Pamela Rebeck, Ph.D. (630) 815-8443

Please print, sign and return during your first appointment.

INFORMED CONSENT FOR TELEPSYCHOLOGY

CONSENT FOR TREATMENT:
Pamela Rebeck, Ph.D. provides evaluation, assessment, and psychotherapy to individuals, couples and families. Dr. Rebeck will generally develop a comprehensive treatment plan which will be modified regularly depending on the needs and progress of services provided. Should a higher level of care be indicated, she will work with you to achieve the most appropriate level of care and, if appropriate, refer you to a therapist, agency or facility that is able to provide you with a level of service appropriate to your needs.

Sometimes the therapy process results in experiencing intense emotional response and processing life experiences which may evoke positive or negative feelings. There is no way to estimate the duration of or quantify results as the therapeutic process is dynamic and unique to the issues, needs, and types of treatment that is most effective to each individual. Therapy, by its nature, requires continuous adjustments to the treatment plan and modalities of treatment. There is a small risk that your condition may worsen during treatment. If at any point you are unhappy about the progress, process, or outcome of your treatment, please discuss this with Dr. Rebeck so that, together, attempts can be made to resolve any difficulties and/or arrive at a treatment plan that better meets your needs.

By signing at the bottom of this document you consent to participate in mental health services/ therapy. You also acknowledge that patients who participate in mental health services must explore and analyze many personal, family, friendships and other interpersonal experiences and behaviors, both good and bad. Therapy will often assist in improving interpersonal relationships and resolution of the specific concerns that led you to seek therapy. Therapy requires commitment, effort, and consistent participation on your part to secure the best results. Successful therapy requires your involvement in the process and is most successful if you commit to being honest with your feelings and being willing to thoughts, feelings and/or behaviors.

Successful therapy is not a one-size-fits-all proposition. Often various treatment options such as various individual psychotherapy, group, couple, family or self-help therapies, and/or, in certain circumstances the referral to an MD for the evaluation and/or management of medication may be helpful. It is not unusual for a therapist to recommend or refer you to seek other treatment options.

This Informed Consent for Telepsychology contains important information focusing on psychotherapy using the phone or the Internet. Please read this carefully, and let me know if you

have any questions. When you sign this document, it will represent an agreement between us.

BENEFITS AND RISKS OF TELEPSYCHOLOGY:
Telepsychology refers to providing psychotherapy services remotely using telecommunications technologies, such as video conferencing, text messaging or telephone. One of the benefits of telepsychology is that the client and clinician can engage in services without being in the same physical location. This can be helpful in ensuring continuity of care if the client or clinician moves to a different location, takes an extended vacation, or is otherwise unable to continue to meet in person. It is also more convenient and takes less time. Telepsychology, however, requires technical competence on both our parts to be helpful. Although there are benefits of telepsychology, there are some differences between in-person psychotherapy and telepsychology, as well as some risks. For example:

- Risks to confidentiality. Because telepsychology sessions take place outside of the therapist's private office, there is potential for other people to overhear sessions if you are not in a private place during the session. On my end I will take steps to ensure your privacy. But it is important for you to make sure you find a private place for our session where you will not be interrupted. It is also important for you to protect the privacyofour session on your cell phone or other device. You should participate in therapy onlywhile in a room or area where other people are not present and cannot overhear the conversation.

- No recording. You also agree that there will be no recording of any kind of electronic sessions by either party. All information disclosed within sessions and written records pertaining to those sessions are confidential and may not be disclosed to anyone without written authorization, except where the disclosure is permitted and/or required by law outlined in the HIPPA Privacy Notice.

- Issues related to technology. There are many ways that technology issues might impact Telepsychology. For example, technology may stop working during a session, other people might be able to get access to our private conversation, or stored data could be accessed by unauthorized people or companies.

- Crisis management and intervention. Usually I will not engage in telepsychology with clients who are currently in a crisis situation requiring high levels of support and intervention. Before engaging in telepsychology, we will develop an emergency response plan to address potential crisis situations that may arise during the course of our telepsychology work.

