Candy Katoa, Psy.D.
Clinical Psychologist
CA PSY 24477

OUTPATIENT SERVICES DISCLOSURE STATEMENT AND CONTRACT

Welcome to my practice. This document contains important information about my professional services and business policies. Please read it carefully and we can discuss any questions you have at our next meeting. If you decide to begin treatment with me, I will ask you to sign this form, which will represent an agreement between us.

PSYCHOLOGICAL SERVICES

Psychotherapy varies depending on the particular problems you bring to treatment and the theoretical approach practiced by the psychologist. Therefore, it is important that you take care in selecting a therapist that fits your style and treatment goals. Our first few sessions will involve an evaluation of your presenting problems, concerns, and needs. We will also discuss your health history, how your problems affect different areas of your life, and your hopes for change. By the end of the evaluation I will offer you my clinical impressions and treatment recommendations. At this time, I will also assess whether I have the skills and expertise to be of benefit to you. I do not accept patients who I believe I cannot be helpful to, and if this is the case, I can provide you with other provider referrals. Please note that I do not provide custody evaluations, medication or prescription recommendations, and legal advice, as these activities are outside my scope of practice.

Because therapy involves a commitment of time, energy, and money, it is also important that you feel comfortable in working with me. I work collaboratively with my patients and will help you evaluate your progress throughout treatment. The length of treatment can vary based on the nature of your presenting problem, your motivation for change, and the treatment approach we select. Therapy requires a very active effort on your part. To be successful, you will also need to work outside of session on the things we discuss. If you have any questions or concerns about our work, please bring it up in session so we can discuss them together.

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. It may be difficult to bring up feelings or thoughts that you have tried not to think about for a long time. It may be scary to make changes in your beliefs or behaviors. On the other hand, psychotherapy has also been shown to have benefits for people who go through with it. Therapy can lead to significant reductions in feelings of distress, increased functioning, and solutions to specific problems. But there are no guarantees of what you will experience.

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MEETINGS

The initial evaluation is 50 minutes in duration. Therapy appointments are 45 minutes in duration. I typically offer my patients one 45-minute session per week at a time we agree on, although some sessions may be more or less frequent as needed. Because the success of therapy depends on the regularity and continuity of our meetings, the expectation is that we will meet regularly at the time that we agree on. It is also your responsibility to come to your appointments on time. Your sessions will need to end on time, even if you arrive late.

ENDING THERAPY

Your participation in therapy is voluntary and you may discontinue at any time. Deciding when to stop our work together is meant to be a mutual process. Therefore, when possible, I encourage you to make this decision in collaboration with me. Psychologists are ethically required to continue therapeutic relationships only so long as it is reasonably clear that patients are benefiting from the relationship. If at any time, I believe that you need additional treatment or that I can no longer be of help to you, I will discuss this with you. My hope is that we can prepare for therapy termination well before your last session, so that we have time to bring sufficient closure to our work together.

If you engage in behaviors that threaten my safety (directly or indirectly), that harass me (verbally, physically, or electronically), or if you harass or threaten the safety of my office, colleagues, patients, or family, I reserve the right to terminate your treatment unilaterally and immediately.

CANCELLATIONS AND MISSED APPOINTMENTS

Scheduling an appointment involves the reservation of time specifically for you. **If you wish to cancel a scheduled appointment, please let me know at least 24 hours in advance, in order to avoid being billed for the session.** If you provide less than 24 hours' notice, you will be expected to pay the full fee for the missed session.

On the rare occasion that I'm out sick or need to reschedule our appointment, I will also give you as much notice as possible. I typically take a few weeks off each year and will let you know of these absences well before they occur.

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PROFESSIONAL FEES

The fee for a 50-minute initial evaluation is $350.00. The fee for a 45-minute individual therapy session is $275.00. Longer sessions can be arranged, if desired, for a prorated amount. In addition to weekly appointments, it is my practice to charge the same fee for other professional services you may need, such as report writing, records review, release of information, my attendance at meetings or consultations that you request. Phone consultations of five minutes or less are free. However, if we spend more than five minutes in a week on the phone, of if you leave more than five minutes' worth of phone messages in a week, you will also be billed for that time. These services will be billed in quarter-hour intervals based on my regular rate. Fees may increase yearly in January. You will be notified of any fee increase by November before they occur.

If you become involved in legal proceedings that require my participation, you will be expected to pay for my professional time, even if I am called to testify by another party. Because of the difficulty of legal involvement and the disruption to my regular practice, I charge the rate of $400.00 per hour for time spent traveling, preparing records, testifying, being in attendance at legal proceedings, along with any other case-related costs.

