**Agreement and Consent to Receive Psychological Services From Sibylle Georgianna, Ph.D., CEO of The Leadership Practice Psychological Consultations Inc. with Services Provided By Sexual Health of Orange County, CA**

This document contains important information about my (Sibylle Georgianna’s) professional services and business policies. The section on privacy practices describes how information about you may be used and disclosed and how you can get access to it. Please read it carefully. When you sign this document, it will represent an agreement between us regarding the psychological services and the privacy practices.

PSYCHOLOGICAL SERVICES

I provide a variety of psychological services consisting primarily of individual and couple’s therapy, workshops, and online courses. Psychotherapy treats a variety of emotional and interpersonal problems. Psychotherapy is intended to reduce or eliminate certain psychological symptoms, and to improve social and occupational functioning. Unlike medical consultations, it requires that all parties work actively to gain awareness of and alter certain maladaptive emotional states and behaviors. The psychotherapeutic process varies depending on the personalities of the psychologist and patient, and the particular diagnosis. Psychotherapy calls for an active effort on your part.

Psychotherapy can have benefits and risks. Since it typically involves discussing unpleasant aspects of your life, you may experience uncomfortable feelings like sadness, guilt, anger, or frustration. During therapy you will learn to deal with these feelings in an effective way. Psychotherapy has also been shown to have significant benefits—solutions to specific problems, reductions in distress, and improved relationships.

Psychotherapy involves a large commitment of time, money, and energy, so you should be careful about the psychotherapist you select. You have the right to ask about other treatments and their risks and benefits. If you have questions about my procedures, we should discuss them whenever they arise. At any time you may obtain, and I will gladly assist you with obtaining, a second opinion.

**The next paragraph pertains to couples counseling (you may skip if you are seeking individual services):**

You have hired me as a professional to treat you relative to your marriage/partnership. If at any time in our therapy I learn something your spouse/partner is not aware of - be it a secret or just something you haven't shared with them yet - you agree to allow me to use my professional judgment in determining how to handle that information. That means if you share a secret with me, I will encourage you to share the secret with your spouse/partner if, from my professional judgment, your marriage/partnership will, in my estimation, become healthier and more authentic than if you kept the secret from your spouse/partner. I am not the bearer of news; nevertheless, you agree that there will be no secrets between you and me or your spouse/partner and me, and that I may disclose anything you tell me to your spouse/partner. **(initial here: \_\_\_\_\_)**. (Spouse’s/partner’s initials) **(initial here: \_\_\_\_\_)**.

If at any point during psychotherapy either of us determine that psychotherapy is not effective in helping you reach therapeutic goals, we will discuss the efficacy of treatment and, if appropriate, terminate treatment. In such a case, you may be referred to other individuals or clinics that may be of help to you. If at any time you want another professional’s opinion or wish to consult with another therapist, you may do so, and, if you provide a written consent, I will provide the essential information needed. You have the right to terminate psychotherapy at any time.

To establish a diagnosis and treatment recommendations, I use a variety of techniques to establish information about your psychological status. When conducting these evaluations, I typically use a combination of interviews, reviews of relevant records, psychological testing, and clinical observations to draw inferences regarding diagnosis, psychological and emotional functioning, or other issues.

SESSIONS

Psychotherapy patient sessions last 50 or 90 minutes, time for preparation and follow up excluded. I have found that clients overall need less time in therapy if they book 90 minutes sessions, in particular for EMDR therapy (see below).

PROFESSIONAL FEES

Psychotherapy services (and other miscellaneous services) are billed at a rate of $ 185 per 50 minutes **(initial here: \_\_\_\_\_).** If your visit takes longer, additional minutes are charged in increments of the 50 minutes fee at 5 minute intervals **(initial here: \_\_\_\_\_)**.

Phone calls that take more than 5 minutes are charged in increments of the 50 minutes fee at 5 minute intervals **(initial here: \_\_\_\_\_)**. Please note that if you are seeking help with an addiction pattern and/or complex trauma, part of my recommendation for your treatment is that -in addition to visiting my office- you seek medical support (e.g., your primary care physician, a specialized physician such as a psychiatrist. I can provide you with recommendations) **(initial here: \_\_\_\_\_)**.

