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TREATMENT CONSENT AGREEMENT

This Treatment Consent Agreement is made as of this _____ day of _____, 20_____ by and between Deisy C. Boscan, PhD ("Dr. Boscan" / "I" / "me") and _____ ("patient" /"parent" / "you") for psychotherapeutic or psychoanalytic clinical and/or assessment services for yourself or, if applicable, for your child or adolescent whose name is _____. Certain services may be provided by another therapist who works under my supervision and is completing post-doctoral training in order to become a licensed psychologist. Services by such other therapist will be undertaken only as you shall agree. This Treatment Consent Agreement contains important information about my professional services and business policies. It also contains summary information about the Health Insurance Portability and Accountability Act (HIPAA), a federal law that provides privacy protections and patient rights about the use and disclosure of your Protected Health Information (PHI) for the purposes of treatment, payment, and health care operations. We can discuss any questions you may have regarding HIPAA and your PHI. You are entitled to receive a copy of this Agreement when each of us has signed it. You are signing this Treatment Consent Agreement as the adult patient or as the parent of a child or adolescent who is to receive clinical treatment or an assessment by me or by another therapist in this office. To the extent that you are signing this Agreement as a parent of a child or adolescent the reference herein to "you" or "patient" is in your capacity as the child's or adolescent's parent.

PSYCHOLOGICAL SERVICES: Psychotherapy is an insight-oriented relationship between the psychotherapist and the patient that works in part because of clearly defined rights and responsibilities held by each person. As a patient in psychotherapy, you have certain rights and responsibilities that are important for you to understand. There are also legal limitations to those rights that you should be aware of. I, as your psychotherapist, have corresponding responsibilities to you. These rights and responsibilities are described in the following sections. Psychotherapy is not easily described in general statements. It varies depending on the personalities of the therapist and the client, and the challenges the client comes to treatment for. Psychotherapy requires you, the client, to take a very active role in your treatment. Therapy is most successful when you make the continued commitment to consider the things, we talk about both during and between session meetings. Psychotherapy has both benefits and risks. Risks may include experiencing uncomfortable feelings, such as sadness, guilt, anxiety, anger, frustration, loneliness and helplessness because the process of psychotherapy often requires discussing the unpleasant aspects of your life. However, psychotherapy has been shown to have benefits for individuals who undertake it. Therapy often leads to feeling less distress, increased satisfaction in relationships, and solutions to specific problems. But there are no guarantees about what you will experience. Psychotherapy requires a very active effort on your part. From time to time, I may do seemingly unorthodox methods of conducting treatment, such as taking the patient for a walk or to a park nearby. Initial below to confirm that you are aware and agree to this: _____.

PSYCHOLOGICAL/NEUROPSYCHOLOGICAL ASSESSMENT: You or your child or adolescent may be encouraged by your provider and/or have been referred from an outside provider to receive an assessment or a series of assessments to determine the nature and extent of a suspected diagnosis. In that event, I (or another therapist in my office) will provide you with details regarding the

nature and purpose of the neuropsychological assessments recommended. Upon completion of your (or your child's or adolescent's) assessment, you will be provided with a printed report explaining your (or your child's or adolescent's) assessment performance. You will be invited for an appointment for the sole purpose of reviewing your (or your child's or adolescent's) assessment scores during which time you are encouraged to ask questions about the meaning of the assessments and scores.

PATIENT FEEDBACK & COMPLAINTS: If you become dissatisfied with your clinical care, in general, it is important to discuss your concerns and attempt to address them directly. If you decide that my work (or that of another therapist in my office) is not satisfactory, I would be happy to help you determine the best course of action to take, which may include stopping treatment altogether or beginning treatment with another mental health professional in the community.

APPOINTMENTS: Your therapist (either me or another therapist in my office), usually conducts an initial comprehensive evaluation that will last from 1 to 4 sessions. During the evaluations period, I (or the other therapist) will work with you to decide if we can best provide the service(s) you need and provide you with an initial impression of what our work together might include. At that point, I (or the other therapist) will discuss your treatment goals and create an initial treatment plan. You should evaluate this information and make your own assessment about whether you feel comfortable working with me or the other therapist. If you have questions about our procedures, you should discuss them with me or the other therapist whenever they arise. If your doubts persist, I (or your therapist) will be happy to help you set up a meeting with another mental health professional for a second opinion.

