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PRACTICE POLICIES

INITIAL CONSULTATION

This office now requests that all new clients pre-pay to reserve their time for an intake and initial consultation.

THERAPY AND THE DURATION OF TREATMENT

Therapy begins with an evaluation of your needs. After your initial consultation, I will offer my impression of what our work together should include and a treatment plan to follow, should you decide to begin therapy. If we decide to work together, we will schedule once or twice weekly 45-minute or 60-minute sessions or longer for EMDR and couple's sessions. As needed (and with your consent), I will consult with your primary care physician, psychopharmacologist and other providers to ensure coordinated treatment. If you are considering medication, I work closely with a number of caring psychiatrists who can assist with that part of your treatment.

APPOINTMENTS AND CANCELLATIONS

Therapy is most effective when scheduled appointments are regular and consistent. Your time is reserved for you and cannot be used by someone else. A 48-hour cancellation policy applies. If less than 48 hours notice is given (72 hours for Monday appointments), I will still make every attempt to reschedule you within the same week at a time that works for both of us and a phone/video session will be offered. If we cannot find a time, you will be charged for the cancellation. I may waive the session charge at my discretion such as serious illness. In the case of hazardous weather conditions, you may cancel without penalty and a telephone or video conference session may be conducted. You will be charged for conflicts related to time management (e.g. homework, forgetfulness), work conflict, etc. To accommodate such situations, I am happy to offer you a phone session at the time of your scheduled appointment or later in the day or week. Unfortunately, missed and cancelled sessions will not receive a code on your statement and are not reimbursed by insurance. Please try to be on time for your sessions as every effort is made to end all sessions on time so as not to cause unnecessary delays for others who have appointments.

INSURANCE

I do not work directly with insurance companies, but if you have a PPO or another plan that allows you to select an out-of-network provider, you may be eligible for reimbursement. Policies vary significantly and I recommend checking with your insurance company to determine the extent of your out-of-network mental health (or "behavioral health") benefits, including your annual deductible, the number of sessions covered per calendar year, and whether or not your sessions need to be pre-authorized. While you would be responsible for payment at the end of each session, this makes the reimbursement process as smooth as possible.

FEES

Fees represent payment for my professional knowledge, training and experience. They also support outside work and between-session consultations needed to support the therapeutic relationship. In addition to regularly scheduled sessions, I charge for other professional services that may be required to support your care. These services may include: telephone conversations lasting longer than 15 minutes, consultations with other professionals involved in your treatment (hospitals, schools, etc.), legal services, preparation of letters, records and treatment summaries or any other professional service that you may request of me. This will be billed as administrative services, and unfortunately are not reimbursed by insurance. Payment is due at the end of your regularly scheduled session unless we make a different arrangement. Session fees will be charged the day of or after each session until you formally terminate. Please email me directly if you do not want to book a session online using your credit card. Additionally, you agree to allow Dr. Spicer to charge for sessions attended and sessions not cancelled within 48 hours. You also agree to provide another form of payment, cash, check or credit card if your previous card has been replaced.

PROFESSIONAL RECORDS

I maintain treatment records as required by the laws of my profession. You are entitled to receive a copy of your records, or if preferred, I can prepare a summary of your treatment. Sometimes these professional records can be upsetting or misinterpreted by the untrained reader. It is best that we review your records together in my office.

TELEPHONE ACCESSIBILITY

While I may try to return messages in a timely manner, I cannot guarantee immediate response and request that you do not use these methods of communication to discuss therapeutic content and/or request assistance for emergencies. If you need to contact me between sessions, please leave a message on my confidential voice mail. I am often not immediately available; however, I make every attempt to return your call as soon as possible. The exception to this is weekends and holidays, when I am traveling or have personal circumstances that prevent me from being available. If you are difficult to reach, please specify when you will be available. If you are unable to reach me and need immediate care, please contact your physician or go to the nearest emergency room and request a clinical social worker/ psychologist/psychiatrist on call. I ask that you not transmit sensitive clinical information via text or email as I do not always have access to either, and your confidentiality cannot be ensured.

MINORS

If you are a minor, your parents may be legally entitled to some information about your therapy. I will discuss with you and your parents what information is appropriate for them to receive and which issues are more appropriately kept confidential and between us.