BILLING AND PAYMENTS

I am pleased to accept Visa Card, MasterCard, American Express, PayPal, and Venmo for your payment today. I, **(please print your name):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** consent that Dr. Sibylle Georgianna charges my credit card account as specified below:

1. I authorize Dr. Sibylle Georgianna to charge my card for payment of each session and/or service at the beginning of the business day that my appointment/service is scheduled. **(initial here: \_\_\_\_\_)**

2. Cancellation of my appointment needs to be received **before noon Pacific Time on the previous business day** to avoid a charge. (Initial here): **(initial here: \_\_\_\_\_)**

3. I release Dr. Sibylle Georgianna from any and all claims arising from the charge of my credit card in accordance with this authorization. **(initial here: \_\_\_\_\_)**

4.I authorize Dr. Sibylle Georgianna to charge the credit card on file (designated in the Credit Card Authorization) for payment of time on the phone as outlined above. **(initial here: \_\_\_\_\_)**

A payment receipt will be emailed to you, reading as follows:

“Your card has been charged by The Leadership Practice Consultations Inc. Below is

your receipt of payment.

Transaction Details

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Date: 06/04/19 12:54:23

Merchant: The Leadership Practice Consultations Inc

Type: Credit Card Sale

Invoice #: …

Amount: …

Description: …

Card Holder: …

Card Number: xxxxxxxxxxxxxx….”

If you are cancelling an appointment less than 24 hours prior to its scheduled date, you are responsible to pay the session charge. The charge for a cancelled session cannot be submitted to your insurance carrier for reimbursement. **(initial here: \_\_\_\_\_).**

If your account has not been paid for more than 60 days and other arrangements have not been made, I may use legal means to secure payment. This may involve hiring a collection agency or negative credit reporting. All disputes arising out of or in relation to your failure to make payment, or disputed payment under this agreement shall first be referred to mediation, before, and as a pre-condition of, the initiation of arbitration. The mediator shall be a neutral third party chosen by agreement, and the mediation shall be administered in Orange County, California by JAMS. The cost of such mediation, if any, shall be borne by you, unless otherwise agreed. In the event that mediation is unsuccessful, any unresolved controversy related to your failure to make a payment, or disputed payment under this agreement will be submitted binding arbitration to be administered by the American Arbitration Association (“AAA”) in accordance with AAA’s commercial arbitration rules then in effect. The prevailing party in arbitration shall be entitled to reasonable attorneys’ fees. Such arbitration shall be venued in Orange County, California, and administered by a single Arbitrator. **(initial here: \_\_\_\_\_).**

CONTACTING ME

I am often not immediately available by telephone. When I am unavailable, my telephone is answered by voice mail that I monitor frequently. I will make every effort to return your call on the same day you make it, with the exception of weekends and holidays. I am not available by pager so, in the case of a true emergency, please call 911 and/or proceed to the nearest emergency room. If I will be unavailable for an extended time, I will provide you with the name of a colleague to contact in case you need to consult a psychotherapist urgently.

PROFESSIONAL RECORDS & REPORTS

Your medical records are confidential and will be kept in a safe, secure location. You are entitled to receive a copy of the records unless I believe that doing so would endanger the life of you or another. I may recommend that you review them in my presence so we can talk about them. **(initial here: \_\_\_\_\_)**.

Please note that I do not interact with attorneys with regards to clients’ records. **(initial here: \_\_\_\_\_)**. Should records be nevertheless requested, please note that the hourly fee for creating the requested records will be $300 for 60 minutes. **(initial here: \_\_\_\_\_)**.

I do not write evaluations on behalf of my clients. **(initial here: \_\_\_\_\_)**.

CONFIDENTIALITY

In general, the privacy of all communications between patients and psychologists is protected by law. I can usually only release information about our work to others with your written permission. (Should this be necessary or desired, I will have you sign a separate Authorization form). But there are a few exceptions, such as in a legal proceeding in which your psychological health is at issue; you may be ordered to disclose information concerning past, present, or future psychological services provided to you. In such a case, I might be ordered to provide this information by a judge.

Some situations legally require that I take action to protect others from harm, even if I have to reveal information about your treatment. For example, if I believe that a child, elderly person, or disabled person is being abused, I must file a report with the appropriate state agency. If I believe that you are threatening serious bodily harm to another, I am required to take protective actions. These actions may include notifying the potential victim, contacting the police, and/or seeking hospitalization for you. If you threaten to harm yourself, I may be obligated to seek hospitalization for you or to contact others who can help provide protection. If such a situation were to occur to, I would make appropriate efforts to fully discuss these possible interventions with you before taking any action.