BILLING AND PAYMENTS

You will be expected to pay for each session at the time it is held. Payment is generally collected at the beginning of each session. Payment can be made with cash, check, electronic transfer (Zelle), or credit card (visa, master, or discover). Please make checks payable to Candy Katoa. Checks that are returned to my office are subject to an additional fee of up to $25.00 to cover the bank fee incurred. If your financial situation changes such that it affects your ability to make payments, please let me know as soon as possible so we can make other arrangements. Failure or refusal to pay for services can result in the use of an attorney or collection agency to obtain payment. If such legal action is necessary, its costs will be included in the claim. In most collection situations, the only information I release regarding a patient's treatment is his/her name, the nature of services provided, and the amount due.

INSURANCE REIMBURSEMENT

I do not accept insurance for payment. However, certain insurance plans offer some coverage for mental health treatment with out-of-network providers. This usually occurs as reimbursement for fees you have already paid for clinical services. It is your responsibility to talk to your insurance to find out the specifics of your coverage. I can provide you with a monthly billing statement, if you wish to

submit that to your insurance later for reimbursement. Please remember that my services are provided and charged to you, not to your insurance company. Therefore, it is your responsibility to provide payment at each session before submitting this information to your insurance company. Lastly, most insurance companies do not reimburse fees for missed sessions.

CONTACTING ME

The best way to contact me is by phone at (415) 813-4085. Although I am often not immediately available by phone, I check my voicemail regularly. With the exception of weekends and holidays, I will make every effort to return your call within 24 hours. If you have an emergency requiring immediate attention and you cannot wait for me to return your call, please call 911 or go to your nearest emergency room.

You can also email me at candykatoa.psyd@gmail.com. While I make every effort to preserve your privacy, it is important to note that your privacy cannot be absolutely guaranteed with electronic communications. Email can be relatively easily accessed by unauthorized people and can compromise the security and confidentiality of contained information. Furthermore, any emails I receive from you and the responses I send back will become part of your medical record. The decision of whether to have any email contact with me is up to you. Email can be useful for scheduling purposes or for exchanging information on resources. However**,** please do not use email to convey any personal information or thoughts related to therapy sessions. You can bring those thoughts to session and we can talk about them there. Please do not email me if you are in crisis. I generally respond to email within 1 business day. Please mark your email preference below.

____ I DO NOT agree to any contact via e-mail.
____ I DO agree to contact via e-mail for the following purposes:
Scheduling, providing access to resources (receiving links, PDF handouts, etc)

My preferred e-mail address is: _____

Signature: _____

SOCIAL NETWORKING AND WEBSITES

I do not engage in relationships via social media networks (Facebook, Twitter, LinkedIn, etc.) with current or former patients. I believe any interactions on these sites can compromise your confidentiality and our respective privacy. It may also blur the boundaries of our therapeutic

relationship. If you have questions about this, please bring them up when we meet and we can talk more about it.

PROFESSIONAL RECORDS

The laws and standards of my profession require that I keep appropriate records of the psychological services that I provide. I keep records noting that you were here, your reasons for seeking therapy, the goals and progress we set for treatment, your diagnosis, topics we discussed, along with your medical, social, and treatment history. You are entitled to receive a copy of your records, or I can prepare a summary for you instead. Because these are professional records, they can be misinterpreted and/or upsetting to untrained readers. For this reason, I recommend that you review them in my presence so that we can discuss the contents.

CONFIDENTIALITY

In general, law protects the privacy of all communications between a patient and a psychologist, and I can only release information about our work to others with your written permission. But there are a few exceptions.

- **In Legal Proceedings…** Although I will make every effort to safeguard your privacy, your records may be subpoenaed by a court of law. In most legal proceedings, you may have the right to restrict access to information about your treatment. In some proceedings, such as those involving child custody and those in which your emotional condition is an important issue, it is possible that a judge may order that my records and/or testimony be released. Confidentiality may also be limited by other situations in which the law requires or directs that confidentiality does not apply.
- **To Protect You…** If I have reason to believe you are at risk for injuring or killing yourself, I am legally and ethically required to work with you to prevent this from occurring. This may range from developing and agreeing to a "no harm" contract, contacting family members or others who can help provide protection, arranging for hospitalization with your consent, or in the event of an emergency, facilitating involuntary hospitalization.
- **To Protect the Public…** In certain situations, I am also legally obligated to take action to protect others from harm, even if this requires that I reveal some limited information about a client's treatment. For example, if I believe that a child, older adult (age 65 or older), or a dependent adult is being neglected or abused, I must file an immediate report with the appropriate county or state agency. If I believe that a client is threatening serious bodily harm towards another individual, I am also legally and ethically required to take preventative and protective actions. These actions may

include notifying the potential victim, contacting the police, or seeking hospitalization for the patient.

