TEMA THERAPY CENTER

Irina Volynsky, Ph.D.
Clinical Director

NYS Lic. 68-017595 NJS Lic. 4732
440 West Street, Fort Lee, NJ 07024
(347) 879-0202

PSYCHOLOGIST-PATIENT SERVICE AGREEMENT
NOTICE OF PRIVACY PRACTICES & INFORMED CONSENT

This notice contains important information about my professional services and business policies; it also will tell you about how I, Irina Volynsky, handle information about you and your child (further, both of these entities are referred to as "patient" or "you"). In addition, it contains summary information about the Health Insurance Portability and Accountability Act (HIPAA), a federal law that provides privacy protection and explains patient rights with regard to the use of disclosure of your Protected Health Information (PHI), used for the purpose of evaluation, treatment, payment, and health care operations. Federal law has also been expanded by the Health Information Technology for Economic and Clinical Health (HITECH) Act, which strengthens privacy and security rules for electronic health information and requires notification in the event of certain types of data breaches. I am required by law to maintain the privacy of your PHI, to provide you with this notice of my legal duties and privacy practices, and to notify you following a breach of unsecured PHI as required by applicable law.

The law protects the privacy of all communications between a patient and a psychologist. In most situations I can only release information about your evaluation or treatment to others if you sign a written authorization form that meets certain legal requirements imposed by state law or HIPAA. Patients who are 14 or older must sign the written authorization form. Under New York law, minors may have additional rights to consent to or withhold consent for certain types of treatment or disclosure under specific circumstances; if such situations arise, I will discuss them with you in more detail. The law requires that I obtain your signature acknowledging that I have provided you with this information. When you sign this document, it will represent an Agreement between us. You may revoke this Agreement at any time. That revocation will be binding on me unless 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.

PSYCHOLOGICAL SERVICES
Various psychological services include evaluation and testing, consultation, and psychotherapy. Evaluation and testing are usually conducted at your request or request of other professionals or agencies. It may include gathering of developmental history, the testing itself, in vivo observation if applicable, a feedback session, and presenting you with a written report.

Consultation usually includes discussing your presenting problem and treatment options that are available; referrals will also be presented to you. Psychotherapy varies depending on the personalities of the psychologist and patient, and the particular problems you bring forward. There are many different methods I may use to deal with problems that you hope to address. Psychotherapy is not like a medical doctor visit. Instead, it calls for a very active effort on your part.

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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 or helplessness. On the other hand, psychotherapy has also been shown to benefit people who go through it. Therapy often leads to better relationships, solutions to specific problems, and significant reductions in feelings of distress. However, one cannot predict how these experiences will unfold or how intense these experiences will be for you.

Our first few sessions will involve an evaluation of your needs. By the end of the evaluation, impressions of what our work will include will be discussed if you decide to continue with me. You should consider this feedback carefully, along with your impressions of how we would work together and whether you feel comfortable going forward. Like any relationship, therapy involves a large commitment of time and energy, as well as a financial commitment, so you should be very careful about the therapist you select. Please feel free to ask any questions you have about my approach so that we may discuss them whenever they arise. If your doubts persist, I will be happy to help set you up with a consultation with another mental health professional for a second opinion.

PROFESSIONAL FEES
My fee is $420 per 60-minute individual, couples, or family session. In cases in which my fee would pose a clear financial burden, TEMA Therapy Center may negotiate a fee reduction based on documented, demonstrated financial need. In addition to weekly appointments, I charge this amount for other professional services, such as consultations, report writing, telephone conversations lasting longer than 15 minutes, attendance at meetings with other professionals you have authorized, preparation of records or treatment summaries, and the time spent performing any other services you may need. If you become involved in legal proceedings that require my participation, you will be expected to pay for my professional time even if I am called to testify by another party. My fee is subject to change at any time, and you will be notified thirty (30) days in advance of this change.

GOOD FAITH ESTIMATE / NO SURPRISES ACT NOTICE

Under federal law (the “No Surprises Act”), you have the right to receive a “Good Faith Estimate” explaining how much your mental health care is expected to cost when you are uninsured or when you choose not to use insurance and pay out of pocket. You may request a Good Faith Estimate before scheduling services, and you may also request an updated estimate at any time during treatment. This estimate is not a contract and does not obligate you to receive services, but it is intended to help you understand and plan for the potential costs of your care.

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CONTACTING ME

I am not immediately available by telephone, and I do not answer the phone when I am in session. When I am unavailable, my telephone is answered by voicemail mail and I will make every effort to return your call within 24 hours, except weekends and holidays. If you are difficult to reach, please inform me of times that will be available, and I will try to call you back then. If you are unable to reach me and feel that you cannot wait for me to return your call, contact your family physician, call 988 (the Suicide and Crisis Lifeline), call 911, or go to the nearest emergency room. If I am unavailable for an extended period of time, I will provide you, in advance of my absence, with the name of a colleague to contact in the event of an emergency.

