Dr. Vanderlip initiated telehealth service to enable continued therapuetic and consultation services during the Coronavirus (COVID-19) Pandemic situation as well as for any ongoing future needs for these services.

Due to this change in providing services, please use his mailing address for all forms and other communications related to any services he provides. That address is:

Ken Vanderlip, Ph.D.
3024 E. Chapman Ave., #112
Orange, CA 92869

Note: Due to COVID-19, he is not currently going to the office. So, please make sure to use the mailing address listed above, as it is the only way to avoid significant delays in his ability to respond.

Ken Vanderlip, Ph.D.
Clinical Psychology • Training • Consulting

INFORMED CONSENT FOR TELEHEALTH
Dr. Vanderlip Initiated this new level of service to enable continued therapuetic services during the Coronavirus (COVID-19) Pandemic situation as well as for any ongoing future needs for this type of service.

This Informed Consent for Telehealth contains important information focusing on providing healthcare services, please read this carefully and let me know if you have any questions.

Telehealth refers to providing psychotherapy services remotely using telehealth technologies, including telephone (landlines, digital, cellular, wifi, etc.) and video conferencing services. There are potential benefits and risks of telehealth services that differ from in-person sessions.

One of the benefits of telehealth is that the patient and clinician can engage in services without being in the same physical location. This can be helpful particularly during situations like the current Coronavirus (COVID-19) pandemic or other situations to ensuring continuity of care, where the patient and clinician likely are in different locations or are otherwise unable to continue to meet in person.

The full extent of confidentiality and the exceptions to confidentiality that I outlined in my *Psychotherapist-Patient Services Agreement* all still apply in telehealth. However, as telehealth sessions take place outside of your psychologist's office, there are potential limits to patient confidentiality. I will take all the reasonable steps I can to help keep your information private. However, the nature of electronic communications technologies is such that I cannot guarantee that our communications can be kept confidential or that other people may not gain access to our communications.

The following information is a list of guidelines for us to follow to make this as safe as possible.

- If you agree to use my HIPPA compliant Doxy.me online telehealth video/audio platform for our virtual sessions, before and at our first virtual session Dr. Vanderlip will explain how to access and use the new platform/system. It is cloud based so you do not need to download any software.
- You need to use a computer with a webcam or smartphone during a video-conferencing session. You are solely responsible for any cost to you to obtain any necessary equipment, accessories, or software to take part in telehealth.
- It is important to use a secure internet connection and not use public/free Wi-Fi which is completely unsecure. It is optimal with hardwired internet connection for videoconferencing.
- It is important to be in a quiet, private space that is free of distractions during either phone or video-conferencing sessions (including phones, or other devices) where you will not be interrupted.
- It is also important for you to protect the privacy of our session on your cell phone or other device.
- With video-conference platform we need a back-up plan (e.g., phone number where you can be reached) to restart/continue the session or to reschedule it, in the event of technical problems.

- The telehealth sessions shall not be recorded in any way unless agreed to in writing by mutual consent.
- I will maintain a record of our session in the same way I maintain records of in-person sessions in accordance with my policies.
- It is important to be on time. If you need to cancel or change your telehealth appointment, you must notify Dr. Vanderlip 24-hours in advance by either phone or text.
- The same fee rates will apply for telehealth as apply for in-person therapy ***(per signed Psychotherapist-Patient Services Agreement). Dr. Vanderlip makes no warranty nor guarantee regarding the patient's insurance coverage and/or payment on the patient's behave for service rendered and therefore the client agrees they are personally responsible for any and all fees paid in full for services rendered. It is, therefore, up to the client/patient to get clarification and attain validation of any and all insurance coverages directly from their insurance company themselves. You are responsible for contacting your insurance company to confirm, whether or not, telehealth sessions will be covered and/or reimbursed. It is important that you contact your insurer to also determine if there are applicable co-pays or fees which you are responsible for. If your insurance, HMO, third-party payor, or other managed care provider does not cover telehealth therapy sessions, you will be solely responsible for the entire fee ($175.00) of the session. So, please contact your insurance company prior to our engaging in telehealth sessions to determine whether these sessions will be covered***.
- 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.
- For anyone that is not a legal or an independent adult, we need the permission of your parent or legal guardian (and their contact information) for you to participate in telehealth/telepsychology sessions.
- Also, as your psychologist, I may determine that due to certain circumstances, telehealth/telepsychology is no longer appropriate and that we should resume our sessions in-person as soon as it is safe within the COVD-19 guidelines to do so.

