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THERAPIST-CLIENT SERVICES AGREEMENT

Welcome to my practice. This document (the Agreement) contains important information about my professional services and business policies. The law requires that I obtain your signature acknowledging that I have provided you with this information. Although these documents are long and sometimes complex, it is very important that you read them carefully before our next session. We can discuss any questions you have about the procedures at that time. When you sign this document, it will also represent an agreement between us. You may revoke this Agreement in writing at any time. That revocation will be binding on me unless I have taken action in reliance on it, if 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

Psychotherapy is collaboration between client and therapist to increase understanding and bring about change. There are many different clinical methods I may use to deal with the problems that you hope to address. Psychotherapy calls for an active effort on your part and therapy will be most successful if you work on things, we talk about both during our sessions and at home.

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, and helplessness. These troubled feelings are normal and will be temporary, depending on the depth of your emotional difficulties and distress. On the other hand, psychotherapy has also been shown to have many benefits. Therapy often leads to better relationships, solutions to specific problems, and significant reductions in feelings of distress. Although there are no guarantees of what you will experience I will devote my attention to ensure we maintain a safe and respectful environment that can maximize the possibilities for you to achieve positive growth and healing.

Our first few sessions will involve an evaluation of your needs. By the end of the evaluation, I will be able to offer you some first impressions of what our work will include and a treatment plan to follow if we decide working together is the appropriate course of action. If we determine another plan would be more appropriate, I will provide referral information. If you have questions about my procedures, we should discuss them whenever they arise. If your doubts persist, I will be happy to help you set up a meeting with another mental health professional for a second opinion.

Couples therapy starts with an assessment of the relationship past and present. Information discussed in couples therapy is for therapeutic purposes and is not intended for use in any legal proceedings involving the partners. By signing this agreement, you agree not to subpoena the therapist to testify for or against either party or to provide records in a court action. If the relationship breaks up and either or both of you wish to re-contract with me for individual counseling, the decision with whom I continue working is at my discretion. In some circumstances a referral will be made.

MEETINGS / SESSIONS

The first session is a diagnostic interview, and will usually be about one hour. I will ask questions about your concerns and other questions that will allow me to determine the issues relevant to your treatment. Subsequent sessions will be 50 minutes in length. **Once an appointment is scheduled, you agree to pay for it unless you provide at least 24 hours advance notice of cancellation unless we both agree that you were unable to attend due to circumstances beyond your control. It is important to note that insurance companies do not provide reimbursement for missed or cancelled sessions**.

Telehealth. Although phone therapy or videoconferencing allows possibilities of extending work where it

was not previously possible, there are inherent limitations involved. For example, it may be difficult for both of us to fully assess or understand each other's emotional state without access to our nonverbal cues. In addition to the standard rules of confidentiality limitations, you should also be aware of the unique confidentiality limitations for phone therapy (for example, cell phone messages can be picked up and overheard by others & it may not be possible to guarantee that the conversation is not overheard by other members of a household). Also, before agreeing to provide teletherapy, I will ask you to set up local backup services that are available to you in case of crises (for example, emergency contacts & nearby hospitals and mental-health treatment centers or therapists). You will more than likely be unable to use your insurance to reimburse because most insurance companies only cover in-person mental-health services. In the end, if you decide to end therapy informally (for example, stop calling or responding to calls), I will ask you to send me an e-mail or leave a message about your decision.

CONTACTING ME

Due to my work schedule, I am often not immediately available by telephone. When I am unavailable, my telephone is answered by voice mail that I monitor frequently. It is typically easier to contact me via email. **Please limit calls and e-mails between sessions for scheduling and administrative purposes only.** I will make every effort to return your call on the same day you make it, with the exception of weekends and holidays. If you are difficult to reach, please inform me of some times when you will be available. If I will be unavailable for an extended time, I will provide you with the name of a colleague to contact, if necessary.

Email: Email communication is not secure, and could be read by others as messages are stored on remote servers. If you choose to contact me via email you are accepting those privacy risks, and accepting email as an acceptable medium for my responses, unless or until you notify me otherwise. I recommend using email for scheduling and administrative purposes, rather than a medium for personal information. If you want to provide personal information, please utilize my encrypted email. You should also know that any emails I receive from you and any responses that I send to you become a part of your medical record.

Social Media I do not interact with clients using social media. If you have questions about this, please bring them up when we meet and we can talk more about it.

Business Review Sites: You may find my psychology practice on sites such as Psychology Today or other places which list businesses. Many of these sites comb search engines for business listings and automatically add listings regardless of whether the business has added itself to the site. If you should find my listing on any of these sites, please know that my listing is NOT a request for a testimonial, rating, or endorsement from you as my client.