ELECTRONIC COMMUNICATION AND TELECOMMUNICATION

I cannot ensure the confidentiality of any form of communication through electronic media, including text messages. If you prefer to communicate via email or text messaging for issues regarding scheduling or cancellations, I will do so. While I may try to return messages in a timely manner, I cannot guarantee immediate response and request that you do not use these methods of communication to discuss

therapeutic content and/or request assistance for emergencies. Please be aware that any email communications will become part of your medical records. If we agree to text or communicate via email, or you reach out to me initially in this way, I will assume that you have made an informed decision regarding this matter.

TERMINATION

Ending relationships can be difficult. Therefore, it is important to have a termination process in order to achieve some closure. The appropriate length of the termination depends on the length and intensity of the treatment. I have the right to terminate treatment with you and I will explain why this is necessary (e.g. psychotherapy is not being used effectively, your needs have changed or you may require a higher level of care, outbursts of rage or other threatening behaviors, persistent drug or substance use/abuse, attending sessions under the influence, engaging in illegal acts, default on payment). I will also terminate with you if you are seeing another therapist, unless we agree that it is clinically indicated. If therapy is terminated for any reason or you request another therapist, I will provide you with a referral. You also have the right to choose someone on your own or from another referral source. Should you fail to schedule an appointment for three consecutive weeks, unless other arrangements have been made in advance, for legal and ethical reasons, I must consider the professional relationship discontinued.

ABOUT SUSAN SPICER, PHD.

Dr. Spicer is licensed by the Board of Psychology in Florida and Michigan. She received her bachelor's degree from Central Michigan University and her master's and doctoral degrees in clinical psychology from Fielding Graduate University. Dr. Spicer has extensive experience in administering assessments and conducting evaluations in legal cases involving disability, child abuse, divorce, and criminal matters. She also conducts neuropsychological assessments of children, teens, and adults with many diverse diagnoses including cognitive disorders, ADHD, learning disabilities, and brain injuries. She provides therapy to children, teens, and adults as well as couples and families. She treats a wide range of disorders including depression, anxiety, trauma (PTSD), relationship issues, and obsessive and compulsive disorder (OCD). She is trained in Eye Movement Desensitization and Reprocessing (EMDR) through the Eye Movement Desensitization and Reprocessing International Association (EMDRIA). She is trained clinical hypnosis through the American Society for Clinical Hypnosis (ASCH).

INFORMED CONSENT FOR THERAPY

GENERAL INFORMATION

The therapeutic relationship is unique in that it is a highly personal and at the same time, a contractual agreement. Given this, it is important for us to reach a clear understanding about how our relationship will work, and what each of us can expect. This consent will provide a clear framework for our work together. Feel free to discuss any of this with me. Please read and indicate that you have reviewed this information and agree to it by signing and returning prior to our first session.

THE THERAPEUTIC PROCESS

You have taken a very positive step by deciding to seek therapy. The outcome of your treatment depends largely on your motivation and willingness to engage in this process, which may, at times, result in considerable discomfort. Should you choose to proceed, a positive outcome then becomes our

mutual responsibility. This begins with your trust in and commitment to the treatment process, and my commitment to address your questions and concerns as they come up during session. It also involves my commitment to you as your therapist, helping you to find healing and wholeness in your thoughts, feelings, behaviors, personal values, general well-being, while you discover more rewarding ways of relating to yourself and others. I can promise to support you and do my very best to understand you and repeating patterns, as well as to help you clarify what it is that you want for yourself. One important aspect of successful therapy involves attending sessions regularly. Treatment is more effective when it is consistent. Together, we will determine what kind of session frequency would best suit your needs.

RISKS ASSOCIATED WITH PSYCHOTHERAPY

Like many things in life, psychotherapy has inherent risks. Some of these risks to you are:

- disruptions in your daily life that can occur because of therapeutic changes
- emotional pain due to exploring personal issues and family history, feeling worse before you feel better
- experiencing emotional pain and changes within your current relationships
- although therapy begins with the hope that your life and relationship(s) improve, there is no guarantee that this will occur.