If you and I (or the other therapist) decide to work together in psychotherapy, we will schedule at least one 45-50-minute session per week at a time agreed upon, although recommendations may be made for more frequent visits. Once an appointment is scheduled, it is assigned to you and you alone. Therefore, you will be expected to pay for it unless you provide at least 48 hours cancellation notice. If you are relying on an insurance policy to pay a portion of the fees for my (or the other therapist's) services, please keep in mind that missed appointments typically cannot be billed to insurance carriers and that you will be solely responsible for paying the administrative cost for those appointments [unless you and I (or the other therapist) both agree that you were unable to attend due to circumstances beyond your control]. If it is possible, I (or the other therapist) will try to find another time to reschedule the appointment. In addition, you are responsible for coming to your session on time; if you are late, your appointment will still need to end on time.

PROFESSIONAL FEES:
The standard fee per session for my psychotherapy services is $220.00. You are responsible for paying at the time of your session unless prior arrangements have been made. Payment may be made by check, cash, or VISA, MasterCard, or American Express credit cards. Any checks returned to my office are subject to an additional fee of up to $25.00 to cover the bank fee that I incur. If you refuse to pay your debt for the services provided by this office, I reserve the right to use an attorney or collection agency to secure payment. In addition to weekly appointments, it is my practice to charge the per session rate prorated for other professional services that you may require such as testing, report writing, telephone conversations that last longer than 15 minutes, attendance at meetings or consultations which you have requested, or the time required to perform any other service which you may request of me or the other therapist. At your request, I can break down the prorated charge for these services. If you anticipate becoming involved in a court case, I recommend that you discuss this

fully with me or the other therapist before you waive your right to confidentiality. If your case requires my participation, including as a witness at trial or in deposition, you will be expected to pay at rates that may be higher than my standard per session rate noted above for the professional time required. This applies even if a party other than yourself compels my testimony or other participation.

FEE-FOR-SERVICE ARRANGEMENTS AND INSURANCE COVERAGE: For us to set realistic treatment goals and priorities, it is important to evaluate what resources you have available to pay for your treatment. I generally provide services on a fee-for-service basis ("FFS") meaning that my patients pay me the full amount for services without any insurance coverage or reimbursement. If, however, you have a health insurance policy, it may provide some coverage for mental health treatment. If you intend to utilize insurance coverage you must advise me of that at the outset of our agreement. If I agree to provide services with insurance coverage, with your permission, my billing service and I will assist you to the extent possible in filing claims and ascertaining information about your coverage, but you are responsible for knowing your coverage and for knowing if/when your coverage changes. Please note that if you do not advise me at the outset of our agreement of insurance coverage, I will be unable to switch from our FFS arrangement to any insurance coverage arrangement.

Should you wish to utilize insurance coverage, please keep in mind that as a result of the rising costs of health care, insurance benefits have increasingly become more complex. It is sometimes difficult to determine exactly how much mental health coverage is available. Managed Health Care plans such as HMOs and PPOs often require advance authorization, without which they may refuse to provide reimbursement for mental health services. These plans are often limited to short-term treatment approaches designed to work out specific problems that interfere with a person's usual level of functioning. It may be necessary to seek approval for more therapy after a certain number of sessions. While a lot can be accomplished in short-term therapy, some patients feel that they need more services after insurance benefits end. Some managed-care plans in which I am an in-network provider will not allow me to provide services to you once your benefits end. In that situation, I will endeavor to help you find another provider who will help you continue your treatment.

You should also be aware that most insurance companies require you to authorize your therapist to provide them with a clinical diagnosis. (Diagnoses are technical terms that describe the nature of your problems and whether they are short-term or long-term problems. All diagnoses come from a book entitled the DSM-IV-TR. There is a copy in my office, and we will be glad to let you see it to learn more about your diagnosis, if applicable.). In some instances, I may need to provide additional clinical information such as treatment plans or summaries, or copies of the entire record (in rare cases). This information will become part of the insurance company files and will probably be stored in a computer. Though all insurance companies claim to keep such information confidential, I have no control over what they do with it once it is in their hands. In some cases, they may share the information with a national medical information databank. I will provide you with a copy of any report we submit, if you request it. By signing this Agreement, you agree that I can provide requested information to your carrier if you plan to pay with insurance.