EMERGENCY PROCEDURES

Because I am not available 24-hours, if an emergency situation occurs and you are at immediate risk and cannot reach me, please dial **911** or contact the nearest hospital emergency room or the University Neuropsychiatric Institute **801/587-3000** or Valley Mental Health **801/483-5444** and **ask for the crisis service**. Another number to contact would be the free, 24-hour National Suicide Prevention Lifeline at **1-800-273-TALK (8255)**. Also, call or e-mail me and leave a message so that I will know what is happening and can get in touch with you as soon as possible.

PROFESSIONAL FEES

Please see the Service Agreement Summary for updated fee information. My fees change infrequently, usually every few years, and by a small percentage, but as you may be a client for many years, this will keep fees the same for all patients. When fees change on my website, they will change on your account. My current fees can be found on the consent forms for psychotherapy services at www.angelajswanson.com.

BILLING AND PAYMENTS

You will be expected to pay for each session at the time it is held, unless we agree otherwise. I accept personal checks or debit/credit cards (VISA, Mastercard, or Discover) or cash. Payment schedules for other professional services will be agreed to when they are requested.

If your account has not been paid for more than 60 days and arrangements for payment have not been agreed upon, I have the option of using legal means to secure the payment. This may involve hiring a collection agency or going through small claims court, which will require me to disclose otherwise confidential information. In most collection situations, the only information I release regarding a client's treatment is his/her name, the nature of services provided, and the amount due. If such legal action is necessary, its costs will be included in the claim.

LIMITS ON CONFIDENTIALITY

The law protects the privacy of communications between a client and a psychologist. In most situations, I can only release information about your treatment to others if you sign a written Authorization form that meets certain legal requirements imposed by HIPAA. There are other situations that require only that you provide written, advance consent. Your signature on this Agreement provides consent for those activities, as follows:

Consultation. I may occasionally find it helpful to consult other health and mental health professionals about my work with you. During this consultation, I would make every effort to avoid revealing your identity. The other professionals are also legally bound to keep the information confidential. If you don't object, I will not tell you about these consultations unless it is important to our work together. I will note all consultations in your Clinical Record.

Please be aware that other professionals rent space in the building where the office of Angela Jette Swanson, Ph.D., LLC is located. While the therapists using the business name "Aspen Grove Counseling" coordinate marketing efforts and engage in routine peer consultation, my practice is a separate business and the other therapists do not have access to your medical record or PHI without your written authorization.

Business Associates. I have formal business associate contracts with Therapy Appointment, Office Ally, and Professionalcharges.com for purposes of electronic billing, practice management, and scheduling. These contracts require the business associates to maintain the confidentiality of these data as required by HIPAA except as specifically allowed in the contract or otherwise required by law.

Insurance. Disclosures required by health insurers or to collect overdue fees are discussed elsewhere in this Agreement.

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

Court order. If you are involved in a court proceeding and a request is made for information concerning the professional services I provided to you, such information is protected by the psychologist-client privilege law. I cannot provide any information without your (or your legal representative's) written authorization, or a 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.

Health Oversight. If a government agency is requesting the information for health oversight activities, I am required to provide it for them.

Lawsuit. If a client files a complaint or lawsuit against me, I may disclose relevant information regarding that client in order to defend myself.

Threat to self. If a client threatens to harm himself/herself, I may be obligated to seek hospitalization for him/her or to contact family members or others who can help provide protection.

Communicable Disease. If a client reports to me that he/she has a communicable disease, and discloses that he/she is engaged in activities that put others at risk of contracting the communicable disease, I am required to report that disease and activity to the Utah State Department of Health. Reportable communicable diseases include, but are not limited to HIV/AIDS, Hepatitis, Sexually Transmitted Diseases, and Smallpox.

Worker's Compensation. If a client files a worker's compensation claim, I must, upon appropriate request, provide a copy of the client's record to the appropriate parties, the client's employer, the workers' compensation insurance carrier or the Labor Commission.

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

Child Abuse. If I have reason to believe that a child has been or is likely to be subjected to incest, molestation, sexual exploitation, sexual abuse, physical abuse, or neglect, the law requires that I immediately notify the Division of Child and Family Services or an appropriate law enforcement agency. Once such a report is filed, I may be required to provide additional information.

Vulnerable Adult Abuse. If I have reason to believe that any vulnerable adult has been the subject of abuse, neglect, abandonment or exploitation, I am required to immediately notify Adult Protective Services intake. Once such a report is filed, I may be required to provide additional information.

Threat to other. If a client communicates an actual threat of physical violence against an

identifiable victim, I am required to take protective actions. These actions may include notifying the potential victim and contacting the police, and/or seeking hospitalization for the client.

While this written summary of exceptions to confidentiality should prove helpful in informing you about potential problems, it is important that we discuss any questions or concerns that you may have now or in the future. The laws governing confidentiality can be quite complex, and I am not an attorney. In situations where specific advice is required, formal legal advice may be needed.

