Dr. Monica Lake, PLLC
Licensed Psychologist
Insight to Grow

Psychological Services
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813-444-8760
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Welcome to Dr. Lake's Psychological Services Practice!

Welcome to Dr. Monica Lake, PLLC. This document outlines the policies, practices, and guidelines followed by Dr. Lake, and also serves as your agreement form for services and fees. It is important that you read this document carefully and ask any questions you might have, as your signature indicates that you have read and understood the information, freely consent to participate in this assessment, and agree to abide by terms outlines in this document. In an event of emergency, please call 911 or go to your nearest emergency room.

Psychotherapy/Consulting

Dr. Lake offers psychotherapy services to children and adolescents. She utilizes various evidence-based approaches, and these vary depending on the personality of the child and the problem presented. Psychotherapy may be difficult for some youth since therapy often involves discussing unpleasant aspects of life. However, therapy has also been shown to have benefits for youth who go through it. There are no guarantees of what your child will experience. Psychotherapy has the most successful outcomes when the child is actively engaged in the process. It may take longer to notice changes in children and adolescents who struggle with motivation. However, Dr. Lake can utilize Motivational Interviewing techniques to encourage positive changes. The first few sessions will involve an evaluation of your child's needs. This will help the development of a treatment plan, which will be shared with you and your child. Any concerns outside of Dr. Lake's scope of practice and competencies will be reviewed with you so that you can seek services with a professional who has expertise in the area of concern.

Assessment/Testing Evaluations

Dr. Lake offers psychological evaluation services to children and adults. She utilizes various assessment methods, which will be selected depending on the presenting concerns. Often evaluations fatigue students, therefore, children will be encouraged to take various breaks and if needed, the evaluation will be broken up into 2-3 sessions. Although Dr. Lake is able to provide diagnoses, please note that such diagnoses do not automatically make a someone eligibility for special programs (i.e., 504 Plan, IEP, housing accommodations).

Contacting Dr. Lake

If you need to contact Dr. Lake, the best way to do so is by email or text. She will make every effort to return your call within 3 business days with the exception of holidays and/or vacations, which may result in a longer wait. Dr. Lake does not provide 24-hour services. If you feel that you cannot wait for your call to be returned, dial 911 or proceed to your nearest emergency room immediately.

Dr. Lake understands the convenience of electronic communication. Email, phone, and text forms of communication are limited in their security. If you choose to send these communications, please understand that there is a risk that your information may be intercepted by a third party and these communications are not encrypted. Therefore, Dr. Lake cannot guarantee the security of the information. If you need to communicate sensitive information with Dr. Lake, it is best to do so in person.

Confidentiality

It is important for youth to discuss problems and concerns with a neutral party without fear of judgment or repercussions. In addition, ethical standards require that Dr. Lake's work with you and your child remains confidential. Thus, the specific information your child discusses during individual sessions will remain private between Dr. Lake and your child. However, there may be instances in which something emerges in a therapy session that Dr. Lake believes should be discussed with you, the parent/guardian. On these occasions, Dr. Lake will work with your child to consider strategies for sharing the information with you. That may involve Dr. Lake disclosing to you with your child's permission or supporting your child's efforts to disclose to you directly. Because for therapy to be success children need to feel confident that is discussed remains confidential, your signature in this agreement also waives your rights to request Dr. Lake's testimony in a court of law regarding child custody issues when therapeutic services are involved.

The only occasions in which Dr. Lake would disclose something discussed in treatment without you or your child's permission are as follows:

- ✓ Abuse & Neglect. Dr. Lake is mandated by law to report cases of suspected child or a vulnerable adult abuse or neglect.
- ✓ Suicide. If your child is in imminent danger of killing himself or herself, Dr. Lake will need to breach confidentiality in order to keep your child safe. This may include informing parents or legal guardians or taking action to see that your child receives additional psychological support.
- ✓ Homicide. If your child discloses that he or she is planning to kill or hurt someone, the Dr. Lake is required by law to inform law enforcement, inform the intended victim(s), and inform any other necessary individuals in order to prevent loss of life.
- ✓ As mandated by law. For example, if Dr. Lake receives a subpoena, she may be required to submit your records as part of a legal proceeding.

