Stuart Andrews, Ph.D.
Licensed Clinical Psychologist
Individual & Couples Therapy

INSTRUCTIONS

Enclosed in this document you will find the following:

1. Private Practice Policies for Child and Adolescent Psychotherapy
2. Informed Consent for Child and Adolescent Individual Psychotherapy
3. Privacy Policies
4. Authorization for Release of Information (optional)

Please carefully read all of the information enclosed in this document. You will be required to print and complete all of the signature forms associated with this information and bring them to your first session with Dr. Andrews.

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PRIVATE PRACTICE POLICIES FORCHILD & ADOLESCENT PSYCHOTHERAPY

The following are some policies related to session length, fees, scheduling, and cancellations:

- The initial individual evaluation usually involves two to three sessions in which I meet with the parents and child separately, and sometimes together in a family meeting. I will adapt this format based on the age and developmental stage of the child.
- After the initial appointment, we will discuss what treatment options will work best for you, in terms of frequency and session length.
- Fees are $215/50 minutes Monday–Friday before 5 p.m.; or $250/50 minutes after 5 p.m. and on weekends (when available).
- If you need to cancel or reschedule an appointment, please do so at least 48 hours in advance of your appointment to avoid being charged for the missed session.
- Return phone calls of less than 10 minutes will not be billed. Professional contacts of more than 10 minutes will be billed at session rates.
- Telephone sessions for clients who are out of town, ill, or unavailable in person must be scheduled in advance through my office. The billing rate is the same as the session rate.

If you have any questions regarding these policies, please do not hesitate to address them with me.

Please sign this Private Practice Policies for Child & Adolescent Psychotherapy form to indicate that you have read this document carefully and you understand and agree to comply with these policies.

Sincerely,

Dr. Stuart Andrews

_____ Date: _____
Signature of Patient or Personal Representative

_____
Printed Name of Patient or Personal Representative

_____ Date: _____
Signature of Parent or Guardian

_____
Printed Name of Parent or Guardian

11870 Sunrise Valley Dr. #200, Reston, VA 20191, USA
stuart@drstuartandrews.com
(703) 598-0036

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INFORMED CONSENT TO CHILD & ADOLESCENT PSYCHOTHERAPY

Welcome to my practice. This document contains important information about my professional services and business policies. When you sign this document, you are acknowledging receipt of this information and it will represent an agreement between us. If you have any questions or concerns about anything contained in this document, please raise them with me directly.

PSYCHOLOGICAL SERVICES

Psychotherapy can vary depending on the personalities of the psychologist and patient, the problems being addressed, and the training and orientation of the practitioner. Psychotherapy calls for active effort and involvement on the part of the child. In order for therapy to be successful, he/she will have to work outside of sessions on things that we discuss. Psychotherapy has both benefits and risks. Because psychotherapy often involves discussing difficult aspects of one's life, the child may experience uncomfortable feelings such as guilt, grief, and anger. Research is clear in demonstrating that engagement in this process helps patients on many different levels — emotionally, physically, and interpersonally. Despite these findings, there is no guarantee that the child will experience any or all of these benefits.

Our first couple of sessions will involve a comprehensive evaluation of the child's needs. By the end of the evaluation, I will be able to offer some initial impressions of what our work might include. We will discuss your treatment goals for the child and create, in collaboration, an initial treatment plan. You and your child should evaluate this feedback along with your own reactions to make your own assessment about whether working with me will be helpful. If you have questions about my procedures, please discuss them with me directly whenever they arise. If you would prefer to work with someone else or feel the child needs a different kind of treatment, I will do my best to provide you with an appropriate referral.

SESSIONS & PROFESSIONAL FEES

After the initial appointment, we will discuss what treatment options will work best for you and your child, in terms of frequency and session length. You are responsible for paying at the time of each session unless prior arrangements have been made. Payment can be made by credit card, check, or cash. Once an appointment is scheduled, you will be expected to pay for it unless you provide notice of at least 48 business hours. Apart from Medicare, I do not work directly with any coverage providers. If you choose, you may seek reimbursement from your insurance company or other coverage provider. I can provide you with a detailed receipt; it will be provided directly to you, with or without a diagnosis, as you request. It is important to note that insurance will not cover you for missed sessions.