PROFESSIONAL RECORDS

You should be aware that, pursuant to HIPAA, I keep Protected Health Information about you in two sets of professional records. One set constitutes your Clinical Record. It includes information about your reasons for seeking therapy, a description of the ways in which your problem impacts on your life, your diagnosis, the goals that we set for treatment, your progress towards those goals, your medical and social history, your treatment history, any past treatment records that I receive from other providers, reports of any professional consultations, your billing records, and any reports that have been sent to anyone, including reports to your insurance carrier. 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, if you request it in writing. Because these are professional records, they can be misinterpreted and/or upsetting to untrained readers. For this reason, I recommend that you initially review them in my presence or have them forwarded to another mental health professional so you can discuss the contents. I would however conduct this review meeting withour normal fee charge. In most situations, I am allowed to charge a copying fee of $1.00 per page(and for certain other expenses). The exceptions to this policy are contained in the attached Notice Form. If I refuse your request for access to your Clinical Record, you have a right of review (except for information supplied to me confidentially by others), which I will discuss with you upon request. In addition, I also keep a set of Psychotherapy Notes. These Notes are for my own use and designed to assist me in providing you with the best treatment. While the contents of Psychotherapy Notes vary from client to client, they can include the contents of our conversations, my analysis of those conversations, and how they impact your therapy. They also contain particularly sensitive information that you may reveal to me that is not required to be included in your Clinical record [and information that is revealed to me by others where I have promised confidentiality]. These Psychotherapy Notes are kept separate from your Clinical Record. These psychotherapy notes are not available to you and cannot be sent to anyone, including insurance companies without your signed Authorization. Insurance companies cannot require your Authorization as a condition of coverage nor penalize you in any way for your refusal to provide it.

CLIENT RIGHTS

HIPAA provides you with several rights with regard to your Clinical Record and disclosures of protected health information. These rights include requesting that I amend your record; requesting restrictions on what information from your Clinical Record is disclosed 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; and having any complaints you make about my policies and procedures recorded in your records; and the right to a paper copy of this Agreement, the attached Notice form, and my privacy policies and procedures.

MINORS & PARENTS

Clients under 14 years of age who are not emancipated and their parents should be aware that the law may allow parents to examine their child's treatment records unless I decide that such access is likely to injure the child, or we agree otherwise. Since parental involvement in therapy is important, it is my policy to request an agreement between a child client between 14 and 18 and his/her parents allowing me to share general information about the progress of the child's treatment and his/her attendance at scheduled sessions. I will also provide parents with a summary of their child's treatment when it is complete. Any other communication will require the child's authorization, unless I feel that the child is in danger or is a danger to someone else, in which case, I will notify the parents of my concern. Before giving parents any information, I will discuss the matter with the child, if possible, and do my best to handle any objections he/she may have.

INSURANCE REIMBURSEMENT

In order for us to set realistic treatment goals and priorities, it is important to evaluate what

resources you have available to pay for your treatment. If you have a health insurance policy, it will usually provide some coverage for mental health treatment. I will submit claims and provide you with whatever assistance I can in helping you receive the benefits to which you are entitled; however, you (not your insurance company) are responsible for full payment of my fees. It is very important that you find out exactly what mental health services your insurance policy covers.

My practice is a fee-for service practice, which means that your payment is expected at the end of each session unless we make other arrangements. I will submit electronic insurance claims to your provider if you request me to do so. You should carefully read the section in your insurance coverage booklet that describes mental health services. If you have questions about the coverage, call your plan administrator. Of course, I will provide you with whatever information I can based on my experience and will be happy to help you in understanding the information you receive from your insurance company. If it is necessary to clear confusion, I will be willing to call the company on your behalf.

You should also be aware that your contract with your health insurance company requires that I provide it with information relevant to the services that I provide to you. I am required to provide a clinical diagnosis. Sometimes I am required to provide additional clinical information such as treatment plans or summaries, or copies of your entire clinical record. In such situations, I will make every effort to release only the minimum information about you that is necessary for the purpose requested. 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 I submit, if you request it. **By signing this Agreement, you agree that I can provide requested information to your carrier.**

ENDING THERAPY

Some clients benefit most from a brief involvement in therapy whereas others will find an extended length of time more valuable. I am committed to working with you as long as the therapeutic process is productive and healthy. It is most productive if you can address the ending of your therapy over the course 4/14/2022of several closure sessions. If I do not have contact or communication from you for a period of 30 consecutive days, I will assume that you no longer intend to remain active in this therapy relationship and your case will be closed. You have the option, however, to contact me again any time in the future to continue psychotherapy with me.