This ***Informed Consent for Telehealth*** Agreement is intended as a supplement to the initial packet of 'New Client Forms' including, ***Psychotherapist-Patient Services Agreement & Consent for Treatment Forms***, that we agreed to at the outset of our treatment together and does not amend any of the terms of that agreement.

Your signature below indicates agreement with its terms and conditions.

_____ _____

Patient Signature Date

_____

Print Patient Name

_____ _____

Provider Signature Date

Ken Vanderlip, Ph.D.

Please also complete *one of my* ***Authorization for Release of Information*** *forms with the name and phone# of your Emergency Contact. Also, on the same form, identify and give the information of the nearest hospital ER. Thank-You.*

Ken Vanderlip, Ph.D.
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PSYCHOTHERAPIST-PATIENT SERVICES AGREEMENT

Welcome to my practice. This document (the Agreement) contains important information about my professional services and business policies. It also contains summary information about the Health Insurance Portability and Accountability Act (HIPAA), a new federal law that provides new privacy protections and new patient rights with regard to the use and disclosure of your Protected Health Information (PHI) used for the purpose of treatment, payment, and health care operations. HIPAA requires that I provide you with a Notice of Privacy Practices (the Notice) for use and disclosure of PHI for treatment, payment and health care operations. The Notice, which is attached to this Agreement, explains HIPAA and its application to your personal health information in greater detail. The law requires that I obtain your signature acknowledging that I have provided you with this information. Although these documents are long and sometimes complex, it is very important that you read them carefully before our session. We can discuss any questions you have about the procedures at that time. When you sign this document, it will also represent an agreement between us. You may revoke this Agreement in writing at any time. That revocation will be binding on me unless I have taken action in reliance on it; if there are obligations imposed on me by your health insurer in order to process or substantiate claims made under your policy; or if you have not satisfied any financial obligations you have incurred.

Treatment Philosophy

Psychotherapy is not easily described in general statements. It varies depending on the personalities of the psychologist and patient, and the particular problems you are experiencing. There are many different methods I may use to deal with the problems that you hope to address. Psychotherapy calls for a very active effort on your part. In order for the therapy to be most successful, you will have to work on things we talk about both during our sessions and on your own between sessions.

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. I [patient] understand that this often is a normal response to working through unresolved life experiences. On the other hand, psychotherapy has also been shown to have many benefits. Therapy often leads to better relationships, solutions to specific problems, and significant reductions in feelings of distress. But there are no guarantees of what you will experience. Your commitment to this treatment approach is necessary for you to experience a successful outcome. If you ever have any questions about the nature of the treatment or care, please do not hesitate to ask.

Initial here: _____

Psychotherapy Sessions

I will usually schedule one (45-50 minute) session per week at a time we agree on, although some sessions may be longer or more frequent. **Cancellation and missed appointment policy**: Since scheduling of an appointment involves the reservation of time specifically for you, a minimum of 24 hours advance notice is required for re-scheduling or canceling an appointment. If an appointment if missed or canceled in less than 24 hours' notice, you will be billed according to the scheduled fee and instructions of the benefit plan. Repeated "no-show" appointments could result in termination of treatment and referral back to your insurance or managed care for reassignment to another practitioner. It is important to note that most insurance companies do not provide reimbursement for late cancelled or missed sessions

Initial here: _____

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Professional Fees

My hourly fee is $175. In addition to weekly appointments, I charge according to the fee schedule provided for other professional services you may need. Other services include report writing, telephone conversations [*note: I bill by half hour increments for telephone contacts lasting longer than 5 minutes*], consulting with other professionals with your permission, preparation of records or treatment summaries, and the time spent performing any other service you may request of me. If you become involved in legal proceedings that require my participation, you will be expected to pay for all of my professional time, including preparation and transportation costs, even if I am called to testify by another party. [Because of the complexity of legal involvement, I charge $500 per hour for preparation and attendance at any legal proceeding.] Note: You have also been given a fee schedule that identifies the most common charges.

Initial here: _____

Contacting Me

Due to my work schedule, I am often not immediately available by telephone. While I am usually in my office Monday to Wednesday by appointment only, I will not answer the phone when I am with a patient. My telephone is answered by a confidential voice mail that I monitor frequently. I will make every effort to return your call on the same day you make it, with the exception of weekends and holidays. If you are difficult to reach, please inform me of times when you will be available. Note, I do respond to calls as soon as possible, but I am not "on call" and do not carry a pager. Therefore, if you are unable/feel that you can't wait for me to return your call, or you have a critical [life-threatening emergency] you are advised to contact the nearest emergency room or dial 911 for immediate assistance.

