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	$140
Individual 60 min Session or Family/Couple Session	$160
Telephone / Video Conference Session 45 min	$140
Telephone / Video Conference Session 60 min	$160
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.

_____

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.

_____

Client Signature Date

_____

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)_____

JILL L. KOFENDER, PHD, PLLC

Licensed Clinical Psychologist

NOTICE AND RECEIPT OF HIPAA PRIVACY PRACTICES

I acknowledge that I have received the Notice of Privacy Practices Form from Jill L. Kofender, PhD, PLLC.

Client's Printed Name Date

Client's Signature (or personal representative) Date

If Personal Representative's signature, please describe relationship to Client:

Jill L. Kofender, Ph.D., P.L.L.C.

(248)867-8766

NOTICE OF PRIVACY PRACTICES

PLEASE REVIEW THE FOLLOWING NOTICE OF PRIVACY PRACTICES, AS THIS NOTICE IS REQUIRED TO BE GIVEN TO YOU BY THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA) OF 1996.

THIS NOTICE OF PRIVACY PRACTICES DESCRIBES HOW PSYCHOLOGICAL AND MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

I. Use and Disclosure of Your Protected Health Information 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 with your consent. *Protected health information* refers to information in your health record that could identify you. *Use* of this information refers only to activities within my office such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you. *Disclosure* of information refers to activities outside of my office such as releasing, transferring, or providing access to information about you to other parties.

In providing for your *treatment*, I may use or disclose information in your record to help you obtain health care services from another provider, or to assist me in providing for your care. For example, I might consult with another health care provider, such as a family physician or another psychotherapist.

In order to obtain *payment* for services, I may use or disclose information from your record to your health insurer. For example, I may provide your PHI to obtain reimbursement for your health care or to determine eligibility or coverage.

I may also use or disclose information from your record to allow *health care operations*, which 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.

II. Use 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. An authorization is written permission 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 the information.

I will also obtain an authorization from you before using or disclosing PHI in a way that is not described in this Notice, and before using or disclosing psychotherapy notes.

You may revoke all such authorizations in writing at any time, but this will not affect any use or disclosure made by me before the revocation. If authorization was obtained as a condition of obtaining insurance coverage, the insurer may have the right to contest the policy or a claim under the policy even if you revoke the authorization.

III. Use and Disclosure Without Consent or Authorization

There are certain circumstances in which I am allowed (or, in some cases, required) to use or disclose information from your record without your permission.

- Child Abuse: If I know, or have reasonable cause to suspect, that a child has been abused, abandoned, or neglected, I must report this to the appropriate authorities as required by law.
- Adult and Domestic Abuse: If I know, or have reasonable cause to suspect that a vulnerable adult (disabled or elderly) has been or is being abused, I am required by law to report this to the appropriate authorities.
- Health Oversight Agency: If I receive a subpoena or other lawful request from the Department of Health or the Michigan Board of Psychology, I must disclose the relevant PHI pursuant to that subpoena or lawful request.
- Judicial and Administrative Proceedings: If you are involved in a court proceeding and a request is made for information about your diagnosis or treatment or the records thereof, such information is privileged under state law, and I will not release information without your written authorization or a court order. The privilege does not apply when you are being evaluated by a third party or where evaluation is court ordered. You will be informed in advance if this is the case.
- Serious Threat to Health or Safety: If I come to believe that there is a serious threat to your health or safety, or to that of another person, or the public, I can disclose relevant PHI and take reasonable steps permitted by law to prevent the threatened harm from occurring.

- Worker's Compensation: If you file a workers' compensation claim, I may disclose information from your record as authorized by workers' compensation laws.
- When the use and disclosure without your consent or authorization is allowed under other sections of Section164.512 of the Privacy Rule and the state's confidentiality law. This includes certain narrowly defined disclosures to law enforcement agencies, to a health oversight agency, to a coroner or medical examiner, for public health purposes relating to disease or FDA regulated products, or for specialized government functions, such as fitness for military duties, eligibility for VA benefits, and national security and intelligence.

IV. Client's Rights and Psychologist's Duties

Client'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 Restrict Disclosures When You Have Paid for Your Care Out of Pocket. You have the right to restrict certain disclosures of PHI to a health plan when you pay out of pocket in full for my services.
- 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. Upon your request, I may be able to arrange to send your bills to another address.)
- Right to Inspect and Copy: You have the right to inspect or obtain a copy 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, given your written request. This may be subject to certain limitations and fees. Upon request, I will discuss with you the details of the request 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. Your request must be in writing, and I may deny the request.
- Right to an Accounting: You have the right to request an accounting of certain disclosures of PHI. Upon 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.

• Right To Be Notified If There Is A Breach Of Your Unsecured PHI. You have the right to be notified if: (a) there is a breach involving your PHI; (b) that PHI has not been encrypted to government standards; and (c) my risk assessment fails to determine that there is low probability that your PHI has been compromised.

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, you will be notified about those changes at your next session.

V. 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 me at 248-867-8766 or by mail at 5119 Highland Rd. # 192 Waterford, MI 48327. I recommend that such inquiries be done in writing. You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services.

The effective date of this notice is September 6, 2020