As of January 1, 2015, AB 1775 requires me to report to the authorities if I learn that “a person who depicts a child in, or knowingly develops, duplicates, prints, or exchanges a film, photograph, videotape, negative, or slide in which a child is engaged in an act of obscene sexual conduct, except as specified. Failure to report known or suspected instances of child abuse, including sexual abuse, under the act is a misdemeanor. This bill provides that sexual exploitation also includes a person who downloads, streams, or accesses through any electronic or digital media, a film, photograph, videotape, video recording, negative or slide in which a child is engaged in an act of obscene sexual conduct.”

This new bill now requires me to report to the authorities e.g., if a 19 year old shares with me that his 16 year old girlfriend sent him a sexually explicit picture. Therefore, if you inform me that you have knowingly downloaded, streamed or accessed such pictures of a minor, I am required to report you. If you inform me that you knowingly accessed any such websites/media/means of communication, I am required to report you. **(initial here: \_\_\_\_\_)** . **(spouse, please initial here: \_\_\_\_\_)**

I may occasionally find it helpful to consult other professionals about a case at which time I make every effort to avoid revealing patients’ identities. The consultant is also legally bound to keep the information confidential. You hereby consent to such consultations as I determine appropriate, and you agree that I may disclose the consultation and the outcome of the consultation if and how I deem appropriate.

If you are a minor, please be aware that the law may provide your parents the right to examine your treatment records. In such a case if your parents seek to review such records, I may permit them to inspect your records only, or provide them only with general information about our work together, unless I feel there is a high risk that you will seriously harm yourself or someone else.

EMDR Therapy

The EMDR Therapy approach has been found as highly effective for reducing symptoms of distress, stress, trauma, and many other types of disorders and dysfunctions. More information on the efficacy of the treatment can be found here: [www.emdria.org](http://www.emdria.org). The EMDR protocol is most efficient if the client visits with the EMDR therapist exclusively during the administration of EMDR therapy sessions. EMDRIA.org recommends that, for the time of the EMDR session, the client does not consult with an additional -individual- therapist.

SPECIFICS OF ONLINE INTERACTIONS

The following is intended to inform you about our office policies and the specifics of our online interactions via a HIPAA compliant online platform, text messages via IM Your Doc (a HIPAA compliant text messaging system), and/or telephone.

Standard Operating Procedures

In general, the same procedures apply to mental health services online as they apply to meetings in person. For example, I am governed by various laws and regulations and by the code of ethics of my profession. The ethics code requires that I make you aware of specific office policies and how these procedures may affect you.

Limits of Confidentiality and Patient’s Rights

Sessions are strictly confidential, except under certain legally defined situations involving threats of self-harm or harm to others, and situations of child abuse, elder abuse, or abuse of otherwise dependent individuals. In the case of danger to others, I am required by law to notify the police and to inform any intended victim(s). In the case of self-harm, I am ethically bound to inform the nearest relative, significant other, or to otherwise enlist methods to prevent self-harm or suicide. In instances of child abuse, elder abuse, or dependent abuse, I must notify the proper authorities. Our relationship is strictly voluntary, and you may leave the relationship any time you wish.

Please list a person (e.g., relative, significant other) to contact if you are at risk of self-harm:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name Phone number

Phone Accessibility

I will return phone calls as soon as possible should you need to speak with me between our sessions. However, I cannot guarantee an immediate call return on weekends or holidays as well as a delay in response. If you have an immediate emergency, please go to the nearest hospital or emergency room.

Online Platform

My Psychology Today telehealth link is:

<https://sessions.psychologytoday.com/dr-sibylle-georgianna>

Meeting online is necessary if you came in contact with a person who tested COVID-19 positive (primary prevention) or if you came in contact with a person who got in contact with another person who tested COVID-19 positive (secondary prevention) within the last 10 days. Please initial here to consent to meeting online if necessary **(initial here: \_\_\_\_\_)** **(spouse, please initial here: \_\_\_\_\_)**

I ask that all online interactions where electronic information is shared (e.g., documents, screen shots) take place through the online platform.

Text Messaging

My phone number is 1 (917) 620 0481. If you would like to reach me via text message (I can send and receive text messages for scheduling purposes only), please download the “IM Your Doc “app and send your message through “IM Your Doc”, not through your regular cell-phone text messaging system.

Connectivity Issues and Post Online Session Care

If you are doing an online session and there are technical issues during our sessions (e.g., loss of connection), please call me at (917) 620 0481. Also, as part of my online session protocol, I ask that you reach out to a significant other (e.g., sponsor, trusted friend, spouse) *after* the online session to inform them that you had an -online- session. You will not need to disclose details, but since therapy is emotional work, I would like to see you being as supported after an online session as you would be if I were to walk you in person to the elevator after an in-office session.