Other professional services, such as preparation of reports and other records, telephone conversations, consultation with other professionals (with your permission), attendance at meetings, and participation in other matters, are charged at the same rate if these go beyond the ordinary 10 minutes per week.

LEGAL PROCEEDINGS

It is my policy to not be involved with or participate in litigation or court proceedings. If I somehow become involved in litigation or legal proceedings related to you or your child, either by yourself or a third party, you will be charged for that time. The fee for this work is $400/hour. The fee must be paid in advance and is related to all services and time, such as consultation, testimony, record review, travel, etc.; additional fees apply for any related expenses. If you are involved in a court proceeding and a request is made for information concerning your child

(e.g., diagnosis and treatment), such information is protected by psychologist-patient privilege law. I cannot provide any information about your child without your written authorization, or a court order. If you are involved in or contemplating litigation, you may want to consult with your attorney to determine whether a court would be likely to order me to disclose information about your child and how that could affect your case.

CONTACTING ME

I will do my best to return your phone call within 24 business hours. I will also try to respond to urgent calls during the evenings and over weekends, but cannot guarantee that I will do so in a timely fashion. Therefore, in case of an emergency, you should also consider contacting your primary physician, visit your local emergency room, or call 911.

PARENTS & MINORS

Privacy in therapy is crucial to successful progress. At the same time, a parent's involvement in therapy is sometimes essential to providing the best possible care. Therapy often requires the therapist to achieve a balance between the child's or adolescent's need for privacy and the parent's natural desire to understand the process of therapy and whether it is helpful. In general, I have found that as children grow older, the need for privacy in therapy increases. For children 13 and older, I normally request an agreement between the child and the parents allowing me to share general information about treatment progress and attendance, as well as a treatment summary upon completion of therapy. All other communication will require the child's agreement, unless I feel there is a safety concern (see also the Privacy Policy for exceptions), in which case I will make every effort to notify the child of my intention to disclose information ahead of time and make every effort to handle any objections raised.

CONSENT TO PSYCHOTHERAPY

Please discuss with me any questions you may have about any of the outlined provisions. Your signature below indicates that you have read this Informed Consent document and agree to its terms.

_____ Date: _____
Signature of Patient or Personal Representative

_____
Printed Name of Patient or Personal Representative

_____ Date: _____
Signature of Parent or Guardian

_____
Printed Name of Parent or Guardian

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PRIVACY POLICIES

As psychologist and therapist, your privacy is extremely important to me. Our communications (and even the fact that you and your child have come to see me) are confidential. My policy is to release your information only:

- to you, or as explicitly authorized by you
- as necessary for treatment (e.g., managing an emergency)
- in rare instances, as otherwise required by law (e.g., as a mandated reporter of child abuse)

If it is important to you that I communicate with you in particular ways (e.g., not to leave a message at your work number), please be sure to let me know. My full HIPAA Notice of Privacy Practices follows this page. The latest version is always available on my Web site (www.drstuartandrews.com/privacy), and will be provided to you in print on request. If you have any questions or issues about privacy, confidentiality, or how I manage your and your child's information, please speak to me or contact me.

E-mail and Text

E-mail and text are inherently insecure. To protect your privacy, I recommend we communicate in person or via telephone. If it is important for you to be able to communicate with me via e-mail or text, please read the section on e-mail and texting in my HIPAA Notice of Privacy Practices (next page), then initial the next paragraphs and sign below. I reserve the right to decline to discuss sensitive matters via e-mail or text.

I understand that if I initiate communication via e-mail or text, I am giving my Informed Consent for Dr. Andrews to reply to those messages (unless they specify not to), knowing the risk that these communication methods are inherently insecure, and messages may be accessible to people other than myself and Dr. Andrews.

Initial here_____

I acknowledge that if I pay Dr. Andrews via credit card, check, or PayPal, this may result in an e-mail or text confirmation or receipt being sent to me and/or to Dr. Andrews, confirming that I have paid Dr. Andrews for counseling services. (My bank or payment processor may give me the option not to receive electronic receipts; I acknowledge it is my responsibility to request this option.