In addition, if you plan to use your insurance, authorization from the insurance company may be required before they will cover therapy fees. If you did not obtain authorization and it is required, you may be responsible for full payment of the fee. Many policies leave a percentage of the fee

(which is called co-insurance) or a flat dollar amount (referred to as a co-payment) to be covered by the patient. Either amount is to be paid by you each time we have a session by check or cash or credit card. In addition, some insurance companies also have a deductible, which is an out-of-pocket amount that must be paid by the patient before the insurance coverage/reimbursement begins to apply. This will typically mean that you will be responsible to pay for initial sessions until your deductible has been met; the deductible amount may also need to be met at the start of each calendar year. Once I have all the information about your insurance coverage, I (or the other therapist) will discuss what I (or the other therapist) can reasonably expect to accomplish with the benefits that are available and what will happen if coverage ends before you feel ready to end your sessions. Again, please know, as set forth above (unless there is some prohibition in my underlying contract with your insurance provider) that you always have the right to pay for my services yourself to avoid some of the insurance coverage/reimbursement related issues. Finally, you should know that I may not be an in-network provider for your insurance carrier. In that case, as an out-of-network psychologist, I will supply you with a receipt of payment for services, which you can directly submit to your insurance carrier for reimbursement. Of course, not all insurance companies reimburse for out-of-network providers. If you prefer to use a participating provider, I can provide referrals to other community providers.

INSURANCE RELATED ADVISEMENT: If you are using managed care benefits under an insurance policy for your mental health services, you should know the following important principles: managed care benefits cover only "medically necessary" services. This is generally defined as ***Evaluation and treatment of mental conditions that significantly affect your ability to perform your usual activities at home, work and/or school.*** Treatment is expected to be action-oriented and symptom resolving with goals for efficiency, effectiveness, and returning you back to your usual level of functioning at work, home or school. Usually, insight-oriented psychotherapy treatment for long-term personal or relationship issues is not covered. Preauthorization of insurance coverage benefits is required. We do this by reporting clinical assessments and treatment plans to a treatment manager with your insurance company either by phone or in writing.

PAYMENT & PATIENT RESPONSIBILITY: You are responsible for payment in accordance with the rate and terms communicated and agreed upon between you and me for my services or those of another therapist in my office. I, or my billing service, will submit the insurance claims to your carrier at no cost to you. However, this is not a guarantee of payment by your insurance company since the claim is based upon agreements between you and the insurer. If payment is not received within 90 days from the date the claim was submitted, you will be responsible for the full amount of the balance due on your account. When clinical services are not covered by your health insurance plan, you are fully responsible for payment for these services. Examples of non-covered services include, but are not limited to: (i) ongoing services beyond insurance-covered short-term psychotherapy for personal growth; (ii) evaluation, crisis-intervention, or other services deemed by the insurance company not to be "medically necessary"; (iii) when your insurance company denies coverage; and (iv) when you fail to give 48-hours' notice of cancellation of an appointment. In non-covered service circumstances, you are responsible for paying my fee (which may or may not be limited by provisions in your specific health insurance plan).

(Health Insurance Benefits/Coverage/Authorizations DISCLAIMER: As a courtesy, Dr. Boscan will attempt to verify your health insurance benefits and/or necessary authorizations for you. Please be aware, this is only "A QUOTE of Benefits/Authorizations." We cannot guarantee payment or verify that definite eligibility of benefits conveyed to us or to

you by your carrier will be accurate or complete. Payment of benefits are subject to all terms, conditions, and exclusions of the member's contract at the time of service. Your health insurance company will only pay for services that it determines to be "reasonable and necessary." Our office will make every effort to bill your insurance in a timely manner. If your carrier determines that a service is not reasonable and necessary, or that a service is not covered under the plan, your insurer will deny payment for that service and it will become your responsibility. We recommend you to be familiar with and verify your benefits with your insurance company).

MEDICAL RECORDS: I am required by law to keep, for seven (7) years, appropriate records of the psychological services that my office provides. Your records are maintained in a secure location in or near my office. I (or the other therapist) may also maintain brief records noting that you were here, your reasons for seeking therapy, treatment goals (and progress), your diagnosis, topics we discussed, your medical, social, and treatment history, records received from other providers, copies of records sent to others (with your written permission), and your billing records. Except in unusual circumstances that involve danger to yourself, you have the right to a copy of your file. Because these are professional records, they may be misinterpreted and/or upsetting to untrained readers. For this reason, we recommend that you initially review them with me or the other therapist or have them forwarded to another mental health professional to discuss the contents. If I refuse your request for access to your records, you have a right to have my decision reviewed by another mental health professional, which I (or the other therapist) will discuss with you upon your request. You also have the right to request (on 72 hours written notice) that a copy of your file be made available to any other health care provider at your written request. You may obtain a request form from me.