Legacy Planning

In the unlikely event that I am somehow unable to provide continued care due to a medical and/or other emergency, I have set up an emergency care coordination plan with my colleague Ms. Cindy Reis, LMFT. In this very unlikely situation, Ms. Cindy Reis will be reaching out to you and support you in setting up continued care with another qualified and caring provider. Your client records from our sessions are protected by HIPPAA for 7 years after the termination of sessions and will remain in a locked location until they will be destroyed by a professional.

Possible Misunderstandings

Please be aware that misunderstandings are possible with text-based and online modalities such as email (since nonverbal cues are relatively lacking) and VSee (since bandwidth is always limited).

Online Specifics

Please note that potential risks of online communication may include (1) messages not being received and (2) confidentiality being breached. Text messages could fail to be received if they are sent to the wrong address (which might also breach of confidentiality) or if the Internet service providers experience technical difficulties. Confidentiality could be breached in transit by hackers or Internet service providers. To protect your confidentiality, my computer and phone are password protected.

Alternatives To Online Mental Health Services

Alternatives to receiving mental health services online include (1) receiving mental health services in person, (2) talking to a friend or family member, (3) exercising or meditating, or (4) not doing anything at all.

Cancellation Policy

Cancellation Policies are applicable to online sessions in the same way as they apply to in-office visits.

I have read, understood, and signed the Credit Card Agreement. **(initial here: \_\_\_\_\_).**

Online Courses Offered By The Leadership Practice Psychological Consultations Inc.

The Leadership Practice Psychological Consultations Inc offers online courses. Terms and Conditions including Privacy Policies associated with these courses are stated at <https://www.theleadershippractice.biz/store>. Please note that they are distinct from online and in-office visits. **(initial here: \_\_\_\_\_)**

I have read, understood, and agree to the online specific conditions stated above.

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Signature Date

PRIVACY PRACTICES

The following paragraphs outline how the Federal Health Insurance Portability and Accountability Act of 1996 (HIPAA) affects how records here are kept and managed. The services you are receiving here concern your psychological status, a most private and intimate component of your life. Therefore, protecting your privacy is of utmost importance. The ensuing paragraphs explain how, when and why I may use and/or disclose your records which are known under the HIPAA legislation as “Protected Health Information” (PHI). Your PHI consists of individually identifiable information about your past, present, or future health or condition and the provision of and payment for health care to you. I may also receive your PHI from other sources, i.e. other health care providers, attorneys, etc. You and your PHI receive certain protections under the law. Except in specified circumstances, I will not release your PHI to anyone. When disclosure is necessary under the law, I will only use and/or disclose the minimum amount of your PHI necessary to accomplish the purpose of the use and/or disclosure.

If you are receiving any type of psychotherapy service, your PHI is typically limited to basic billing information. Only I have access to that information. Clinical notes taken after sessions are known as Psychotherapy Notes and are not part of your PHI. Except in unusual, emergency situations, such as child abuse, homicidal or suicidal intention, your PHI will only be released with your specific Authorization.

In accordance with the HIPAA act and its Privacy Rule (Rule), your PHI may be used and disclosed for a variety of reasons. Again, however, every effort is made to prevent its dissemination. For most other uses and/or disclosures of your PHI, you will be asked to grant your permission via a signed Authorization which is a separate form. However, the Rule allows for certain specified uses and/or disclosures of your PHI. These consist of the following:

A. Uses and/or disclosures related to your treatment (T), the payment for services you receive (P), or for health care operations (O):

1. For treatment (T): I might conceivably use and/or disclose your PHI to psychologists, psychiatrists, physicians, nurses, and other health care personnel involved in providing health care services to you – but only with your specific Authorization. The only conceivable reason that a specific Authorization might not be obtained would be in the case of a medical emergency.

2. For payment (P): I may use and/or disclose your PHI for billing and collection activities without your specific Authorization.

3. For health care operations (O): I may use and/or disclose your PHI in the course of operating the various business functions of my office. For example, I may use and/or disclose your PHI for my personal assistant or me to do third party or insurance billing without your Authorization.

B. Uses and/or disclosures requiring your Authorization: Generally, my use and/or disclosure of your PHI for any purpose that falls outside of the definitions of treatment, payment and health care operations identified above will require your signed Authorization. If you grant your permission for such use and/or disclosure of your PHI, you retain the right to revoke your Authorization at any time except to the extent that a disclosure might already have been made.

