JILL L. KOFENDER, PHD, PLLC

Licensed Clinical Psychologist

POLICIES REGARDING PROFESSIONAL SERVICES

CONFIDENTIALITY

Information and records that are provided or maintained by Dr. Jill Kofender will be kept confidential, as required by law. Some examples of when information or records may be released include: life threatening situations, cases of suspected child abuse, when otherwise required by law, or when you request that Dr. Kofender release information or records.

FEES

I understand that the current fee schedule is as follows:

Initial Psychological Evaluation	$200
Individual 45 min Session or Family/Couple Session	$150
Individual 60 min Session or Family/Couple Session	$175
Telephone / Video Conference Session 45 min	$150
Telephone / Video Conference Session 60 min	$175
Late Cancelation/No Show	$50

The fees for patients with participating carriers will be adjusted according to our contractual arrangements. The above fee schedule applies for private pay patients, those with non-participating insurance coverage, or when direct pay insurance benefits are exhausted.

PATIENT CONSENT

I understand that the amount of time required to see the benefits of therapy varies by individual and specific goals for therapy. I understand that my therapist will use evidenced-based treatment techniques to assist me in meeting my therapeutic goals. I understand that there may be risks to treatment, such as temporarily feeling worse before I may feel better.

I understand and agree that I am responsible for deductibles and copays related to my insurance, and that regardless of my insurance status, I am ultimately responsible for the balance of my account for all professional services rendered. Uncollected fees over 90 days may be forwarded to a collection agency. I understand that if I do not provide a minimum of 24 hour notice for not attending a session, I may be charged $50 for that session. This charge will not be deferred by insurance benefits.

I am voluntarily requesting services for psychological evaluation or treatment. I give my consent to allow Jill Kofender PhD, PLLC and billing staff to communicate with my insurance carrier any medical information necessary to process my medical claim.

Client Signature (or parent/guardian if minor) Date

Therapist Signature Date

Jill L. Kofender, Ph.D.
Licensed Clinical Psychologist

SOCIAL MEDIA AND TECHNOLOGY POLICIES

This document outlines my office policies related to the use of Social Media and Technology. Please read it to understand how I conduct myself on the Internet as a mental health professional, and how you can expect me to respond to various interactions that may occur between us on the Internet.

Friending:

I do not accept friend or contact requests from current or former clients on social networking sites. I do not do so on my personal accounts or my business accounts. I believe that adding clients as friends or contacts on these sites can compromise your confidentiality, and our respective privacy, and may blur the boundaries of our therapeutic relationship.

Following:

I publish a blog on my practice website, and I post psychology related material on my business Facebook page, my business Instagram, and my LinkedIn page. I do not post these for my clients, but rather for the general public. I do not expect that you as my client will follow my social media posts. If however, you choose to do so, please be aware that some material, such as my blog, has some basic personal information about myself on it, as well as of my practice of psychology. However, I never share any identifying client information on social media of any form.

My primary concern is your privacy, and my policies exist to protect you. Therefore, please use discretion when considering any action on the internet that could link you to my psychological services. Please understand that I do not follow current or former clients on any social media sites. I will not view your online activities without your consent, and only if you specifically ask me to, for a specific, therapeutically-relevant purpose.

Interaction:

Client Portal:
The use of technology carries potential risks to privacy and confidentiality. Therefore, I have provided my clients with the option of using a Client Portal that allows for HIPAA secure communication with me, as well as secure access for videoconferencing sessions with me. In addition, the Client Portal allows you to view and schedule your own appointments, if you choose to do so. You may go to my website and follow the instructions to create a new portal account, or if you prefer, you may receive a Client Portal invite via text message from my office. You may also download the mobile app called Jituzu which gives you access to Client Portal wherever you go.

Email:
Email is not guaranteed to be completely secure or confidential. If you understand the potential risks in using unencrypted email, but still prefer the use of email over using the Client Portal, please try to limit email to scheduling/modifying appointments, rather than content related to therapy sessions.

Text Messaging:
The use of text messaging also carries with it risks to security and confidentiality. If you understand the risks involved in texting, yet choose to use this form of communication over the Client Portal messaging, it is best that it be for scheduling/modifying appointments, and other non-therapeutic issues.

Distance Counseling/Video Sessions:
Telepsychology may only be conducted through the HIPAA compliant Client Portal platform. You will need to set up an account to access this platform. Video sessions may only be conducted when you are in the state of Michigan, as that is where I am licensed.

I have read and understand Dr. Kofender's policy on social media and technology, and I understand the potential risks inherent to using social media and technology.

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Client Signature Date

INFORMED CONSENT FOR TELEPSYCHOLOGICAL SERVICES

1. There are potential benefits and risks of video conferencing (e.g. limits to client confidentiality) that differ from in-person sessions.
2. Confidentiality still applies for telepsychology services, and nobody will record the session without the permission from the other person(s).
3. We agree to use the video-conferencing platform selected for our virtual sessions, and Dr. Kofender will explain how to use it.
4. You will need a computer, tablet, or smartphone (one that has a webcam).
5. It is important to be in a quiet, private space that is free from distractions during the session.
6. It is important to use a secure internet connection, rather than public/free WIFI.
7. It is important to be on time. If you need to cancel or change your teletherapy appointment, you must notify Dr. Kofender at least 24 hours in advance as you would for in-person sessions.
8. We need a back-up plan (e.g. phone number where you can be reached) to restart the session in the event of technical problems.
9. We need a safety plan that includes at least one emergency contact and the closest emergency room to your location, in the event of a crisis situation.
10. If you are a minor, we need the permission of your parent or legal guardian (and their contact information) for you to participate in teletherapy sessions.
11. You should confirm with your insurance company that the video sessions will be reimbursed. If they are not reimbursed, you are responsible for the full payment.
12. As your psychologist, I may determine that due to certain circumstances, teletherapy is no longer appropriate and that we should resume our sessions in-person.

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Client Signature Date

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Parent/Guardian Signature if a Minor Date

CREDIT CARD PAYMENT AUTHORIZATION FORM

Type of Card _____

Is this an HSA card? _____

Name on card _____

Billing address of cardholder_____

Credit Card Number_____

CVC (3 digit code) _____

Expiration date _____

I _____, ***authorize Dr. Jill Kofender to charge the credit card indicated above. I understand that unless I notify Dr. Kofender otherwise, my credit card will be charged if I have a current account balance that has not previously been paid.***

Client Signature_____

Credit Card Holder's Signature (if different than client)_____