If I will be unavailable for an extended time, I will provide you with the name of a colleague to contact, if necessary.

Please be advised that my primary means of making calls is by cellular phone and that communications occurring via cellular or cordless telephones, fax and email are not secure; therefore, confidentiality cannot be guaranteed. Knowing this, by signing this agreement you authorize me to use any of these means to disclose any and all confidential information with both you and others per the Notice of Privacy Practices and all signed consents to disclose.

Initial here: _____

Limits on Confidentiality

All information between practitioner and patient is held strictly confidential. In most situations, I can only release information about your treatment to others if you sign a written Authorization form that meets certain legal requirements imposed by state law and/or HIPAA. But, there are some situations where I am permitted or required to disclose information without either your consent or Authorization. These include:

- When there is reasonable suspicion of child abuse or abuse to a dependent ore elder adult.
- When the patient communicates a threat of bodily injury/harm to others.
- When the patient is suicidal.
- When disclosure is required pursuant to a legal proceeding.

I may occasionally find it helpful to consult other health and mental health professionals about a case. During a consultation, neither your name nor other identifying information about you is revealed. The other professionals are also legally bound to keep the information confidential. I will note all consultations in your Clinical.

.

You should be aware that I practice in the same suite with other mental health professionals; however, we each practice independently. All of the mental health professionals are bound by the same rules of confidentiality.

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At this time I have no contracts with outside providers [such as billing services, etc]. If, in the future, I do have such services, as required by HIPAA, any outside services will be required to maintain the confidentiality of this data except as specifically allowed in the contract or otherwise required by law.

Please note: once confidential information is released, this office no longer controls the confidentiality of that information. If group therapy is utilized as part of the treatment, details of the group sessions/ discussions are not to be discussed outside of the counseling sessions. Please be advised that conversations occurring on cellular or cordless telephones are not always secure; therefore, confidentiality cannot be guaranteed.

If your treatment is being covered by a mental health insurance or EAP benefit, this office may be required to provide (by telephone, mail, fax or email) clinical information to obtain payment and/ or authorization for treatment. Information provided to the insurance company or managed care organization for the purposes of billing and/or obtaining additional treatment is no longer under the control of this office; therefore, confidentiality of the information cannot be assured.

Initial here: _____

Billing and Payments

You will be expected to pay for each session at the time it is held, unless we agree otherwise or unless you have insurance coverage that requires another arrangement. Payment schedules for other professional services will be agreed to when they are requested.
Should this account become delinquent and sent for collection, any reasonable legal fees, court costs, collection agency fees, or any associated costs, fees or penalties will be added to the balance. It is understood that in the event your portion of the balance due becomes 90 days or more delinquent, a late fee of $15.00 per month will be charged until the amount you owe is paid in full. There will be a $15.00 charge on all returned checks. If your account has not been paid for more than 90 days and arrangements for payment have not been agreed upon, I have the option of using legal means to secure the payment. This may involve hiring a collection agency or going through small claims court which will require me to disclose otherwise confidential information. 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. [If such legal action is necessary, its costs will be included in the claim.]

Initial here: _____

Insurance Coverage and Co-payments

You are responsible for obtaining prior authorization for treatment from your insurance carrier. I am willing to bill your insurance; however, you (not your insurance company) are responsible for full payment of my fees. Therefore, it is very important that you find out exactly what mental health services your insurance policy covers.

Co-payment amounts are set by your benefit plan. **These payments are due and payable at each appointment**. Information regarding the co-payments set by your insurance plan for each visit will be provided to you or you may contact your health plan for this information.

For special modalities of treatment not covered by your benefits plan, a written agreement needs to be signed between you and this office/practitioner. This agreement should outline your understanding that it is not a covered benefit and will also cover the agreed fees and treatment plan you may expect.

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At any time during treatment should you become ineligible for insurance coverage, you will notify the practitioner and understand you will become responsible for 100% of the bill.

Initial here: _____

Release of Information

I [patient] authorize release of information to my Primary Care Physician, other health care providers, institutions, and referral sources for the purpose of diagnosis, treatment, consultation and professional communication. I further authorize the release of information for claims, certification, case management, quality improvement, benefit administration and other purposes related to my health plan.