Release of Information

It is understood that any and all data (including standardized test data) obtained by Dr. Lake will require formal written consent prior to disclosure in any form to anyone other than me. Moreover, should Dr. Lake present her finds in the form of a written evaluation report, the report will be subject to review by the receiving agency. Whether or not the receiving agency accepts the data submitted in the report is solely the responsibility of that agency.

Fees & Payments

Assessment: Fees for assessments are discussed upfront, and typically involved a flat fee for service. Fees are set in accordance with the type and extent of services that are conducted. This fee covers the full assessment process from intake through feedback session. Parent/Legal Guardian must pay a 50% non-refundable deposit to secure the first testing session. The remainder 50% fee is

due prior to the scheduled feedback session and completion of a written report. No evaluation reports will be written until full payment is made. Please notify Dr. Lake if any problem arises regarding your ability to make timely payments.

If this assessment is being paid for by a school district or other referring party, the parent and/or client is responsible for payment of any balance above what the secondary party pays. Dr. Lake's fee for other non-legal professional services is $150 per hour (including any travel time), which is charged in minimum increments of 15 minutes. These services may include off-site consultation (e.g., school, medical office, with a mental health provider), documents (e.g., letters, abbreviated reports, email communication, completion of paperwork), telephone conversations lasting longer than 15 minutes, and the time spent performing any other service you may request. Payment for these fees will be agreed to when the services are requested.

Psychotherapy & Consultation: Parent/Legal Guardian are expected to pay their session fee at the time services are rendered. If denied/rejected or not covered by their insurance or other payor, payment is due within 15 days of the date of service or 5 days of invoice. The Parent/Legal Guardian is ultimately responsible for all fees regardless of their insurance status.

All Services: At the time of scheduling the first appointment, Parent/Legal Guardian will be asked to pay for the session to hold your spot, using a secure, HIPAA-secure credit card processing service called **Ivy Pay**. Card processing adheres to PCI Data Security Standard (PCI DSS). You will receive a text message from Ivy, asking you to enter your credit card information and make your first payment. This is a one-time set up. Thereafter, each time a fee is generated, it will be charged to this credit card using Ivy. (If you prefer, you may pay for in-person services after the first appointment with cash. We can discuss other payment options if you'd like.) If your card is charged for a session or for one of the other services described above, you will receive a text message notifying you that a fee has been processed.

The fee for a returned check is $35. If payment is not received within 60 days, or payments are not made as agreed, Dr. Lake may submit the invoice to an attorney or collection agency. If such legal action is necessary, you will be responsible for all costs of collection, including reasonable attorneys' fees. In most collection situations, the only information Dr. Lake will release regarding a client is their name, the nature of the services provided, and the amount due.

If you become involved in legal proceedings that require Dr. Lake's participation, you will be expected to pay for her professional time even if she is called to testify by another party. Because of the complex issues involved in legal proceedings, Dr. Lake's hourly fee is $350 (with a $2,800 retainer) for preparation, travel, and attendance at any legal proceeding. You will also be billed for any out-of-pocket expenses that may be incurred on your behalf such as delivery charges, travel costs, and court expenses.

Cancellations and Missed Appointments

If you wish to change any scheduled appointment, you are required to do so 24-hours prior to the appointment in order to avoid being billed for the session. Please call, email, or text Dr. Lake to change your appointment. If a cancellation or rescheduling occurs with less than 24 hours' notice,

you will be responsible for paying an additional late cancellation fee of $150 for assessment appointments or the full fee is charged for counseling/consultation sessions.

Termination
Consistence attendance is critical for achieving the goals of selected services. Dr. Lake reserves the right to terminate services when 2 consecutive sessions are missed.