C. Use and/or disclosures not requiring your Authorization: The Rule provides that I may use and/or disclose your PHI without your Authorization in the following circumstances:

1. When required by law: I may use and/or disclose your PHI when existing law requires that I report information including each of the following areas:

2. Reporting abuse, neglect or domestic violence: I may use and/or disclose your PHI in cases of suspected abuse, neglect, or domestic violence including reporting the information to social service agencies.

3. Judicial and administrative proceedings: I may use and/or disclose your PHI in response to an order of a court or administrative tribunal, a warrant, subpoena, discovery request, or other lawful process.

4. To avert a serious threat to health or safety: I may use and/or disclose your PHI in order to avert a serious threat to health or safety. For example, if I believed you were at imminent risk of harming a person or property, or of hurting yourself, I may disclose your PHI to prevent such an act from occurring.

The HIPAA Privacy Rule grants you each of the following individual rights:

A. In general, you have the right to view your PHI that is in my possession or to obtain copies of it. You must request it in writing. You will receive a response from me within 30 days of my receiving your written request. Under certain circumstances, such as if I fear the information may be harmful to you, I may deny your request. If your request is denied, you will be given in writing the reasons for the denial. I will also explain your right to have my denial reviewed. If you ask for copies of your PHI, the preparation of the copies are charged at the 60 minutes fee. (initial here: \_\_\_\_\_). I may see fit to provide you with a summary or explanation of the PHI, but only if you agree in advance to it, as well as to the cost. (initial here: \_\_\_\_\_).

B. You have the right to ask that I limit how I use and disclose you PHI. While I will consider your request, I am not legally bound to agree. If I do agree to your request, I will put those limits in writing and abide by them except in emergency situations. You do not have the right to limit the uses and disclosures that I am legally required or permitted to make.

C. It is your right to ask that your PHI be sent to you at an alternate address or by an alternate method, e.g., email. I am obliged to agree to your request providing that I can give you the PHI in the format you requested without undue inconvenience.

D. You are entitled to a list of disclosures of your PHI that I have made. The list will not include uses or disclosures to which you have already consented, e.g., those for treatment, payment, or health care operations. I will respond to your request for an accounting of disclosures within 60 days of receiving your request. The list will include the date of the disclosure, to whom PHI was disclosed (including their address if known), a description of the information disclosed, and the reason for the disclosure. I will provide the list to you at no cost, unless you make more than one request in the same year, in which case I will charge you a reasonable fee for each additional request.

E. If you believe that there is some error in your PHI or that important information has been omitted, it is your right to request that I correct the existing information or add the missing information. Your request and the reason for the request must be made in writing. You will receive a response within 60 days of my receipt of your request. I may deny your request in writing if I find that the PHI is: (a) correct and complete, (b) forbidden to be disclosed, (c) not part of my records, or (d) written by someone other me. My denial must be in writing and must state the reasons for the denial. It must also explain your right to file a written statement objecting to the denial. If you do not file a written objection, you still have the right to ask that your request and my denial be attached to any future disclosures of your PHI. If I approve your request, I will make the change(s) to your PHI. Additionally, I will tell you that the changes have been made, and I will advise all others who need to know about the change(s) to your PHI.

F. You have the right to get this notice by email. You have the right to request a paper copy of it as well.

If you believe that I may have violated your individual privacy rights, or if you object to a decision I made about access to your PHI, you are entitled to file a complaint by submitting a written complaint to me. Your written complaint must describe the acts and/or omissions you believe to be in violation of the Rule, or the provisions outlined in this Privacy Practices section. If you prefer, you may file your written complaint with the Secretary of the U.S. Department of Health and Human Services (Secretary) at 200 Independence Avenue S.W., Washington, D.C., 20201. However, any complaint you file must be received by me, or filed with the Secretary, within 180 days of when you knew, or should have known, that the act or omission occurred. I will take no retaliatory action against you if you make such complaints.

ACKNOWLEDGING SIGNATURES

I understand that Federal regulations (HIPAA) allow health service providers to disclose my Protected Health Information (PHI) from your records in order to provide you treatment services, obtain payment for the services provided, or for other professional activities known as “health care operations”. How, why, and where I might release your PHI was described above. I consent to the use or disclosure of my Protected Health Information as specified. This consent is voluntary, and you may refuse to sign it now or revoke your consent later.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient(s) Name(s) (print) Signature(s) Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Sibylle Georgianna, Ph.D. Signature Date