- **In Professional Consultation…** I may occasionally find it helpful to consult other professionals about a case. During a consultation, I make every effort to avoid revealing the identity of my patient. The consultant is 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.

While this written summary of exceptions to confidentiality should prove helpful in informing you about potential problems, it is important that we discuss any questions or concerns that you may have at our next meeting. I will be happy to discuss these issues with you if you need specific advice.

COMPLAINTS

If you are unhappy with what is happening in therapy, or have a concern or complaint about your treatment, please talk about it with me so I can respond to your concerns. Your comments will be taken seriously and handled with care and respect. If you continue to feel dissatisfied, you may file a complaint by contacting the Board of Psychology at: Board of Psychology. 1625 North Market Street, Suite N-215, Sacramento, CA 95834. 1-866-503-3221.

OTHER RIGHTS

You have the right to considerate, safe and respectful care, without discrimination to race, ethnicity, color, gender, sexual orientation, age, religion, or national origin. You have the right to ask questions about any aspects of therapy and about my specific training and experience. You have the right to expect that I will not have social, sexual, or business relationships with my patients or former patients.

CONSENT TO THERAPY

My signature below indicates that I have read and understand the information in this document and agree to abide by its terms.

_____ _____

Patient's Printed Name Date

_____

Patient's Signature

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VERIFICATION OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have read a copy of Dr. Candy Katoa's Notice of Privacy Practices of the Health Insurance Portability and Accountability Act (HIPAA), and agree to its terms.

_____ _____

Patient's Printed Name Date

_____

Patient's Signature

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Teletherapy Informed Consent

I _____ hereby consent to engage in teletherapy (e.g., internet or telephone based therapy) with Dr. Candy Katoa. I understand that teletherapy includes the practice of mental health care delivery, diagnosis, consultation, treatment, transfer of medical data, and education using interactive audio, video, and/or data communications.

I understand that I have the following rights with respect to teletherapy:

1. I have the right to withhold or withdraw consent at any time without affecting my right to future care or treatment.

2. The laws that protect the confidentiality of my medical information also apply to teletherapy. As such, I understand that the information disclosed by me during the course of my therapy is generally confidential. However, there are both mandatory and permissive exceptions to confidentiality including, but not limited to: reporting child, elder, and dependent adult abuse; suicidality or imminent danger to myself; expressed threats of violence towards an ascertainable victim; and where I make my mental or emotional state an issue in a legal proceeding. (See also Office Policies and HIPAA Notice of Privacy Practices forms, provided to me, for more details of confidentiality and other issues.)

I also understand that the dissemination of any personally identifiable images or information from the teletherapy interaction to researchers or other entities shall not occur without my written consent.

3. I understand that there are risks and consequences from teletherapy. These may include, but are not limited to, the possibility, despite reasonable efforts on the part of my provider, that: the transmission of my medical information could be disrupted or distorted by technical failures; the transmission of my medical information could be interrupted by unauthorized persons; the electronic storage of my medical information could be accessed by unauthorized persons and/or misunderstandings can more easily occur, especially when care is delivered in an asynchronous manner.

In addition, I understand that teletherapy may not yield the same results nor be as complete as face-to-face service. I also understand that if my provider believes I would be better served by another form of psychotherapeutic service (e.g. face-to-face service), I will be given referrals to other providers in my area who can provide such service. Finally, I understand that there are potential risks and benefits associated with any form of psychotherapy, and that despite my efforts and the efforts of my provider, my condition may not improve and in some cases may even get worse.

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4. I understand that I may benefit from teletherapy, but results cannot be guaranteed or assured. The benefits of teletherapy may include, but are not limited to: finding a greater ability to express thoughts and emotions; transportation and travel difficulties are avoided; time constraints are minimized; and there may be a greater opportunity to prepare in advance for therapy sessions.

5. I accept that teletherapy does not provide emergency services. During our first session or prior, Dr. Candy Katoa and I will discuss an emergency response plan. If I am experiencing an emergency situation, I understand that I can call 911 or proceed to the nearest hospital emergency room for help. If I am having suicidal thoughts or making plans to harm myself, I can call the National Suicide Prevention Lifeline at 1.800.273.TALK (8255) for free 24 hour hotline support.

6. I understand that I am responsible for (1) providing the necessary computer, telecommunications equipment and internet access for my teletherapy sessions, (2) the information security on my computer, and (3) arranging a location with sufficient lighting and privacy that is free from distractions or intrusions for my teletherapy session.

7. I understand that I must be physically located within California during each of my teletherapy sessions.

8. I understand that I have a right to access my medical information and copies of medical records in accordance with HIPAA privacy rules and California law.

I have read, understand and agree to the information provided above.

Signature:_____ Date:_____

Print Name: _____

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