Insurance
At this time, Dr. Lake is not an in-network provider for any medical insurance plan, except Medicare. She may be able to provide you with an itemized statement which documents your/your child's diagnosis(es), CPT codes, and payments so that you may file your own claims. You (not your insurance company) are responsible for full payment of Dr. Lake's fees. In instances where extraordinary professional time is required, you may incur additional fees, charged at $150 per hour/prorated in 15-minute increments. Psychological service fees may also be considered under your flexible or health spending (FSA/HSA). Families may wish to check with their insurance provider and employer for more information. It is also recommended to obtain pre-approval for out-of-network and getting clear feedback about reimbursement rates prior to accepting services with Dr. Lake.

Consent & Acknowledgements
I hereby request and authorize Dr. Lake and/or anyone contracted to work with Dr. Monica Lake, PLLC to provide services to my child/adolescent. I understand that psychological services may include assessment, coaching/behavior management, psychotherapy, and/or consultation. I understand that, at any time, I can terminate this consent by putting such request in writing. The fee for ☐psychotherapy or consultation / ☐assessment services is $_____ ☐each / ☐total.

- I have read and understand these office policies.
- I certify that the purpose of the services to be provided have been explained.
- I certify that Dr. Lake can communicate, bill, and release any needed information with my insurance carrier, EAP, or any other party responsible for the cost of services.
- I certify that Dr. Lake can communicate, release records, release records on my behalf (with a signed Release of Information) via phone, fax, mail, and/or email.
- I have been given an opportunity to ask questions and those questions have been answered.
- I understand the potential ramifications of any disclosures to any legal, occupational and/or academic referral source under this waiver of confidentiality.

Client Name	DOB

Parent/Legal Guardian Signature	____/____/____ Date
Parent/Legal Guardian Signature	____/____/____ Date

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Notice of Privacy Practices (HIPAA Final Rule Notification)

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

This notice describes how health information about you may be used and disclosed and how you can get access to this information. It is effective April 22, 2020 and applies to all protected health information contained in your health records maintained by this practice. We have the following duties regarding the maintenance, use and disclosure of your health records:

(1) We are required by law to maintain the privacy of the protected health information in your records and to provide you with this Notice of our legal duties and privacy practices with respect to that information.
(2) We are required to abide by the terms of this Notice currently in effect.
(3) We are required to provide notification if there is a breach of insecure (unencrypted) Protected Health Information (PHI) (violation of HIPAA Privacy Rule) and a risk assessment fails to determine there is a low probability that your PHI has been compromised.

We reserve the right to change the terms of this Notice at any time, making the new provisions effective for all health information and records that we have and continue to maintain. All changes in this notice will be prominently displayed and available at our office.

There are a number of **situations in which we may use or disclose** to other persons or entities your confidential health information. Certain uses and disclosures will require you to sign an acknowledgement that you received this Notice of Privacy Practices. These include treatment, payment, and health care operations. Any use or disclosure of your protected health information required for anything other than treatment, payment or health care operations requires you to sign an Authorization. Certain disclosures that are required by law, or under emergency circumstances, may be made without your Acknowledgement or Authorization. Under any circumstance, we will use or disclose only the minimum amount of information necessary from your medical records to accomplish the intended purpose of the disclosure.

We will attempt in good faith to obtain your signed Acknowledgement that you received this Notice to use and disclose your confidential medical information for the following purposes. These examples are not meant to be exhaustive, but to describe the types of uses and disclosures that may be made by our office once you have provided Consent.

Treatment: We will use your health information to make decisions about the provision, coordination or management of your healthcare, including analyzing or diagnosing your condition and determining the appropriate treatment for that condition. It may also be necessary to share your health information with another health care provider whom we need to consult with respect to your care. Psychologist may contact previous treatment provider to help understand the mental health history. They may provide treatment consultation for your psychiatrist or primary care physician to inform them of medical and other health

treatments. We may provide you with information about additional services in the area for your conditions when there is no financial remuneration (third party payment for communication itself) involved. These are only examples of uses and disclosures of medical information for treatment purposes that may or may not be necessary in your case.

