Confidentiality Statement

Information about you will be kept strictly confidential. Please be aware of the following exceptions:

1. If you present a danger to yourself or others, I have a legal requirement to help keep you safe and a duty to warn potential victims.

2. If you identify any known or suspected abuse of a child, an elder, or person with a disability, I am required by law to report such abuse to the appropriate state agency.

3. If ordered by a judge in a court of law, I am required to provide access to your records; however, I would first assert legal privilege in an effort to protect your confidentiality.

In the case of minors (17 years of age and younger), parents have a legal right to health protected information.

Please ask any questions necessary regarding the limits of confidentiality. If you have no further questions, please initial here: ______ and sign below to indicate that you have read this statement and understand the contents.

Financial Investment, Scheduling and Cancellations

All consults will be conducted via the HIPAA secure platform **doxy.me/dreddieoc**. If for some reason that doesn't work, we may use FaceTime (my number is 616-328-3686) or Zoom. If there is a connection problem, we may use just audio, as necessary. Please be sure to be in a quiet, private space (remove pets, phones and other distractions) and secure a strong, reliable internet connection (be close to your router and minimize other devices on your wifi). Please place your face at the top of the screen (for best eye contact) and using a larger, stable screen (laptop or desktop) is preferred over smaller, hand-held phone.

The initial 55-min consultation is $275. Follow-up consultations are $225 per 40-45-min. ($265 if we extend past 50 min; $175 for 25-min or less).

Payments will be made via Ivy Pay, a HIPAA secure service that stores your credit/debit/HSA card. I will text you the link at the conclusion of our first meeting. Consults will be billed immediately after each meeting and you will be e-mailed a receipt.

I do not bill insurance. Please check limits of "out of network" coverage with your insurance provider for codes 90791-95 (Psychiatric Evaluation) and 90834-95/90837-95 (Psychotherapy 45 min/55 min) (-95 indicates tele-health, which may be different coverage than in-person) prior to meeting as pre-authorization may be needed for reimbursement. I will send an invoice at the end for every month for you to submit to your insurance as an out-of-network provider, if requested by initialing here: _____ and *if a psychological diagnosis can be given*. Mental training is not covered by insurance.

Please arrive on-time to respect our work together. If you are late, sessions may not be able to run late (I will if I can) and you will be billed for the full scheduled appointment. Insurance will only cover the face-to-face time, so there may be a difference in reimbursement.

If you need to cancel a scheduled appointment, please do so **48 hours in advance**. This allows me to offer that hour to someone else. I recognize that life happens and therefore, one "emergency" cancellation (without 48 hours notice) is accepted. After your one "emergency" cancellation is used, ALL future cancellations will be billed in full if less than 48 hours notice is given, <u>even if it is an emergency</u>. Insurance does not cover this.

Preparing for Tele-Health Meeting

Please be sure to test your internet connection and the link prior to our first appointment. Be sure your microphone and camera are on. Choose a comfortable, private location so that you will not be disturbed. You may want to lock the door. Remove all distractions such as pets and silence your cell phone. Using a laptop or desktop computer is best for visual contact. Arrive a few minutes early to each session to be sure you have a good connection. You will be in the virtual waiting room and I will start our session when it is time to begin.

Consent to Consultation

I have read all the information above. I have been given a copy of this document. I have discussed any and all concerns about this information to my satisfaction and agree to the terms within. I am willingly consenting to working with Dr. O'Connor under the parameters stated in this document.

Signature & Date ______________________ Parent/Guardian Signature if client is a minor ______________________

Printed Name ______________________ Client Birthdate ______________________

Street Address ______________________ City, State, Zip ______________________

Home/Cell Phone __________/__________ E-mail ______________________

Emergency Contact Name ______________________ Emergency Contact Phone # ______________________

Cell # to text Ivy Pay link ______________________ Name on Credit/Debit/HSA card ______________________

________ **Yes, please add me to the e-mail list so I can stay up to date with free mental training resources and updates. (Your e-mail will never be shared with third-parties or be used for anything other than communication from Dr. Eddie O'Connor, PLLC)**