CONFIDENTIALITY

The session content and all relevant materials to the client's treatment will be held confidential unless the client requests in writing to have all or portions of such content released to a specifically named person/persons. Limitations of such client-held privilege of confidentiality exist and are itemized below:

1. If a client threatens or attempts to commit suicide or otherwise conducts him/her self in a manner in which there is a substantial risk of incurring serious bodily harm.

2. If a client threatens grave bodily harm or death to another person.

3. If the therapist has a reasonable suspicion that a client or other named victim is the perpetrator, observer of, or actual victim of physical, emotional or sexual abuse of children under the age of 18 years.

4. Suspicions as stated above in the case of an elderly person who may be subjected to these abuses.

5. Suspected neglect of the parties named in items #3 and # 4.

6. If a court of law issues a legitimate subpoena for information stated on the subpoena.

7. If a client is in therapy or being treated by order of a court of law, or if information is obtained for the purpose of rendering an expert's report to an attorney. Occasionally I may need to consult with other professionals in their areas of expertise in order to provide the best treatment for you. Information about you may be shared in this context without using your name.

HIPPA/NOTICE OF PRIVACY PRACTICES THIS NOTICE DESCRIBES HOW HEALTH INFORMATION MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. I AM REQUIRED BY LAW TO GIVE YOU THE FOLLOWING INFORMATION.

I. MY PLEDGE REGARDING HEALTH INFORMATION: I understand that health information about you and your health care is personal. I am committed to protecting health information about you. I create a record of the care and services you receive from me. I need this record to provide you with quality care and to comply with certain legal requirements. This notice applies to all of the records of your care generated by this mental health care practice. This notice will tell you about the ways in which I may use and disclose health information about you. I also describe your rights to the health information I keep about you, and describe certain obligations I have regarding the use and disclosure of your health information. I am required by law to:

• Make sure that protected health information (PHI) that identifies you is kept private.

• Give you this notice of my legal duties and privacy practices with respect to health information.

• Follow the terms of the notice that is currently in effect.

• I can change the terms of this Notice, and such changes will apply to all information I have about you. The new Notice will be available upon request, in my office, and may be on my website.

II. HOW I MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU:

The following categories describe different ways that I use and disclose health information. For each category of uses or disclosures I will explain what I mean and try to give some examples. Not every use or disclosure in a category will be listed. However, all of the ways I am permitted to use and disclose information will fall within one of the categories.

For Treatment Payment, or Health Care Operations: Federal privacy rules (regulations) allow health care providers who have direct treatment relationship with the patient/client to use or disclose the patient/client's personal health information without the patient's written authorization, to carry out the health care provider's own treatment, payment or health care operations.

I may also disclose your protected health information for the treatment activities of any health care provider. This too can be done without your written authorization. For example, if a clinician were to consult with another licensed health care provider about your condition, we would be permitted to use and disclose your person health information, which is otherwise confidential, in order to assist the clinician in diagnosis and treatment of your mental health condition. However, it is my practice to request that you sign a consent to obtain and release information form. It will be added to your file. Disclosures for treatment purposes are not limited to the minimum necessary standard. Because therapists and other health care providers need access to the full record and/or full and complete information in order to provide quality care. The word (treatment) includes, among other things, the coordination and management of health care providers with a third party, consultations between health care providers and referrals of a patient for health care from one health care provider to another.

Lawsuits and Disputes: If you are involved in a lawsuit, I may disclose health information in response to a court or administrative order. I may also disclose health information about your child in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

III. CERTAIN USES AND DISCLOSURES REQUIRE YOUR AUTHORIZATION:

1. Psychotherapy Notes. I do keep (psychotherapy notes) as that term is defined in 45 CFR 164.501, and any use or disclosure of such notes requires your Authorization unless the use or disclosure is: a. For my use in treating you. b. For my use in training or supervising mental health practitioners to help them improve their skills in group, joint, family, or individual counseling or therapy. c. For my use in defending myself in legal proceedings instituted by you. d. For use by the Secretary of Health and Human Services to investigate my compliance with HIPAA. e. Required by law and the use or disclosure is limited to the requirements of such law. f. Required by law for certain health oversight activities pertaining to the originator of the psychotherapy notes. g. Required by a coroner who is performing duties authorized by law. h. Required to help avert a serious threat to the health and safety of others.

