Consent for Psychological Treatment

The information form that you are about to read contains a brief description of my practice and other issues related to our work together. This treatment consent form is required by the Texas State Board of Examiners of Psychologists, so please take a moment to review the information and feel free to ask any questions you might have.

I am a licensed psychologist specializing in pediatric, child and adolescent, and family psychology. I completed my doctorate in child psychology at the University of Texas at Austin in 2006 and my pre-doctoral pediatric psychology internship in July 2006 in the Division of Child and Adolescent Psychiatry at Stanford University Medical Center. I completed my postdoctoral fellowship also in the Division of Child and Adolescent Psychiatry at Stanford University Medical Center and Lucile Packard Children Hospital at Stanford University Medical Center.

My training there was in pediatric psychology with a focus on childhood cancer, blood disorders, and neurooncology treatment and survivorship and a range of specialty pediatric services, including but not limited to solid organ and bone marrow transplant, neonatal intensive care, feeding disorders, developmental disorders, adolescent medicine, eating disorders, and gastroenterology. I also have extensive experience working with children with severe emotional and behavioral issues that are in foster care or require residential treatment and am the contract child psychologist for Helping Hand Home for Children in Austin. I currently work with children, adolescents, and their families and utilize an ecological, family-systemic, and interpersonal approach to therapy. I also conduct psychological assessments of children and adolescents.

Confidentiality

I regard the information that you share with me with the greatest respect and will not divulge any information about you to anyone without your written consent. If we are working together in a family therapy format, information will be released to no one without the written consent of all adults involved. The exceptions to this, as mandated by Texas State Law, are as follows: 1) if you are in imminent danger of harming yourself or others, 2) if you are a minor, elderly, or disabled and I suspect that you are a victim of physical or sexual abuse, or if you divulge information about such abuse, 3) if a judge orders my records, or 4) if the patient is under the age of 18 and has not been emancipated, their parents have the right to information pertaining to their child's treatment. If the child is being treated for suicide prevention, physical, sexual, or emotional abuse, or chemical dependency, however, the law requires that parents may not have access to their child's treatment record. It is my policy in such instances, however, to ask the child for permission to discuss general issues regarding their treatment with their parents.

With respect to a court order, you should know that I will do whatever I can to protect such records if you do not wish to have them submitted. And finally, I do

consult currently with my supervisor and other colleagues and specialists about my work. This pursuit of quality assurance, however, would never involve your name or identifying information through which you might be identified. If you have any questions about confidentiality issues, please feel free to discuss them with me.

Fees and Billing

My current clinical fee for a regular 60-minute individual or family psychotherapy session is $275. Longer sessions are also available and my fees prorated.

My fee for a comprehensive psychological evaluation ranges depending on the depth of assessment necessary, and dependent on diagnostic questions. The rate for each clinical hour or billable unit for evaluation is $275.

It is required that a valid credit card number be placed on file upon initiation of treatment to hold all appointments and in the event of missed appointments or delinquent fees. You will be notified in writing if the card is to be charged in the event of one of these occurrences.

Aside from psychological evaluations, letters on behalf of patients to schools and other medical professionals and any other clerical or case management activities, including phone calls to said professionals or school personnel, and provision of treatment summaries are provided at my standard fee, prorated for time spent.

Phone calls with parents and/or patients that exceed 15 minutes are billed on a prorated basis for time spent.

I often attend Admission Review and Dismissal or 504 meetings at schools to assist with interpretation of testing results or to represent a client's needs in the school setting. My clinical fee applies to my attendance of these meetings.

I am not a provider for any insurance companies. *Your health insurance providers may or may not help you pay for these charges and clients are generally encouraged to pay at the time of service and to file for insurance reimbursement.* Arrangements are occasionally made for sliding scale fees when insurance reimbursement is not feasible.

My fee for legal services is currently $475 per hour. This includes all time required for participation, including preparation, awaiting dockets, and actual court time. I request that an advanced retainer be paid to secure the time required for participation. For more information on forensic related services, please see the addendum to this form. *If parental or custodial litigation is imminent or occurring, both parents will be required to read and sign this addendum.*

Please be advised that should you miss an appointment without providing 24 hours cancellation notice, your will be charged your fee for the planned length of the missed appointment.

While every effort will be made to avoid this, delinquent accounts may be subject to action by a collection agency, in which case the agency will assess a 30% surcharge.

Telemedicine

In the event that treatment is conducted via telephone or computer, it must be recognized that while all steps will be taken to protect identity, there are limits to this beyond the control of either party. In addition, other potential risks include unclear or inadequate video imaging, disruption to the connection, or in rare circumstances, the acquisition of information may be intercepted by unauthorized persons. That said, all information from telemedicine sessions will be protected by HIPPA privacy laws. It remains the right of the patient to terminate use of telemedicine at any time.

Office Location

My office is located near the intersection of Loop 360 (Capital of Texas Highway) and Bee Cave Road, approximately one mile West of 360 on Bee Cave Road, in the Overlook at Rob Roy office complex. Suite 254 is located on the 2nd floor of the main building (you will see a number of medical offices on the ground floor). Upon exiting the elevator, continue straight, passing restrooms and a large conference room on your left. Take your first right, and my waiting room will be your first door on the right.

Emergencies

Please note that the Mental Health Deputy or the emergency room are available to you in the event of a psychiatric emergency and I am not immediately available.

I very much look forward to working with you!

The No Surprises Act Standard Notice

The purpose of this document is to let you know about your protections from unexpected medical bills. It also asks whether you would like to give up these protections and pay more for out-of-network care.