- Emergency contact. You agree to provide your location in case of an emergency to Dr. Rebeck. You agree to inform her of the address where you are at the beginning of each session. She will require that a contact person may be contacted in an emergency only. This person will only be contacted to go to your location or take you to the hospital in the event of an emergency.

- Please provide this contact information below.

_____

Emergency Contact Name Relationship Phone Number

- Efficacy. Most research shows that telepsychology is about as effective as in-person psychotherapy. However, some therapists believe that something is lost by not being in the same room. For example, there is debate about a therapist's ability to fully understand non-verbal information when working remotely.

ELECTRONIC COMMUNICATIONS:
We will decide together which kind of telepsychology service to use. You may need a computer or cell phone systems to use telepsychology services. You are solely responsible for any cost to you to obtain any necessary Wi-Fi connectivity, equipment, accessories, or software to take part in telepsychology.

For communication between sessions, I use text messaging with your permission and only for administrative purposes, unless we have made another agreement. This includes things like setting and changing appointments, billing matters, and other related issues. While it is unlikely that anyone will see or acquire copies of any text communications, they are, by their nature, not secured. You should be aware that I cannot guarantee the confidentiality of any information communicated by text messaging. Therefore, I will not discuss any clinical information through text messaging and ask that you do not either.

Dr. Rebeck does not use email or any form of social media to communicate with patients. Neither email, text nor social media are HIPAA compliant and do not meet the ethical standards of therapists in the State of Illinois. Dr. Rebeck does not regularly read messages left on social media. Please sign below if you agree to text messaging of administrative matters.

_____

Printed Name Signature Date

COMMUNICATION:
I authorize Dr. Rebeck to communicate with me in the following ways: (Please check & initial)

□_____ Call / □_____ Leave a message Cellular phone _____

□_____ Call / □_____ Leave a message Home phone _____

□_____ Call / □_____ Leave a message Office phone _____

Treatment is most effective when clinical discussions occur at your regularly scheduled sessions. But if an urgent issue arises, you should feel free to attempt to reach her by phone and she will try to return your call within 24 hours. Sometimes a message gets lost due to technical issues or

unexpected circumstances on her end. If she does not call back within 24 hours, please leave a second message. If you are unable to reach her and feel that you cannot wait for her to return your call, contact your family physician or the nearest emergency room. If Dr. Rebeck will be unavailable for an extended time, she will provide you with the name of a colleague or referral source to contact, if necessary. Dr. Rebeck is unable to provide 24-hour crisis services.

CONFIDENTIALITY:
Dr. Rebeck has a legal and ethical responsibility to make her best efforts to protect all communications that are a part of telepsychology. However, the nature of electronic communication technologies is such that there cannot be a guarantee that our communications will be kept confidential or that other people may not gain access to our communications. She will try to use updated encryption methods, firewalls, and backup systems to help keep your information private, but there is a risk that our electronic communications may be compromised, unsecured, or accessed by others. You should also take reasonable steps to ensure the security of our communications (for example, only use secure networks for telepsychology sessions and strong passwords to protect the device(s) you use for telepsychology).

The extent of confidentiality and the exceptions to confidentiality that are outlined in Dr. Rebeck's other HIPPA documents go into more detail about privacy policy and these documents still apply to telepsychology. Please let her know if you have any questions about exceptions to confidentiality.

APPROPRIATENSS OF TELEPSYCHOLOGY:
Assessing and evaluating threats and other emergencies can be more difficult when conducting telepsychology than in traditional in-person therapy. By signing this document you agree that sometimes Dr. Rebeck may determine that her services are not appropriate and that a higher level of care is necessary. We would discuss emergency measures or engaging in-person counseling or referrals to another profession/agency/facility near your location who can provide appropriate services. Examples of some such circumstances are if you are having suicidal or homicidal thoughts, actively experiencing psychotic symptoms or experiencing a mental health crisis.

TECHNOLOGY:
If the session is interrupted and it is an emergency call 911. If you are not having an emergency, and we lose a connection while in session, Dr. Rebeck will wait two (2) minutes and then re-contact you via the telepsychology platform on which we agreed to conduct therapy. If you do not receive a call back within four (4) minutes, then call her at (630) 815-8443. If we attempt to call each other simultaneously we may encounter technical difficulties. If there is a technological failure and we are unable to resume the connection, you will only be charged the prorated amount of actual session time.