Initial here_____

[Initial or cross out:] I give permission for Dr. Andrews to e-mail me about appointment scheduling/rescheduling. Initial here_____

You may withdraw any Informed Consent you've given any time in the future.

Please sign below to acknowledge you have read this page and been offered a copy of my full HIPAA Notice of Privacy Practices (next page, and online at www.drstuartandrews.com/privacy).

_____ Date: _____
Signature of Patient or Personal Representative

_____
Printed Name of Patient or Personal Representative

_____ Date: _____
Signature of Parent or Guardian

_____
Printed Name of Parent or Guardian

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HIPAA NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL/MENTAL HEALTH INFORMATION ABOUT THE PATIENT MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

I take the privacy of health and personal information extremely seriously. Almost every contact with a medical or mental-health professional involves communicating information related to the patient's health. This might be something you describe, a diagnostic impression, or even just your phone number. I need to record this information to provide good care, and it is my responsibility to keep it private and confidential.

All health information is protected under the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA) and other laws. Like most other mental-health professionals, I maintain even stricter standards of privacy than these laws require. This notice describes ways in which I may use such information, circumstances under which I may disclose it, what my obligations are in handling it, and what your rights are. My most current policy is always available on my Web site at www.drstuartandrews.com. If at any time you want a paper copy of this policy, please tell me and I will provide it for you.

In addition to keeping patient information confidential, I have a responsibility to communicate with you in ways that maintain privacy. Please be sure to tell me if there are addresses, phone numbers, or e-mail addresses you have provided to me that you do not want me to use for conversations, messages, etc.

Because mental-health treatment involves information that is often more personal and sensitive than general medical information, psychotherapy notes are kept separate from the medical record and receive an even higher level of privacy protection under HIPAA. The medical record includes information such as the initial evaluation, subsequent information about symptoms and functioning, and information (as applicable) about medical problems, medications, and side effects. It also includes information about life circumstances as they relate to any of those matters. The psychotherapy notes include information beyond what is necessary in the medical record, including feelings, thoughts, worries, and more intimate details of personal circumstances.

How I Use and Disclose Health Information

I routinely use health information for the following purposes: 1) Treatment: I use health information for diagnosis, treatment planning, and the treatment itself. As part of that process, I may provide information to other professionals and their staff, e.g., mental health professionals who cover for me when I am on vacation, and any person or organization with whom I share your information is also bound by the terms of HIPAA; 2) Health Care Operations: I use health information for administrative purposes, e.g., to contact you about appointment scheduling; 3) Payment: I use your information for billing and collection of payment for the services I provide. If you wish to use insurance, you will need to sign a consent form that permits me to share any necessary information with my billing service and your insurance provider(s), all of whom are also bound by the terms of HIPAA. This information generally includes a diagnosis code, and may include information about symptoms, functional status, risk behaviors, etc.

Subject to professional judgment, I may also use or disclose a patient's information in the following exceptional circumstances, without additional authorization: 1) In an emergency, I will disclose information when necessary to prevent a serious threat to a patient's health and safety, or the health and safety of the public or another person; 2) I can disclose information, subject to all applicable legal requirements, when required by law, subpoena, court order, etc. — for example, as a psychologist, I am a mandated reporter of child abuse; 3) I can use a patient's information to defend myself in the event of legal proceedings against me brought by or on behalf of that patient. In all of the above situations, I will try to disclose the minimum amount of information necessary to the situation at hand. Every other use of patient health information requires a specific authorization, signed by you. After you give such an authorization, you can prevent further disclosures at any time by giving me a written request revoking the authorization. The revocation does not affect any action taken prior to its receipt.