At your request, limited communication may occur via email or text messages, such as you informing me of appointment cancellation or a need to reschedule. At your request, I may respond to such an email or text. You should be aware that such communication is not secure and confidential by its nature, and you should not provide me with any information via text or emails that you are not comfortable disclosing to the general public. If you choose to communicate with me by email or text, you acknowledge and accept these risks. You may request in writing that I limit or avoid using these forms of communication, and I will make reasonable efforts to honor your preferences.

TELEHEALTH SERVICES

From time to time, services may be provided using telehealth technologies (for example, secure video or telephone sessions) instead of in-person sessions. Telehealth can be a helpful way to receive care when in-person visits are not possible or practical. However, telehealth also has potential limitations and risks, including technical difficulties, interruptions, and increased risks to confidentiality if you are in a location that is not private or if there are security failures on the part of your internet, phone, or other service providers. By participating in telehealth, you agree that you will inform me of your physical location at the start of each telehealth session, and that you will make reasonable efforts to participate from a private, safe environment. If a telehealth session is disrupted due to technical problems, we will attempt to re-establish the connection or resume by phone. If I believe that you are at risk of harming yourself or others during a telehealth session, I may use the information you have provided about your location and emergency contacts to try to arrange for help, including contacting local emergency services. You may withdraw your consent to telehealth at any time by informing me in writing, understanding that this may affect the availability of services.

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BILLING AND PAYMENTS
I expect full payment at the end of every session. If you need to miss a session and inform me at least 24 hours in advance, I will offer you a make-up appointment within the next 2-3 weeks. However, if you missed a session without 24-hour notice, I have a right to charge you the full amount for this session. Please note that insurance companies typically do not provide reimbursement for cancelled or missed sessions. I will inform you in advance of my vacation and will expect you to discuss such plans as well. At the end of each month, you will be presented with a written statement of services provided, which includes dates of your sessions and the amount paid. You should keep track of your sessions, as errors are always possible. Please bring any discrepancies to my attention for review.

If your account has not been paid for more than 30 days and arrangements for payment have not been agreed upon, I have the option of using legal means to secure payment. This may involve hiring a collection agency or filing an action in small claims court. 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.

INSURANCE REIMBURSEMENT
I practice mostly on a self-pay basis. If you have a health insurance policy, it may provide some coverage for out- of-network mental health treatment. I will provide whatever assistance I can to help you receive benefits to which you are entitled, such as providing statements or "superbills" that list diagnosis codes, dates of service, and fees. However, in the end, you - not your insurance company - are responsible for full payment.

PROFESSIONAL RECORDS
The laws and standards of my profession require that I keep Protected Health Information about you in your Clinical Record. It is likely to include the following:

• Your personal history
• Reasons you came for treatment: problems, symptoms, needs, goals
• Diagnoses: medical terms for your problems, symptoms, disabilities
• Treatment Plan: services that I think will help you
• Progress Notes
• Records from others who treated or evaluated you
• Psychological test scores, school records, and the like
• Information about medications you are taking
• Legal matters
• Billing and insurance information

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Except in unusual circumstances that involve danger to yourself and/or others or where information has been supplied to me confidentially by others, you may examine and/or receive a copy of your Clinical Record (electronic or paper, depending on the way information was stored), if you request it in writing. Because these are professional records, they can be misinterpreted to untrained readers. For this reason, I recommend that you review them in my presence so that we can discuss the contents. If I refuse your request for access to your records, you have a right of review, which I will discuss with you upon request. In accordance with applicable New York and New Jersey law and professional standards, I retain adult patient records for at least seven (7) years after the last date of service. For minor patients, records are retained for at least seven (7) years after the patient reaches the age of eighteen (18), or for any longer period required by law.

PATIENTS RIGHTS
HIPAA provides you with expanded rights with regard to your Clinical Records and disclosures of Protected Health Information (PHI). These rights include requesting that I amend your record, requesting restrictions on what information from your Clinical Record is supplied to others, requesting an accounting of most disclosures of Protected Health Information that you have neither consented to nor authorized, determining the location to which protected information disclosures are sent, having any complaints you make about my policies and procedures recorded in your records, and the right to a paper copy or electronic copy of this Agreement, the included Notice Form, and my privacy policies and procedures. You also have the right, in most cases, to receive your records in electronic form if you so request.

In addition, you have the right to equal consideration and treatment regardless of your sex, age, race, religion, color, economic status, or sexual preference. You have the right to know my assessment of your (or your child's) problem, the recommended treatment plan, and resources available to help improve this problem. You also have the right to refuse treatment, which means that even though I may strongly suggest that you (and/or your child) seek help, you may choose not to follow my advice. Should you choose to refuse treatment, you will be advised of the consequences that may result from your refusal. Alternative forms of treatment or help may be available.

I am happy to discuss all of the above-mentioned rights with you.