FEES:
Therapy sessions are generally between 53 to 55 minutes long, although the precise length may vary. Please arrive on time. If you are late your appointment time will not be extended. The number and and frequency of sessions are determined based on what is clinically necessary and may be affected by insurance coverage, each of our availabilities, or other relevant

circumstances. Regular and consistent sessions are necessary for effective therapy.

Please cancel or reschedule an appointment at least 48 hours in advance by voice mail or text message. Failure to cancel within at least 24 hours' notice will require you to pay for the missed session personally. The fee for sessions that are canceled more than 3 hours before the scheduled time, but less than 24 hours, is reduced from the full fee. However any appointments that are canceled less than 3 hours ahead or failure to show are charged the full fee, both the part that insurance would have covered and the part the client would have covered. It is important for you to understand that Dr. Rebeck has set aside your appointment time for you and cannot simply do other work if you are unable to attend. Fees for missed sessions are never paid by insurance companies and therefore you will be responsible for the payment for any missed appointments**.**

Payment is expected at the time of service. If you have an outstanding balance and you have trouble paying it, please discuss this issue with Dr. Rebeck so a solution can be attempted. Usually there is no outstanding balance on the patient's part because the patient's financial responsibility is collected at each session. The same fee rates will apply for telepsychology as apply for in-person psychotherapy. However, insurance or other managed care providers MAY not cover sessions that are conducted via telecommunication. If your insurance does not cover electronic psychotherapy sessions, you will be solely responsible for the entire fee of the session. Please contact your insurance company prior to our engaging in telepsychology sessions in order to determine whether these sessions will be covered. Be sure to record the conversation and get the related confirmation number from the representative.

PAYMENTS AND INSURANCE:

If Dr. Rebeck is not an in-network provider for your insurance, you will be expected to pay the entire session fee for each session at the time of the session. She has opted out of Medicare and Medicaid. The only insurance plans that Dr. Rebeck is in-network with are Blue Cross Blue Shield (BCBS) PPO and BCBS Blue Choice. If you are covered by them, as an in-network provider, she must comply with and accept payment pursuant to the contract that all of us have. The rates for in-network insurance companies may not be negotiated and they are fixed by contract. You are responsible, by law, for any co-payments, co-insurance or deductibles associated with your insurance coverage for services that are covered by your policy. There are certain services that Dr. Rebeck provides that MAY not be covered by insurance companies, including, but not limited to, telephone and video conversations/sessions, site visits, report writing and reading, drafting of summaries, and consultations with other professionals. If you have a telephone conversation with Dr. Rebeck that extends beyond 10 minutes it may be billed. Some expenses are never covered by insurance, such as expenses related to any legal process (including attorney's fees) or if a therapist is obligated to attend depositions or trials. If any of these uncovered services or expenses are provided or incurred, you will be charged an hourly rate. Charges for all of Dr. Rebeck's involvement in legal proceedings are significantly higher than psychotherapy charges.

If you have BCBS PPO or BCBS Blue Choice as primary insurance, then Dr. Rebeck normally billsthem directly as a convenience offered to you. You must inform her immediately regarding any changes to your insurance if she is billing your plan on your behalf. You will be

responsible for any co-payments, co-insurance or deductibles associated with your policy at the time of the session as well as any uncovered services as identified above. Merely because an insurance company authorizes services, they often do not guarantee payment and you will be ultimately responsible for the cost of services provided which are not reimbursed by insurance providers for whatever reason they are not covered. You (not your insurance company) are responsible for full payment of fees. It is important to confirm exactly what mental health services your insurance policy covers, record the conversation and get the related confirmation number from the representative. If you must obtain authorization from your primary care physician or your insurance company prior to treatment, it is your obligation to do so. Normally this type of authorization is only required if Dr. Rebeck is an out of network provider. Any secondary insurance claim filing is your responsibility.

If you do not have health insurance, you must pay the full private pay rate at the time of service. If Dr. Rebeck is an out of network provider, she will provide you with a bill suitable to present to your insurance company to secure any out of network reimbursement that your plan provides.