Your Rights Regarding the Patient's Health Information

Under HIPAA, you have the following rights regarding health information I maintain about the child:

- Right to Inspect and Copy: You have the right to inspect and copy the health information, such as medical and billing records. You do not have the right to inspect and copy psychotherapy notes, though I will attempt to accommodate such a request subject to my professional judgment. You do not have the right to inspect or copy information compiled by me in reasonable anticipation of, or for use in, a civil, criminal, or administrative action or proceeding.
- Right to an Accounting of Disclosures: You have the right to a list of the disclosures I have made of clinical information about the child for purposes other than treatment, payment, and health-care operations.
- Right to Request Restrictions: You have the right to request a restriction or limitation on the health information I use or disclose about the child for treatment, payment, or health-care operations. You also have the right to request a limit on the health information I disclose to someone who is involved in the child's care or the payment for it. Although I am not required under HIPAA to agree to all such requests, I am generally able to do so, except in cases where emergency treatment demands otherwise.
- Right to Amend: If you believe that clinical or billing information I have about the child is incorrect or incomplete, you can request that I change the information. If I accept the request, I will make reasonable efforts to inform others of the correction, as appropriate. If I deny the request, I will provide you with an explanation, and you may respond with a statement of disagreement that will be added to the information you wanted changed.

Continued ...

E-Mail and Text

I recommend that we communicate in-person or via telephone, because e-mail and text communication are inherently insecure. At the same time, HIPAA requires me to make the child's health information available to you (see "Right to Inspect and Copy" under "Your Rights Regarding Your Health Information," above). Therefore, if you request, I may be willing to communicate with you via e-mail or text, after you have read the following regarding the risks and have given your informed consent:

- You should not use an e-mail account or a phone provided by your employer to communicate with me. The employer has complete rights to all communications sent through such employer-provided services. Even appointment scheduling may be sensitive: You may not want everyone who has access to the employer's e-mail and phone systems to know the child is seeing a therapist.

- When using your own private e-mail or text-capable phone, be aware that it's possible those messages could be accessed by people working for the e-mail or phone company; they could be accidentally misdirected or forwarded to the wrong person, including by automated methods (e.g., an incorrectly configured forwarding rule); they may be seen by anyone with access to your e-mail account (e.g., a spouse); they may be stored for an extended period of time on computers owned by the e-mail service provider or by any Internet service providers involved in messages transmitted between you and me; they could be accessed by hackers (especially when using public WiFi, such as provided at cafés, or when a hacker steals or guesses your account password). Someone could see the message on your screen over your shoulder or when you step away from the device, or see a notification displayed on your phone's lock screen. Anyone who uses your phone or computer might see it.

- E-mails and texts may be considered part of patient health records, and I may store them as such.

- While I will endeavor to respond promptly, it may take up to 48 business hours (Monday–Friday excluding holidays) for me to reply to an e-mail or text message. For urgent matters, a phone call is preferred. My time spent on electronic communications is subject to the same fees as telephone communications.

Social Media

I do not communicate with or about clients or former clients using social media, including via direct messaging (txt or sms), nor do I accept "friend" or "connection" requests. It is very difficult, perhaps impossible, to ensure that such communications won't be seen by unwanted readers, and it may raise privacy concerns for other potential or actual clients. Some business review sites allow anyone to create a page or post about a business or service provider. While I cannot control such posts, I recommend that any clients wishing to post public reviews of therapists do so anonymously.

If you have any questions, comments, or concerns about my privacy practices, please speak to me, or contact me by mail, telephone, or e-mail, or via the contact form on the home page of my Web site, www.drstuartandrews.com (note that the security risks of e-mail apply). If you are not satisfied by my response to a complaint, you can also contact the Department of Health and Human Services (www.hhs.gov/ocr). HIPAA specifically forbids any sort of penalty for filing a complaint.

Updated September 15, 2018

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AUTHORIZATION FOR RELEASE OF INFORMATION

Your Name: _____

Address: _____

City: _____ State: _____

I authorized the following individual or facility to: ☐ **release** or ☐ **exchange** medical and/or mental health information with/to Dr. Stuart Andrews:

Name: _____

Address: _____

_____

City: _____ State: _____

Phone: _____ Fax: _____

Information authorized to be released:

☐ Medical Records
☐ Psychiatric Records
☐ Psychological Evaluation
☐ Behavioral Report
☐ Teacher's Report
☐ Verbal Exchange
☐ Other_____

Approximate Dates of Service: _____

For the Purpose of: _____

Release is valid: ☐ **for one year** ☐ **until termination of treatment**

_____ Date: _____
Signature of Patient or Personal Representative

_____
Printed Name of Patient or Personal Representative

_____ Date: _____
Signature of Parent or Guardian

_____
Printed Name of Parent or Guardian

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