Initial here: _____

Your signature below indicates that your have read this agreement and agree to its terms

_____ _____

Signature of Patient (or Parent/legal representative if patient is a minor/dependent) Date

_____ _____

Signature of Witness/Provider Date

Acknowledgement of Receipt of Notice of Privacy Practices

By signing below, I hereby acknowledge receipt of the Notice of Privacy Practices of Ken Vanderlip, Ph.D.

_____ _____

Patient's Name Date of Birth

_____

Parent/Legal representative's Name (if patient is a minor/dependent)

_____ _____

Signature of Patient (or Parent/legal representative if patient is a minor/dependent) Date

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CLIENT INTAKE INFORMATION

NAME Lst_____Fst_____Mdl_____

ADDR_____City_____St____Zip_____

PHONE Home (____) ____-_____ Alt (____) ____-_____Alt Name_____

Marital Status: _____ (S=single M=married W=widowed, D=divorced X=separated)

Sex_____ SSN_____-___-_____ Date of Birth____/____/_____ Age: _____

Driver's License Number/State: _____

Employer_____ Occupation_____ Ph (___) ___-____

Addr_____City_____St____Zip_____

Length of Time Employed: _____

RESPONSIBLE PARTY INFORMATION:

NAME Lst_____Fst_____Mi_____Title_____

ADDR_____City_____St___Zip_____

Phone (_____) _____-_____

Client's Relationship to Resp. Party:____ (S=self, P=spouse, C=child, O=other)

REFERRAL INFORMATION

NAME

Lst_____Fst_____MI____Title_____

Bus. Name_____ Phone (____) _____-_____

ADDR_____City_____ST___Zip_____

I authorize Ken Vanderlip, Ph.D. to contact me at my home address for mailings and either my home, work or cell phone numbers regarding changes in appointments, billing information, etc.

_____ _____

Date Signature of Patient (or Parent/Legal Representative if patient is a minor/dependent)

Payment for services is due each visit and any charges incurred due to collection or attorney's fees become the responsibility of the client. We, the undersigned, have read this statement of responsibility and understand and agree to its contents.

_____ _____

Date Signature of Patient (or Parent/Legal Representative if patient is a minor/dependent)

I authorize Dr. Vanderlip to acknowledge and thank the above listed person and/or agency that referred me to him.

_____ _____

Date Signature of Patient (or Parent/Legal Representative if patient is a minor/dependent)

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ADDITIONAL CLIENT INFORMATION

Have you seen a mental health professional before? _____

If so:

Who: _____ When: _____

Where: _____ How long: _____

Spouse's name_____ Age_____ Yrs Married_____

Spouse's SS#: _____-____-_____

Address (If different) _____

Occupation: _____Time Employed_____

Approximate Gross Family Income $_____/yr.

Names/ages of children or others living with you and relationship

_____ _____

_____ _____

_____ _____

Person and phone # to call in emergency: _____

****

Briefly describe your reasons for seeking help: _____

_____

What are the goals you would like to realize through therapy? _____

_____

Describe any major changes in your life in the past five years: _____

_____

List some of the words/phases used by others to describe you as a child:_____

_____

adult: _____

Would you add any other descriptors of your own? _____

List two of your greatest assets: _____

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Present Medications: _____

Present Handicaps: _____

Date of last physical exam: _____ Doctor: _____

List any history of health/medical problems: Date first seen for condition:

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

(Please use separate page if necessary for medical history)

Do you smoke? _____ if so, how much? _____

Do you drink coffee/caffeinated drinks? ____ if so, how much? _____

Substance Use: (Alcohol/Drugs: avg day/wk intake): _____

Do you exercise regularly? _____ Specify type exercise: _____

PLEASE CHECK ANY OF THE FOLLOWING AREAS THAT APPLY:

□Nervousness	□Depression	□Fears(phobias)	□Shyness
□Sexual Problems	□Suicidal thoughts	□Divorce	□Boredom
□Finances	□Drug use	□Alcohol use	□Friends
□Anger	□Self-control	□Unhappiness	□Sleep
□Stress	□Work	□Relaxation	□Headaches
□Dating skills	□Legal matters	□Memory	□Assertiveness
□Energy	□Chronic	□Making decisions	□Loneliness
□Self-esteem	□Concentration	□Education	□Career choices
□Health problems	□Relationships	□Nightmares	□Marriage
□Children	□Eating problems	□Perfectionism	□Bowel troubles
□Being a parent	□My thoughts	□Irritability	□Isolation
□Trauma	□Family	□Spiritual	□Sudden Mood Change

□Other: _____

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INSURANCE INFORMATION

PRIMARY INSURANCE:

