree with a I made about access to your records, please feel free to discuss your concerns with me. You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services. I will provide you with the appropriate address upon request.

_____ , _____
have received a copy of these *Policies And Practices To Protect The Privacy Of Your Health Information*.

_____
NAME Signature

_____
Date

_____
NAME Signature

_____
Date

MEDICARE OPT OUT AGREEMENT

This agreement is between Dr. Robert Reiser ("Provider"), whose principal place of business is **1036 Sir Francis Drake Blvd, Suite 13, Kentfield, CA 94904** and _____ ("Patient"), who resides at _____ and is a Medicare Part B beneficiary seeking services covered under Medicare Part B pursuant to Section 4507 of the Balanced Budget Act of 1997. The Provider has informed Patient that Provider has opted out of the Medicare program effective on _____ for a period of at least two years, and is not excluded from participating in Medicare Part B under Sections 1128, 1156, or 1892 or any other section of the Social Security Act.

Provider agrees to provide the following medical services to Patient (the "Services"): Psychotherapy and psychological counseling services

In exchange for the Services, the Patient agrees to make payments to Provider pursuant to the Fee Schedule in the Treatment Agreement. Patient also agrees, understands and expressly acknowledges the following:

1. Patient agrees not to submit a claim (or to request that Provider submit a claim) to the Medicare program with respect to the Services, even if covered by Medicare Part B.
2. Patient is not currently in an emergency or urgent health care situation.
3. Patient acknowledges that neither Medicare's fee limitations nor any other Medicare reimbursement regulations apply to charges for the Services.
4. Patient acknowledges that Medi-Gap plans will not provide payment or reimbursement for the Services because payment is not made under the Medicare program, and other supplemental insurance plans may likewise deny reimbursement.
5. Patient acknowledges that he has a right, as a Medicare beneficiary, to obtain Medicare-covered items and services from Providers and practitioners who have not opted-out of Medicare, and that the patient is not compelled to enter into private contracts that apply to other Medicare-covered services furnished by other Providers or practitioners who have not opted-out.
6. Patient agrees to be responsible, whether through insurance or otherwise, to make payment in full for the Services, and acknowledges that Provider will not submit a Medicare claim for the Services and that no Medicare reimbursement will be provided.
7. Patient understands that Medicare payment will not be made for any items or services furnished by the Provider that would have otherwise been covered by Medicare if there were no private contract and a proper Medicare claim were submitted.
8. Patient acknowledges that a copy of this contract has been made available to him.

Executed on [date] _____

by [Patient name1] _____[Patient signature1] _____

by [Patient name2] _____[Patient signature2] _____

[Provider name] _____

[Provider signature] _____