Payment: We may need to use or disclose information in your health record to obtain reimbursement from you, from your health-insurance carrier, or from another insurer for our services rendered to you. This may include determinations of eligibility or coverage under the appropriate health plan, pre-certification and pre-authorization of services or review of services for the purpose of reimbursement. This information may also be used for billing, claims management and collection purposes, and related healthcare data processing through our system. You have the right to restrict certain disclosures of Protected Health Information (PHI) to a health plan if you pay out-of-pocket in full for the healthcare service.

Operations: Your health records may be used in our business planning and development operations, including improvements in our methods of operation, and general administrative functions. We may also use the information in our overall compliance planning, healthcare review activities, and arranging for legal and auditing functions.

There are certain circumstances under which we may use or disclose your health information **without first obtaining your Acknowledgement or Authorization**. Those circumstances generally involve public health and oversight activities, law-enforcement activities, judicial and administrative proceedings, in the event of death and for specialized government functions. Specifically, we may be required to report to certain agencies information concerning fitness for military duty, eligibility for VA benefits, and national security and intelligence. We may also be required to report certain communicable diseases, sexually transmitted diseases or HIV/AIDS status. We may also be required to report instances of suspected or documented abuse, neglect or domestic violence. We are required to report to appropriate agencies and law-enforcement officials information that you or another person is in immediate threat of danger to health or safety as a result of violent activity. We must also provide health information when ordered by a court of law to do so.

We may contact you from time to time to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you. You should be aware that we utilize an "open waiting room" in which several people wait at the same time and in close proximity. We will try to speak quietly to you in a manner reasonably calculated to avoid disclosing your health information to others; however, complete privacy may not be possible in this setting. If you would prefer to be addressed in a private room, please let us know and we will do our best to accommodate your wishes.

We will obtain an authorization from you before using or disclosing: (1) Protected Health Information in a way that is not described in this Notice, or (2) Marketing purposes involving financial remuneration (third party payment for communication itself).

Others Involved in Your Healthcare: With your consent, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your protected health information that directly relates to that person's involvement in your healthcare. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We may use or disclose protected health information to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care of your location, general condition or death. Finally, we may use or disclose your protected health

information to an authorized public or private entity to assist in disaster relief efforts and to coordinate uses and disclosures to family or other individuals involved in your healthcare. If you have any concerns about disclosures of personal information to family members or others involved in your care, you may specify the types of information you are comfortable disclosing with your provider. Only in an emergency, would your personal information be share without your prior consent.

Communication Barriers and Emergencies: We may use and disclose your protected health information if we attempt to obtain consent from you but are unable to do so because of substantial communication barriers and we determine, using professional judgment, that you intend to consent to use or disclosure under the circumstances. We may use or disclose your protected health information in an emergency treatment situation. If this happens, we will try to obtain your consent as soon as reasonably practicable after the delivery of treatment. If we are required by law or as a matter of necessity to treat you, and we have attempted to obtain your consent but have been unable to obtain your consent, we may still use or disclose your protected health information to treat you.

Except as indicated above, your health information will not be used or disclosed to any other person or entity without your specific Authorization, which may be revoked at any time. In particular, except to the extent disclosure has been made to governmental entities required by law to maintain the confidentiality of the information, information will not be further disclosed to any other person or entity with respect to information concerning mental-health treatment, drug and alcohol abuse, HIV/AIDS or sexually transmitted diseases that may be contained in your health records. We likewise will not disclose your health-record information to an employer for purposes of making employment decisions, to a liability insurer or attorney as a result of injuries sustained in an automobile accident, or to educational authorities, without you written authorization.