Name_____ Phone(____)_____-_____

ADDR_____City_____St____Zip_____

Subscriber's Name Lst_____Fst_____MI___

ADDR_____City_____ST___Zip_____

CLIENT RELATIONSHIP TO INSURED _____ (S= self, P= spouse, C=child, O= other)

Subscriber's Employer: _____Phone (____) _____-_____

Group#: _____Subscriber#: _____Policy#: _____

SECONDARY INSURANCE:

NAME_____ Phone (_____) _____-_____

ADDR_____City_____St___Zip_____

Subscriber's Name Lst _____ Fst_____MI___

ADDR_____City_____St___Zip_____

CLIENT RELATIONSHIP TO INSURED _____ (S=self, P = spouse, C= child ,O= other)

Subscriber's Employer_____ Phone (____) _____-_____

Group#:_____Subscriber#:_____Policy#:_____

****

I authorize Dr. Vanderlip to release any medical information regarding the medical, mental health, or alcohol/drug abuse history, verification of diagnosis, treatment, or benefits payable, including disability or employment related information to any insurance company, the Plan Administrator, or their authorized agents that I have coverage with, for the purpose of validating and determining benefits payable for my treatment. This includes any information/reports that may be required by any managed care contracts associated with my insurance coverage. In signing this statement, I am aware that confidentiality regarding information given to managed care/insurance companies is relinquished. My confidentiality, in this regard, is only protected by the laws and ethics governing the managed care and insurance companies. This agreement extends from the first date of service rendered under my insurance until 1 year after last date of service rendered under my insurance. I understand that I have the right to revoke or cancel this authorization at any time by either directly communicating so to my provider (Ken Vanderlip, Ph.D.) or sending written notification of that revocation or cancellation to his office address or billing mailing address. If I revoke or cancel this consent, I understand it will not apply to any information previously released with this authorization.
Also, Dr. Vanderlip makes no warranty nor guarantee regarding the patient's insurance coverage and/or payment on the patient's behave for service rendered and therefore the client agrees they are personally responsible for any and all fees paid in full for services rendered. It is, therefore, up to the client/patient to get clarification and attain validation of any and all insurance coverages directly from their insurance company themselves.

_____ _____

Date Patient's Signature (or Parent/legal representative if patient is a minor/dependent)

I also authorize payment of medical benefits to provider of services rendered (Ken Vanderlip, Ph.D.). This applies for any services rendered that I have not paid for at time of service. I also request payment of government benefits either to myself or to the party rendering the services who accepts assignment.

_____ _____

Date Patient's Signature (or Parent/legal representative if patient is a minor/dependent)

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Consent For Treatment

I _____ authorize and request that Ken Vanderlip, Ph.D. carry out psychological examinations, treatments, and/or diagnostic procedures, which now or during the course of my care as a patient, are advisable.

I understand that, at my request, the purpose of recommended procedures will be explained to me and are subject to my agreement. It is also acknowledged that there can be no guarantees of treatment results. Further, the psychotherapy process can bring up uncomfortable feelings and reactions. I understand that the psychotherapy process can bring up uncomfortable feelings and reactions. I understand that this may be a normal response to working through unresolved life experiences, problems and trauma. The results of treatment may yield improvement, worsening or no change in symptomology and/or condition.

I have read, fully understand and agree to this Consent for Treatment.

I also agree to pay for the treatment services according to the statements in the Psychotherapist-Patient Services Agreement.

_____ _____

Date Signature of Patient

_____ _____

Date Signature of Provider

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Ken Vanderlip, Ph.D.
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Consent for Treatment of Minor Child or Dependent

I/we _____ authorize and request that Ken Vanderlip, Ph.D. carry out psychological examinations, treatments, and/or diagnostic procedures which now or during the course of my/our child's care as a patient are advisable. It is further acknowledged that I/we are the legal parent/guardian or legal representative of the patient and on the patient's behalf legally authorize Ken Vanderlip, Ph.D. deliver mental health services to the patient. I also understand that all policies described in this statement apply to the patient I represent. I understand that my child is the identified patient and that other family members who may participate I his or her treatment are not considered to be a patient for purposes such as confidentiality or continuity of treatment.

I understand that the psychotherapy process can bring up uncomfortable feelings and reactions. I understand that this may be a normal response to working through unresolved life experiences, problems and trauma. The results of treatment may yield improvement, worsening or no change in symptomology and/or condition.

I understand that privacy and trust between my child and the practitioner are necessary for psychotherapy to be effective and that the practitioner, using sound professional judgment, will release information to me only if determined to be critical to my child's mental and/or physical well-being.