This notice indicates that this provider is not within your health plan's network. This means the provides does not have an agreement with your plan. Accordingly, getting care from this provider could cost you more.

If your plan covers the item or service you are receiving, federal law protects you from higher bills 1) when you get emergency care from out-of-network providers and facilities and 2) when an out-of-network provider treats you at an in-network hospital or ambulatory surgical center without your knowledge or consent.

If you sign this form, you may pay more because 1) you are giving up your protection under the law, 2) you m ay owe the full costs billed for items or services received, and 3) your health plan might not count any of the amount you pay towards your deductible and out-of-network limit. Contact your health plan for more information.

You should not sign this form if you did not have a choice of providers when receiving care. For example, if a doctor was assigned to you with no opportunity to make a change.

Before deciding to sign this form, you can contact your health plan to find an in-network provider or facility. If there isn't one, your health plan might work out an agreement with this provider or facility, or another one.

It is your ethical right to determine your goals for treatment and how long you would like to remain in therapy unless you are pursuing mandatory treatment.

Dr. Trapani's hourly rate is $265 per clinical hour for individual psychotherapy, family psychotherapy with or without patient, collaborative care with other providers including psychiatrists, school counselors, and other ancillary service providers. Dr. Trapani will collaborate with you throughout your treatment to determine how many sessions and/or services you may need to receive the greatest benefit based on your diagnosis and presenting clinical concerns. This estimate is the full estimated cost of these services rendered. It does not include any information about what your health plan may cover. This means the final cost of services may be different than this estimate. Contact your health plan to find out how much, if any, your plan will pay and how much you have to pay.

Questions about your rights? Contact No Surprises Help Desk at 1-800-985-3059 from 8 am to 8 pm EST, 7 days a week, or submit a complaint online at https://www.cms.gov/nosurprises/consumers

Signatures

I have read and understand the policies described above.

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Signature of Patient or Guardian Date: ______________________

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Signature of Second Patient or Guardian, if applicable Date: ____________________

Patient Information

Patient Name: ____

Patient's Date of Birth: _____________________________________

Patient's Parent(s) or Guardian(s): _____________________________

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Patient's Address: ____

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Secondary Address (if applicable: _________________________

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Parent or Guardian Contact Information:

Telephone (Mother): ____

Telephone: (Father) ____

Email Address (Mother): ____

Email Address (Father): ____

Collateral Information

My practice model is of a collaborative nature and included contact with a child's teachers, school counselors, and other professionals, such as pediatricians and psychiatrists, as is appropriate. As aforementioned, contact with these professionals and other correspondence, such as letters and treatment reports, are billed at the hourly or prorated hourly rate. Please provide the following information as it applies to your child and or/family.

Pediatrician or Primary Care Physician: ______________________________________

Pediatrician Contact Number: ____

Child's School: ____

School Contact Number: ____

School Counselor (if known or involved): ___________________________________

Psychiatrist (as applies): ____

Psychiatrist Contact Number: ____

Other Medical Specialists: ____

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Any Other Relevant Parties: ____

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*Provision for Serving as a Child Psychologist for Litigating Parents or Families

When separating or divorcing parents , who are involved in litigation, bring their child for treatment, a special risk situation exists regarding the child's therapy. Specifically, if the psychologist is asked to participate in any way in the litigation, the therapy may be seriously compromised. Effective child psychotherapy is best accomplished when *both* parents have a good relationship with the psychologist. Information that the psychologist provides the court is likely to benefit one parent at the expense of the other. The parent whose position has been weakened by this information cannot but harbor animosity toward the psychologist, and such feelings toward the therapist is likely to compromise significantly the child's treatment. In order to prevent such deterioration of the child's therapy, it is crucial that I have every reassurance that there will be absolutely no involvement on my part in the litigation between parents. This is best accomplished by both parents signing this statement.

> We wish to enlist Dr. Jennifer N. Trapani's services in the treatment of our child. We recognize that such treatment will be compromised if information revealed therein may subsequently be brought to the attention of the court in the course of litigation.
>
> Accordingly, we mutually pledge that we will neither individually not jointly involve Dr Trapani in any way in our litigation. We will neither request nor require that Dr. Trapani provide testimony in court, either as an advocate or as an impartial. We ill neither request nor require that Dr. Trapani provide written reports of the treatment because such documents might ultimately be used in the litigation. We will not permit Dr. Trapani to communicate with either of our attorneys in any manner, either verbally or in written form. In short, we will strictly refrain from involving Dr. Trapani in any litigation, in any whatsoever, either directly or indirectly.
>
> If the services of a mental health professional are considered desirable for the purposes of litigation, either as an advocate or an impartial, the services of another person other than Dr. Jennifer N. Trapani will be enlisted.

We have read the above, discussed these provisions with our attorneys, and agree to proceed with treatment.

____ ____________________

Signature of Parent or Guardian Date

____ ____________________

Signature of Parent or Guardian Date

Credit Card Information

Dr. Trapani requires that a valid credit card number be placed on file upon initiation of treatment to hold all appointments and in the event of missed appointments or delinquent fees. You will be notified in writing if the card is to be charged in the event of one of these occurrences.

If you would like to have sessions charged by card on file, please note a 4% upcharge will be applied.

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Printed Card Holder's Name

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Credit Card Type (Visa, Master Card, American Express, etc.)

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Credit Card Number

_______________ _______________

Expiration Date CV Code

____

Billing Address

I understand that in the event of a missed appointment or outstanding and delinquent fees, this card will be charged for those fees unless other payment arrangements have been made.

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Card Holder's Signature