Failure to keep payments current may result in termination of services. If payment is not received from the insurance carrier or any other responsible third party within 90 days, the outstanding balance will be transferred and billed to you directly.

Dr. Rebeck accepts payment in the form of cash or check. Credit and debit cards are not accepted.

Please check & initial one of the two options below.

□_____ I authorize Dr. Rebeck to act as my agent in order to help me obtain payment from my healthcare/insurance provider. I also authorize the release of necessary information to the insurance company for the pursuit of payment. If my healthcare company changes, it is my responsibility to let her know immediately. If not, I will be responsible for payment of the balance on my account. I authorize insurance payments directly to Dr. Rebeck.

□_____ I do not authorize Dr. Rebeck to contact my healthcare provider for 3rd party payment. I understand that if I have insurance and have decided not to process any claims through my insurance company then I am personally obligated to pay the private pay/non-insured rates and waive any rights to a reimbursement rate as provided under my insurance policy. If at any time I choose to seek reimbursement for my services through any insurance policy, I will notify Dr. Rebeck and amend this section to provide for reimbursement for any prospective appointments and waive my rights to any prior completed appointments and costs.

TERMINATION OF THERAPY:
The length of your treatment and the timing of the eventual termination of your treatment depends on the specifics of your treatment plan and the progress you achieve. It is a good idea for us to plan together for your termination. You may discontinue therapy at any time. If you or Dr. Rebeck determine you are not benefiting from treatment, either you or Dr. Rebeck may elect

to initiate a discussion of your treatment alternatives and terminate treatment. In the unfortunate circumstance that you have an outstanding balance withher and you do not enter into an agreement to resolve payment of the outstanding balance, she may initiate suspension or termination of treatment until payment. If possible, upon termination Dr. Rebeck will attempt to provide you with referral resources.

DIVORCE/SEPARATION AGREEMENT:
When Dr. Rebeck provides services to individuals, children or adults, of families experiencing separation or divorce, the purpose is to aid the patient whom Dr. Rebeck is seeing through the challenges inherent with these trying circumstances, not to become a witness in the proceedings. Dr. Rebeck will not participate in or provide opinion in any custody arrangements, visitation schedules, or other family court matters.

HIPAA: (Please check & initial)
I understand, and have been given a copy of, the Privacy Notice as required by the Health Insurance Portability and Accountability Act. I will ask for explanation and clarification of any part of the notice I do not understand.

□_____ HIPPA Received

CONSENT TO TREATMENT OF MINORS UNDER 18 YEARS OLD: (If Applicable)
This section must be completed by the parents or legal guardian of each minor who attends therapy sessions. Both parents, unless the minor is in sole custody of only one parent,must certify that they consent to mental health services for the minor patient and accept all financial responsibilities for any services provided by Dr. Rebeck. I, hereby, give my authorization and consent for the minor patient to receive outpatient treatment from Dr. Rebeck. Please note that minors 12 years of age and over have many privacy rights similar to adults, however, in the event that the minor patient is making poor decisions that are dangerous and rise to an imminent risk of harm, disease or death, the parent will be notified immediately. I hereby consent to the treatment of the minor patient subject to the terms outlined above:

_____

Patient (printed name) Birth Date

_____

Parent/Legal Guardian (printed name) Signature Date

_____

Parent/Legal Guardian (printed name) Signature Date

GUARANTEE:
I, as guarantor/person assuming financial responsibility, understand that I will be unconditionally responsible for the payment of any uncovered services, costs, and expenses provided to the above identified patient in return for providing services to the identified patient. It is understood that as guarantor of payment I agree that prior to discontinuance of my unconditional

responsibility to pay for charges contemplated in this document I will give 90 days notice.

Guarantor (printed name) Signature Date

Street Address City State Zip Code

INFORMED CONSENT:
This agreement is intended as a supplement to the general informed consent and the Privacy Notice that we agreed to at the outset of our clinical work together and does not amend any of the terms of that agreement.

Your signature below indicates agreement with the terms and conditions herein.

Printed Name Signature Date

Printed Name Signature Date

Pamela Rebeck, Ph.D.
Signature Date