In addition, it is agreed that the therapeutic relationship (interactions/content) be confidential between our/my child and therapist. That our/my periodic involvement in treatment and/or feedback regarding our/my child's treatment will be provided by Dr. Vanderlip, as he deems necessary and appropriate to the therapeutic relationship, goals of treatment and my child's safety and well-being.

I/we have read, fully understand and agree to this Consent for Treatment form.

I/we also agree to pay for the treatment services for our child according to the statements in the Psychotherapist-Patient Services Agreement.

_____ _____
Date Signature of Parent/Legal Representative

_____ _____
Date Signature of Parent/Legal Representative

_____ _____
Date Signature of Patient

_____ _____
Date Signature of Provider

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CONSENT FOR EYE MOVEMENT DESENSITIZATION & REPROCESSING TREATMENT (EMDR)

I have been advised and understand that Eye Movement Desensitization and Reprocessing (EMDR) is a specialized treatment approach. I have been informed that studies have shown EMDR as an effective approach in most areas of treatment within psychotherapy. It is most noted and recognized by the World Health Organization (WHO) for its effectiveness in reducing post-traumatic stress symptoms, such as intrusive thoughts, nightmares, and flashbacks. I have also been advised that although there are currently no known serious side effects to EMDR, and that only properly trained and licensed therapists *(or properly trained and supervised* interns) are deemed appropriate persons to administer EMDR treatment. I have also been advised that additional information regarding EMDR can be obtained from the EMDR Institute (www.EMDR.com) and/or the EMDR International Association (EMDRIA) website (www.EMDRIA.org).

I have also been specifically advised of the following:

A. Memories tend to surface more often through the use of the EMDR procedure than with other forms of treatment.
B. Some clients have experienced reactions during the treatment sessions that neither they nor the administrating clinician may have anticipated, including a high level of emotion or physical sensations.
C. Subsequent to the treatment session, the processing of incident material may continue and other dreams, memories, flashbacks, feelings, etc. may surface.

Before commencing EMDR treatment, I have thoroughly considered all of the above, I have obtained whatever additional input and/or professional advice I deemed necessary or appropriate to having EMDR treatment, and by my signature below I hereby consent to receiving treatment with EMDR.

My signature on this Acknowledgment and Consent is free from pressure or influence from any other person or entity. It is also acknowledged that, at any time and for any reason, I may choose to discontinue EMDR treatment *(by verbal &/or written statement)*.

_____ _____
Date Signature of Patient (or Parent/Legal Representative if patient is a minor/dependent)

_____ _____
Date Signature of Practitioner

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Authorization for Release of Information

(*including any/all protected health information - PHI)*

I, _____, authorize Ken Vanderlip, Ph.D. to release/disclose confidential treatment information and records including, but not limited to: any and all social, medical, psychological and academic information; any and all psychotherapy notes, as well as alcohol/drug use/abuse information and psychological evaluation and testing information pertaining to the following individual:

Patient's Name: _____ DOB: _____

I authorize this information to be shared with the following individual or agency:

_____

I further authorize that the information released may be transmitted by facsimile (FAX), cell phone, cordless telephone or email to any and all individuals and or agencies listed above. I give this authorization, knowing that information shared in these ways are not always secure and knowing that confidentiality cannot be guaranteed by these means.

I understand that my psychologist generally may not condition psychological services upon my signing an authorization that would allow a disclosure of PHI that is not permitted as described in the Notice form provided by my psychologist, or a disclosure that is otherwise not permitted by law

I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient of my information and that Ken Vanderlip, Ph.D. cannot prevent the person or organization who has access to it from sharing that information with others, and this information may no longer be protected by the HIPAA Privacy Rule.

This authorization is effective as of:___/_____/_____.

The Authorization expires as of: ____/_____/_____ or when (specify):_____

_____

I understand that I have the right to revoke or cancel this authorization at any time by either directly communicating so to my provider (Ken Vanderlip, Ph.D.) or sending written notification of that revocation or cancellation to his office address or billing mailing address. If I revoke or cancel this consent, I understand it will not apply to any information previously released with this authorization.

By signing this form, you authorize me to release any and all protected information from your clinical record to those indicated. Your signature also acknowledges you received a copy of this consent form.