My (our) signature(s) below indicate that I (we) have received access to the Therapist-Client Services Agreement the HIPAA Notice of Psychologist's Policies and Practices to Protect the Privacy of Your Health Information document. My (our) signature(s) below also indicate that I(we) consent to treatment by Angela Jette Swanson, Ph.D.

_____ _____

Client Signature Date

_____ _____

Alpha-Stim/Cranial Electrotherapy Stimulation (CES) Informed Consent

Please read the following before using Alpha-Stim (CES):

Alpha-Stim® AID cranial electrotherapy stimulation (CES) technology is a treatment for anxiety, depression, and insomnia which utilizes small pulses of electric current. Alpha-Stim® AID (CES) technology is continuously being subjected to rigorous study and evaluation by the international medical community. Findings to date indicate that the Alpha-Stim® AID (CES) is an effective treatment for anxiety, depression, and insomnia along with other medical conditions. CES may be used as an adjunct to anxiolytic medication and/or psychotherapy. CES is an FDA approved treatment. As with any therapeutic intervention, not all people will respond to the Alpha-Stim® AID. The degree of efficacy will vary based on factors such as the nature of the problem being treated and the overall health of the person.

Treatment. The treatment is very simple. Current is applied by clip electrodes that attach on the ear lobes. A small electrical current (powered by a 9 volt battery) passes into the electrode which normalizes the electrical activity of the brain and balances neurotransmitter production. The average CES session lasts between 20 to 60 minutes. CES can help induce a pleasant, relaxed feeling of well-being. It will not interfere with most other treatments.

Benefits. The benefits of CES are that it is well tolerated and very safe in contrast to drugs used in the treatment of mood disorders, many of which have been proven to have undesirable side effects and can be addictive. Unlike drugs, CES leaves the mind alert. CES is known to assist most patients by decreasing symptoms associated with depression, anxiety, and insomnia. Anxiety reduction is usually experienced during each treatment; but may be seen hours later, or up to 24 hours after treatment (one 20 minute session may reduce anxiety for up to twenty-four hours). Other benefits include the possibility of reducing problem behaviors and relief from pain. Depression and insomnia control is generally experienced after two to three weeks of daily treatment. Maintenance of a relaxed, yet alert state is generally achieved with treatments three times per week. It may be used as an adjunct to medication and/or psychotherapy. After treatment, there are usually no physical limitations imposed so the majority of people can resume normal activities immediately. CES is widely regarded as safe and effective alternative treatment modality to pharmacotherapy.

Contraindications. Risks associated with CES include side effects that may include headache, lightheadedness, or skin irritation by electrodes. Patients may feel a tingling/pricking feeling/sensation in their ear lobes. It is also possible that the patient might feel dizziness or nausea. These symptoms can be corrected by decreasing the intensity setting and will go away immediately. Mild headaches have been reported in some patients and these headaches go away within a few hours. CES may affect the operation of cardiac pacemakers and implanted defibrillators. CES is usually not recommended for people with a history of epilepsy or seizures. Safety of stimulation has not been established during pregnancy. There have been isolated reports of blood pressure being lowered by CES so care should be taken while using the Alpha-Stim® AID with high blood pressure medication. Treatment immediately prior to going to sleep may cause difficulty sleeping due to increased alertness. It is recommended that AID be used at least 3 hours before going to sleep. Paradoxical reactions such as hyper-excited states, increased anxiety, and sleep disturbances may occur, but are rare.

I HAVE READ AND UNDERSTAND THE ABOVE INFORMATION ABOUT THE ALPHA-STIM® DEVICE. I WILL USE IT AS ADJUNCT TREATMENT TO PSYCHOTHERAPY FOR SYMPTOMS OF ANXIETY, DEPRESSION, AND INSOMNIA.

I AGREE TO PAY $25/SESSION IN ADDITION TO THE REGULAR SESSION FEE.

_____ _____

NAME DATE

Informed Consent (HYPMIND):

Please print your name in the first space, then sign, print, and date below to indicate that you understand what you have read.

I,_____, agree to the process of therapeutic hypnotherapy and meditation. I understand that I will have all choices at all times and can start and end the process at anytime. I understand that hypnotherapy and meditation can provide assistance in resolving problems I present to my therapist, but that other solutions, including medical intervention, may also be of value or even required. I agree to continue medication as prescribed by my attending physicians and understand that hypnotherapy and meditation is not a substitute for medical care. If my symptoms progress I agree to seek medical attention. In the event of a medical emergency or if I feel suicidal, I will call 911 or other emergency help. I understand that the methods of hypnotherapy and meditation include relaxation, deep breathing, creative visualization and other techniques of producing physical and emotional responses. I have been informed as to the limits of effectiveness of these interventions and offered referral to other providers. I am over age 18, and consent to hypnotherapy and meditation services offered by Angela Jette Swanson, Ph.D.

Signature:_____

Print Name:_____

Date:_____