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LIMITS ON CONFIDENTIALITY

When your information is read by me or other professionals related to your treatment, it is called "use." If the information is shared with or sent to others outside this office, it is called "disclosure." Except in some special circumstances, when I use your PHI or disclose it to others, I share only the minimum necessary PHI needed for the purpose. The law gives you rights to know about your PHI, how it is used, and to have a say in how it is disclosed. The law protects the privacy of all communication between a patient and a psychologist. In most situations, I can only release information about our work to others if you sign an Authorization Form that meets clear legal requirements imposed by HIPAA. There are other situations that require your advanced written consent. Your signature on this Agreement provides consent for those activities, as follows:

- I may occasionally find it helpful to consult with other professionals about your case. During a consultation, I make every effort to conceal your identity. Other professionals are also legally bound to keep this information confidential. I will note all consultations in your Clinical Record.
- Disclosures required by health insurers, or to collect overdue fees, are described in this Agreement.
- If you present danger to yourself or others, I may be obligated to seek hospitalization for you, and/or to contact family members, and/or anyone else who can help provide protection.

- **Treatment Team Information Sharing:** We, at TEMA Therapy Center, LLC, are a treatment team of mental health professionals who play various roles in serving your mental health needs. I may consult with other members who participate in your treatment process (your family therapist, for example, if I work with you individually, or your child's therapist) regarding varied details of your case. Consulting with other providers within TEMA Therapy Center is covered in this document, and I will not obtain a separate "Disclosure of Information Form" from you to consult with my colleagues who are pertinent to your treatment. Each treatment team member is bound by the same confidentiality rules.

There are some situations in which I am permitted or required to disclose information without either your consent or Authorization:

- If you are involved in a court proceeding and a request is made for information concerning the professional services that I provided, or provide for you, such information is protected by the psychologist-patient privilege law. I cannot provide any information without your written authorization or court order. If you are involved in or contemplating litigation, you should consult with your attorney to determine whether a court would be likely to order me to disclose information.

If a government agency is requesting the information for health oversight activities, I may be required to provide this to them.

- If you file a complaint or lawsuit against me, I may disclose any relevant information in order to defend myself.
- If I am providing treatment for conditions directly related to a Worker's Compensation claim, I may have to submit such records, upon appropriate request, to the Chairman of the Worker's Compensation Board on such forms and at such times as the chairman may require.
- I have to disclose information necessary to enable a patient to apply for or receive benefits when that person is not capable of consenting or is not available to do so.
- I may have to disclose to an officer of the law or prosecuting attorney conducting an investigation of a criminal offense, or attempting to apprehend a fugitive, in which case I may disclose whether a person is present at my office or office building. The police must present a case number and the purpose of the investigation or an outstanding arrest warrant.
- I may have to disclose your PHI to the Office of the Inspector General for the Department of Children and Family Services in cases in which the patient is an alleged perpetrator of abuse or neglect, the subject of an abuse or neglect.

There are some situations in which I am legally obligated to take actions that I believe are necessary to attempt to protect others from harm and I may have to reveal some information about your treatment. These situations are unusual in my practice.

- If, in my professional capacity, I receive information from a child or the parents, guardian or other custodian of a child that gives me a reasonable cause to suspect that a child is being abused or neglected, the law requires that I report to the appropriate governmental agency, usually to the statewide central register of child abuse and maltreatment, or to the local child protective services office. Once such a report is filed, I may be required to provide additional information.

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● If you communicate the intention or convey plausible likelihood to act on an immediate threat of serious physical harm to an identifiable victim(s), then a Duty to Warn and Protect will be legally incurred by me as a healthcare clinician and I will be required to take protective actions. These actions include but may not be limited to:

- notifying the potential victim about the prospective danger;
- seeking voluntary or involuntary psychiatric hospitalization for the patient;
- contacting the Chief of Police or acting officer in this capacity in the jurisdiction(s) where the intended victim and patient reside for the purpose of protecting the victim and conducting a firearms check.

If either such situation arises, I will make every effort to fully discuss it with you before taking any action and I will limit my disclosure to nonclinical information.

Timely written permission. If an urgent but non-life-threatening situation requires my correspondence with another party, I may use or disclose your information with parties that are directly involved in your treatment with your electronic written permission, such as by email or text.

Unless you tell me not to, I may contact you or leave messages on your voicemail to remind you of appointments and to offer information about referrals and treatment alternatives.

YOUR RIGHTS REGARDING YOUR PHI: You have the following rights regarding PHI I maintain about you. To exercise any of these rights, please submit your request in writing to: Irina Volynsky, Privacy Officer, 440 West Street, Suite 323, Fort Lee, New Jersey 07024:

HI-TECH BREACH NOTIFICATION: In the event that unsecured PHI about you is subject to a breach, I will notify you without unreasonable delay and in accordance with federal and state law. This notice will include, to the extent known, a description of what happened, the types of information involved, steps you can take to protect yourself, what I am doing to investigate and reduce harm, and contact information for further questions.

If you have a problem with how your PHI has been handled, or if you believe your privacy rights have been violated, please let me know. You have the right to file a complaint with me and with the Secretary of the Federal Department of Health and Human Services. I will not in any way limit your care or take any actions against you if you complain. I am the designated privacy officer for my practice and for TEMA Therapy LLC, and I can be reached by phone at (347) 879-0202.

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