_____ _____

Date Signature of Patient (or Parent/Legal Representative if patient is a minor/dependent)

_____ _____

Date Signature of Witness/Provider

In the case where this consent of information is revoked:
Notice of revocation received as of this date: ____/_____/_____ - _____
Signature

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Authorization for Release of Information

(*including any/all protected health information - PHI)*

I, _____, authorize the following individual or agency:

_____

to release/disclose confidential treatment information and records including, but not limited to: any and all social, medical, psychological and academic information; any and all psychotherapy notes, as well as alcohol/drug use/abuse information and psychological evaluation and testing information pertaining to the following individual:

Patient's Name: _____ DOB: _____

I authorize that any or all the information is to be released to and/or shared with Ken Vanderlip, Ph.D.

I further authorize that the information released may be transmitted by facsimile (FAX), cell phone, cordless telephone or email to any and all individuals and or agencies listed above. I give this authorization, knowing that information shared in these ways are not always secure and knowing that confidentiality cannot be guaranteed by these means.

I understand that my psychologist generally may not condition psychological services upon my signing an authorization that would allow a disclosure of PHI that is not permitted as described in the Notice form provided by my psychologist, or a disclosure that is otherwise not permitted by law

This authorization is effective as of:___/_____/_____.

The Authorization expires as of: ____/_____/_____ or when (specify):_____
_____

I understand that I have the right to revoke or cancel this authorization at any time by either directly communicating so to my provider (Ken Vanderlip, Ph.D.) or sending written notification of that revocation or cancellation to his office address or billing mailing address. It is also my/patient's responsibility to notify the above listed disclosing individual or agency to complete the revocation of this part of this release. If I revoke or cancel this consent, I understand it will not apply to any information previously released with this authorization.

By signing this form, you authorize me to release any and all protected information from your clinical record to those indicated. Your signature also acknowledges you received a copy of this consent form.

_____ _____
Date Signature of Patient (or Parent/Legal Representative if patient is a minor/dependent)

_____ _____
Date Signature of Witness/Provider

In the case where this consent of information is revoked:
Notice of revocation received as of this date: ____/_____/_____ - _____
Signature

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PRIMARY CARE PHYSICIAN DISCLOSURE

It may be beneficial for me to confer with your primary care physician in regard to your psychological treatment or to discuss any medical problems for which you are receiving medical advice.

Please check one of the following:

____ You are authorized to contact my primary care physician whose name and address is shown below to discuss the treatment that I am receiving while under your care and to obtain information concerning my medical diagnosis and treatment.

____ I do not authorize you to contact my primary care physician with regard to the treatment that I am receiving while under your care or to obtain information concerning my medical diagnosis and treatment. I am providing you with the name and address of my primary care physician only for your records.

Please complete all information below:

Name of Primary Care Physician: _____

Address of Primary Care Physician: _____

_____

_____

_____

Telephone Number of Primary Care Physician: _____

Patient's Signature: _____

Please print name of patient: _____

Date: _____

_____
Signature of Parent/Legal Representative if patient is a minor/dependent)

Date: _____

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Fee Schedule

CPT Code	Procedure	Fee
90791	Diagnostic Evaluation 1hr.	$175.00
90791*	Diagnostic Evaluation 1.5hr.	$262.50
Individual Psychotherapy Office		
90834	45 minutes	$175.00
90837	60 minutes	$262.50
90841	100 minutes	$350.00
90832	30 minutes	$87.50
Family Psychotherapy		
90846	45 minutes w/o patient	$175.00
90847	Cjt/Family	$175.00/hr.
90849	Multiple Family Group	$175.00/hr.
Psychotherapy Hospital		
90818*Hos	45 minutes	$275.00
90816*Hos.5	20-25 minutes	$137.50

Services Listed Below Not Covered by Insurance
(therefore, <u>the full fee due is due from client</u> rather than copay)

90899*L/C	Appointment Canceled w/o Adequate Notice	$175.00
90899*N/S	No Show/Missed Appointment	$175.00
90820	Telephone Consultation 5-15 minutes	$42.75
90821	Telephone Consultation 25-30 minutes	$87.50
90822	Telephone Consultation 45-50 minutes	$175.00
90887	Reports: Interpretation or Explanation of Results	$175.00/hr.
90889	Status Report Preparation	$175.00/hr.
99080	Special Report	$175.00/hr.
90825	Evaluate. Records, Reports, Tests, etc.	$175.00/hr.

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Patient's Insurance Opt-Out Form

I _____ personally desire to not use my insurance benefit/plan [to "Opt-Out" of having my insurance be used] to cover [or make any payment for] any and all services/treatment rendered by Dr. Vanderlip. I desire and request to enter into a private pay contract for any and all services/treatment rendered by Dr. Vanderlip.