2. Marketing Purposes. As a psychotherapist, I will not use or disclose your PHI for marketing purposes.

3. Sale of PHI. As a psychotherapist, I will not sell your PHI in the regular course of my business.

IV. CERTAIN USES AND DISCLOSURES DO NOT REQUIRE YOUR AUTHORIZATION. Subject to certain limitations in the law, I can use and disclose your PHI without your Authorization for the following reasons:

1. When disclosure is required by state or federal law, and the use or disclosure complies with and is limited to the relevant requirements of such law.

2. For public health activities, including reporting suspected child, elder, or dependent adult abuse, or preventing or reducing a serious threat to anyone’s health or safety.

3. For health oversight activities, including audits and investigations.

4. For judicial and administrative proceedings, including responding to a court or administrative order, although my preference is to obtain an Authorization from you before doing so.

5. For law enforcement purposes, including reporting crimes occurring on my premises.

6. To coroners or medical examiners, when such individuals are performing duties authorized by law.

7. For research purposes, including studying and comparing the mental health of patients who received one form of therapy versus those who received another form of therapy for the same condition.

8. Specialized government functions, including, ensuring the proper execution of military missions; protecting the President of the United States; conducting intelligence or counterintelligence operations; or, helping to ensure the safety of those working within or housed in correctional institutions.

9. For workers' compensation purposes. Although my preference is to obtain an Authorization from you, I may provide your PHI in order to comply with workers' compensation laws.

10. Appointment reminders and health related benefits or services. I may use and disclose your PHI to contact you to remind you that you have an appointment with me. I may also use and disclose your PHI to tell you about treatment alternatives, or other health care services or benefits that I offer.

V. CERTAIN USES AND DISCLOSURES REQUIRE YOU TO HAVE THE OPPORTUNITY TO OBJECT:

1. Disclosures to family, friends, or others. I may provide your PHI to a family member, friend, or other person that you indicate is involved in your care or the payment for your health care, unless you object in whole or in part. The opportunity to consent may be obtained retroactively in emergency situations.

VI. YOU HAVE THE FOLLOWING RIGHTS WITH RESPECT TO YOUR PHI:

1. The Right to Request Limits on Uses and Disclosures of Your PHI. You have the right to ask me not to use or disclose certain PHI for treatment, payment, or health care operations purposes. I am not required to agree to your request, and I may say "no" if I believe it would affect your health care.

2. The Right to Request Restrictions for Out-of-Pocket Expenses Paid for In Full. You have the right to request restrictions on disclosures of your PHI to health plans for payment or health care operations purposes if the PHI pertains solely to a health care item or a health care service that you have paid for out-of-pocket in full.

3. The Right to Choose How I Send PHI to You. You have the right to ask me to contact you in a specific way (for example, home or office phone) or to send mail to a different address, and I will agree to all reasonable requests.

4. The Right to See and Get Copies of Your PHI. Other than (psychotherapy notes) you have the right to get an electronic or paper copy of your medical record and other information that I have about you. I will provide you with a copy of your record, or a summary of it, if you agree to receive a summary, within 30 days of receiving your written request, and I may charge a cost based fee for doing so.

5. The Right to Get a List of the Disclosures I Have Made. You have the right to request a list of instances in which I have disclosed your PHI for purposes other than treatment, payment, or health care operations, or for which you provided me with an Authorization. I will respond to your request for an accounting of disclosures within 60 days of receiving your request. The list I will give you will include disclosures made in the last six years unless you request a shorter time. I will provide the list to you at no charge, but if you make more than one request in the same year, I will charge you a cost based fee for each additional request.

6. The Right to Correct or Update Your PHI. If you believe that there is a mistake in your PHI, or that a piece of important information is missing from your PHI, you have the right to request that I correct the existing information or add the missing information. I may say "no" to your request, but I will tell you why in writing within 60 days of receiving your request.

7. The Right to Get a Paper or Electronic Copy of this Notice. You have the right get a paper copy of this Notice, and you have the right to get a copy of this notice by e-mail. And, even if you have agreed to receive this Notice via e-mail, you also have the right to request a paper copy of it.

Acknowledgement of Receipt of Privacy Notice Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), you have certain rights regarding the use and disclosure of your protected health information. By checking the box below, you are acknowledging that you have received a copy of HIPPA Notice of Privacy Practices.

Signature_____Date_____