CONFIDENTIALITY: Professional ethics and California state law require that communications to medical staff (including mental health providers) be kept confidential and privileged and cannot be released or shared without your written permission. All patients are assured of confidentiality in psychotherapy. A Release of Information form must be signed by you to authorize me or the other therapist to discuss information. You may revoke this agreement at any time. There are some exceptions to confidentiality of which you should be aware:

1. In order to coordinate patient care, many insurance companies explicitly expect communication between specialist clinicians (including mental health providers) and your primary care physician. This will only apply to you if we are billing your insurance for services provided.
2. There are some situations in which clinicians are expected or required by California law to disclose patient information (without patient consent) to relevant state or local agencies. Some of the situations in which this is the case are: (i) suspected child abuse or neglect; (ii) suspected elder abuse or neglect; (iii) danger to self; (iv) serious threat to injury of a person or property; (v) legitimate subpoena or court order; and (vi) a situation under the United States Patriot Act for Counter-Terrorism.
3. In order to obtain reimbursement or authorization for services from insurance companies or similar agencies, as discussed previously under the above "INSURANCE" section, I or the other therapist must disclose certain personal and clinical information. In the event you absolutely do not want any information to be released to any insurance company or similar agency; you may wish to consider utilizing my (or the other therapist's) service on an FFS basis instead of using your insurance benefits. In this regard, if you have any questions about how your insurance company handles and stores sensitive information, you should contact the company directly.

TERMINATION OF THERAPY: I (or the other therapist) reserve the discretionary right to terminate therapy. Reasons for termination may include, but are not limited to: untimely

payment of fees, failure to comply with treatment recommendations, conflicts of interest, failure to participate in therapy, my (or the other therapist's) determination that: the patient's needs are outside the scope of my (or the other therapist's) competence or practice, or that the Patient is not making adequate progress in therapy. You, as the Patient (including you as the Patient's parent), has the discretionary right to terminate therapy. Upon either your or my decision to terminate therapy, I (or the other therapist) will generally recommend that you participate in at least one, or possibly more, termination sessions. These sessions are intended to facilitate a positive termination experience and give both parties an opportunity to reflect on the work that has been done. I (or the other therapist) will also attempt to ensure a smooth transition to another therapist by offering referrals to you.

CONTACTING YOUR THERAPIST: I (or the other therapist) may not be available by telephone. For example, neither I nor the other therapist will answer the phone when with other patients or otherwise unavailable. At these times, you may leave a confidential voice message at (858) 263-4226 and your call will be returned as soon as possible, but it may take a day or two for non-urgent matters. If, for any number of unseen reasons, you do not hear from me (or the other therapist) or we are unable to reach you, and you feel you cannot wait for a return call or if you feel unable to keep yourself safe, (i) contact San Diego County Access and Crisis Hotline at 1-888-724-7240, (ii) go to your Local Hospital Emergency Room, or (iii) call 911 and ask to speak to the mental health worker on call. I (and the other therapist) will make every attempt to inform you in advance of planned absences and provide you with the name and phone number of the mental health professional covering for us. You may also reach out to Dr. Boscán at (858) 263-4226.

ACKNOWLEDGEMENT: By signing below, Patient acknowledges that he/she has reviewed and fully conditions of this Agreement. Patient has discussed any questions regarding its terms and conditions answered to Patient's satisfaction. Patient agrees to abide by terms of this Agreement and consents to participate in treatment. Moreover, Patient agrees to hold the Therapists free for damages from any injury or complications, whatsoever, save negligence, that may result from such treatment.

ADULT:

_____ _____ _____

Patient's Printed Name Patient's [or Responsible Party's] Signature Date

(MINOR) CHILD/ADOLESCENT:

_____ _____ _____

Minor Patient Name Patient's [or Responsible Party's] Signature Date

_____ _____ _____

PSYCHOLOGIST:

_____ _____ _____

Therapist's Printed Name Therapist's Signature Date