In this private pay contract, I [the insurance beneficiary] agree to give up insurance plan/payment for services furnished by the physician or practitioner and to pay the physician or practitioner without regard to any limits that would otherwise apply to what the physician or practitioner could charge.

In addition it is acknowledged that:

- Per this "Opted out" status in regards to my insurance, neither Dr. Vanderlip nor the above listed Patient [beneficiary] are allowed to submit a claim or bill to any insurance company for any services/treatment that are provided by Dr. Vanderlip.
- The above listed Patient agrees to cash pay arrangement for the "full-fee" of the services that are provided by Dr. Vanderlip.
- I/Patient also acknowledge that any supplemental or secondary insurance is will also not be billed, because of the "Opt-out" agreement; as above it is agreed that no insurance can be billed nor make payment for any services/treatment rendered by Dr. Vanderlip.
- I/Patient also acknowledge that I/[beneficiary] both have the right and can choose, at any time I want, to go to any other provider of my choice if I desire or choose to have insurance pay for my psychological services/treatment.

With this knowledge it is still my choice and desire to receive treatment from Dr. Vanderlip under my decision to "Opt-Out" of using my insurance and will pay for these services on a cash basis.

The above agreement was discussed, acknowledged and agreed to as of this date. Therefore, all services rendered and associated charges including and since this date are to be included in this agreement.

_____ _____
Client/Patient's Signature Date

_____ _____
Witness/Provider Signature Date

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Patient's Medicare Opt-Out Form

I _____ am aware that Ken Vanderlip, Ph.D. no longer accepts Medicare and has discontinued his status as a Medicare provider [Opted out]. Therefore, all services/treatment rendered by Dr. Vanderlip are entered into as a private pay contract.

In this private pay contract, I [the Medicare beneficiary] agree to give up Medicare payment for services furnished by the physician or practitioner and to pay the physician or practitioner without regard to any limits that would otherwise apply to what the physician or practitioner could charge.

In addition, it is acknowledged that:

- Per the "Opted out" status that Dr. Vanderlip has with Medicare, neither Dr. Vanderlip nor the above listed Patient [beneficiary] are allowed to submit a claim or bill to Medicare for any services/treatment that are provided by Dr. Vanderlip.
- The above listed Patient agrees to cash pay arrangement for the "full-fee" of the services that are provided by Dr. Vanderlip.
- I/Patient also acknowledge that any supplemental or secondary insurance is will also not be billed, because of the "Opt-out" agreement; as above it is agreed that no insurance can be billed nor make payment for any services/treatment rendered by Dr. Vanderlip. .
- I/Patient also acknowledge that I/[beneficiary] both have the right and can choose, at any time I want, to go to any other provider of my choice that is a Medicare provider if I desire or choose to have Medicare and my supplemental insurance pay for my psychological services/treatment.

With this knowledge it is still my choice and desire to receive treatment from Dr. Vanderlip and will pay for these services on a cash basis.

The above agreement was discussed, acknowledged and agreed to as of: _____/_____/_____. Therefore, all services rendered and associated charges including and since this date are to be included in this agreement.

_____ _____
Client/Patient's Signature Date

_____ _____
Witness/Provider Signature Date

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NOTICE TO MEDICARE PATIENTS

It may be beneficial for me to confer with your primary care physician in regard to your psychological treatment or to discuss any medical problems for which you are receiving medical advice. Medicare requires that I notify your physician by telephone, or in writing, concerning services that are being provided by me, unless you request that notification not be made.

Please check one of the following:

____ You are authorized to contact my primary care physician whose name and address is shown below to discuss the treatment that I am receiving while under your care and to obtain information concerning my medical diagnosis and treatment.

____ I do not authorize you to contact my primary care physician with regard to the treatment that I am receiving while under your care or to obtain information concerning my medical diagnosis and treatment. I am providing you with the name and address of my primary care physician only for your records.

Please complete all information below:

Name of Primary Care Physician: _____

Address of Primary Care Physician: _____

_____

_____

_____

Telephone Number of Primary Care Physician: _____

Patient's Signature: _____

Please print name of patient: _____

Date: _____

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Revocation of Insurance Information Authorization

Dr. Vanderlip,

I, _____, am sending this notice revoking the authorization
(Printed Name)
to release any information to my insurance company regarding any treatment.

_____ _____

Date Patient's Signature
(or Parent/legal representative if patient is a minor or dependent)

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