You have certain **rights regarding your health record information**, as follows:

(1) You may request that we restrict the uses and disclosures of your health record information for treatment, payment and operations, or restrictions involving your care or payment related to that care. We are not required to agree to the restriction; however, if we agree, we will comply with it, except with regard to emergencies, disclosure of the information to you, or if we are otherwise required by law to make a full disclosure without restriction.

(2) Any uses or disclosures of personal information not described in this Privacy Notice require a signed Authorization before Protected Health Information can be released.

(3) You have a right to request receipt of confidential communications of your medical information by an alternative means or at an alternative location. If you require such an accommodation, you may be charged a fee for the accommodation and will be required to specify the alternative address or method of contact and how payment will be handled.

(4) You have the right to inspect, copy and request amendments to your health records. Access to your health records will not include psychotherapy notes contained in them, or information compiled in anticipation of or for use in a civil, criminal or administrative action or proceeding to which your access is restricted by law. We will charge a reasonable fee for providing a copy of your health records, or a summary of those records, at your request, which includes the cost of copying, postage, and preparation or an explanation or summary of the information.

(5) All requests for inspection, copying and/or amending information in your health records, and all requests related to your rights under this Notice, must be made in writing and addressed to the Privacy Officer at our address. We will respond to your request in a timely fashion.

(6) You have a limited right to receive an accounting of all disclosures we make to other persons or entities of your health information except for disclosures required for treatment, payment and healthcare operations, disclosures that require an Authorization, disclosure incidental to another permissible use or

disclosure, and otherwise as allowed by law. We will not charge you for the first accounting in any twelve-month period; however, we will charge you a reasonable fee for each subsequent request for an accounting within the same twelve-month period.

(7) If this notice was initially provided to you electronically, you have the right to obtain a paper copy of this notice and to take one home with you if you wish. You may file a written complaint to us or to the Secretary of Health and Human Services if you believe that your privacy rights with respect to confidential information in your health records have been violated. All complaints must be in writing and must be addressed to the Privacy Officer (in the case of complaints to us) or to the person designated by the U.S. Department of Health and Human Services if we cannot resolve your concerns. You will not be retaliated against for filing such a complaint. More information is available about complaints at the government's web site, http://www.hhs.gov/ocr/hipaa.

All questions concerning this Notice or requests made pursuant to it should be addressed to Dr. Monica Lake.

Patient Consent for Use and Disclosure of Protected Health Information
(HIPPA Acknowledgement)

I hereby give my consent for Dr. Lake, Dr. Monica Lake PLLC, and employees to use and disclose protected health information (PHI) about me to carry out treatment, payment and health care operations (TPO). (The Notice of Privacy Practices-Updated 4/2020 provided by Dr. Lake describes such uses and disclosures more completely.) Any uses or disclosures of personal information not described in this Privacy Notice require a signed Authorization before PHI can be released. We are required to provide notification if there is a breach of insecure PHI.

I have the right to review the Notice of Privacy Practices prior to signing this consent.
Dr. Lake reserves the right to revise its Notice of Privacy Practices at any time. An up-to-date Notice of Privacy Practices may be obtained by forwarding a written request to Dr. Lake, monica@drmonicalake.com (HIPAA Compliant email). I can call (813) 444-8760 for more information.

With this consent, Dr. Lake may call my home, cellphone, or other alternative location and leave a message on voicemail or in person in reference to any items that assist the practice in carrying out TPO, such as insurance items and any calls pertaining to my clinical care, including test results, among others. With this consent Dr. Lake may mail and/or email to my home or other alternative location any items that assist the practice in carrying out TPO, such patient billing statements and medical records.

I have the right to request that Dr. Monica Lake, PPLC restrict how they use or discloses my PHI to carry out TPO. The practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to allow Dr. Lake to use and disclose my PHI to carry out TPO.
I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, Dr. Lake may decline to provide treatment to me.

_____ _____
Signature Date

_____ _____
Print Patient's Name Print Name of Legal Guardian, if applicable