SECURE FOUNDATIONS

First Name _____ Last Name _____ MI _____

Address _____

City _____ State _____ Zip _____

Telephone: Home _____ Cell _____

Special Instructions for Telephone Contact (e.g. no voicemail messages, do not contact home number, or no calls after a certain time)

_____

DOB _____ Age _____ Sex _____

Marital Status _____ Spouse Name _____

Person Responsible for Payment: ☐ client ☐ other _____

Emergency Contact:

Name _____ Relationship _____

Address _____

City _____ State _____ Zip _____

Telephone _____

Employer (if client is a child, use parent's employer) _____

Physician _____

Psychiatrist (if applicable) _____

Current Medications & Dosage _____

SECURE FOUNDATIONS

Informed Consent & Privacy of Information Policies

Confidentiality: All information disclosed within sessions and the written records pertaining to those sessions are confidential and may not be revealed to anyone without your permission except where disclosure is required by law.

State and Federal laws require that your medical records are kept private. Such laws require that we provide you with this notice informing you of our privacy of information policies, your rights, and our duties. We are required to abide by these policies until replaced or revised. We have the right to revise our privacy policies for all medical records, including records kept before policy changes were made. Clients will be notified of any changes in this notice before the changes take place.

The contents of material disclosed to us in an evaluation, intake, psychotherapy, or consultation session are covered by the law as private information. We respect the privacy of the information you provide us and we abide by ethical and legal requirements of confidentiality and privacy of records.

When Disclosure May Be Required: Some of the circumstances where disclosure is required or may be required by law are where there is a reasonable suspicion of child, dependent, or elder abuse or neglect; where a client presents a danger to self, to others, to property, or is gravely disabled; where prenatal exposure to controlled substances that are potentially harmful is revealed; or when a client's family members communicate to the therapist that the client presents a danger to others. Disclosure may also be required pursuant to a legal proceeding by or against you. If you place your mental status at issue in litigation initiated by you, the defendant may have the right to obtain the psychotherapy records and/or testimony by your therapist.

Information about you may be used by the personnel associated with this practice for diagnosis, treatment planning, treatment, and continuity of care. We may disclose it to health care providers who provide you with treatment, such as mental health professionals, psychology students and business associates affiliated with this clinic such as billing, quality enhancement, training, audits, and accreditation.

Generally, verbal information and written records about a client cannot be shared with another party without the written consent of the client or the client's legal guardian or personal representative. It is the policy of Secure Foundations not to release any information about a client without a signed release of information except in certain emergency situations or exceptions in which client information can be

disclosed to others without written consent. Some of these situations are noted above, and there may be other provisions provided by legal requirements.

Emergencies: If there is an emergency during therapy, or in the future after termination, where the therapist becomes concerned about your personal safety, the possibility of you injuring someone else, or about you receiving proper psychiatric care, s/he will do whatever s/he can within the limits of the law, to prevent you from injuring yourself or others and to ensure that you receive the proper medical care. For this purpose, s/he may also contact the emergency contact whose information you have provided on the screening information sheet.

In the Event of a Client's Death: In the event of a client's death, the spouse or parents of a deceased client have a right to access their spouse's or child's records.

Minors/Guardianship: Parents or legal guardians of non-emancipated minor clients have the right to access the client's records.

Other Provisions: When payment for services is the responsibility of the client, or a person who has agreed to provide payment, and payment has not been made in a timely manner, collection agencies may be utilized to collect debts. The specific content of the services (e.g., diagnosis, treatment plan, progress notes, testing) is not disclosed. If a debt remains unpaid it may be reported to credit agencies, and the client's credit report may state the amount owed, the time-frame, and the name of the clinic or collection source.

Insurance companies, managed care, and other third-party payers are given information that they request regarding services to the client. Information which may be requested includes type of services, dates/times of services, diagnosis, treatment plan, description of impairment, progress of therapy, and summaries.

Litigation Limitation: Due to the nature of the therapeutic process and the fact that it often involves making a full disclosure with regard to many matters which may be of a confidential nature, it is agreed that, should there be legal proceedings (such as, but not limited to divorce and custody disputes, injuries, lawsuits, etc.), neither you nor your attorney(s), nor anyone else acting on your behalf will call on the therapist to testify in court or at any other proceeding, nor will a disclosure of the psychotherapy records be requested unless otherwise agreed upon.

Consultation & Supervision: Our clinicians consults regularly with other professionals regarding his/her clients; however, each client's identity remains completely anonymous and confidentiality is fully maintained. Student therapists receive regular

supervision from Dr. Malinoski regarding their clients, and Dr. Malinoski is aware of each client's identity and relevant clinical information.

Telephone Contact, E-mails, Computers: In the event in which the Secure Foundations or your therapist must telephone you for purposes such as appointment cancellations or reminders, or to give/receive other information, efforts are made to preserve confidentiality. Please notify us in writing where we may reach you by phone and how you would like us to identify ourselves on the Screening Form. For example, you might request that when we phone you at home or work, we do not say the name of the clinic or the nature of the call, but rather the therapist's name only.

The therapists do not accept friend requests from current or former clients on social networking sites, such as Facebook or Linked-In. Adding clients as friends on these sites and/or communicating via such sites is likely to compromise their privacy and confidentiality. For this same reason, clients are asked not to communicate with the therapist via any interactive or social networking web sites.

Data on clinicians' computer is protected by virus protection and passwords. Secure Foundations uses HIPAA-compliant confidential email from G-Suite using our domain (rocksolidhelp.com). It is important to be aware that computers and unencrypted e-mail, text, and e-fax communication can be relatively easily accessed by unauthorized people and hence can compromise the privacy and confidentiality of such communication. It is always a possibility that e-faxes, texts, and emails can be sent erroneously to the wrong address and computers. If you communicate confidential or private information via unencrypted e-mail, texts or e-fax or via phone messages, we will assume that you have made an informed decision, will view it as your agreement to take the risk that such communication may be intercepted, and will honor your desire to communicate via such services, in spite of that risk. You are responsible for the security of the devices you use to communication.

The Process of Therapy: Participation in therapy can result in a number of benefits to you, including improving interpersonal relationships and resolution of the specific concerns that led you to seek therapy. Working toward these benefits, however, requires effort on your part. During therapy and/or assessment interviews, remembering or talking about unpleasant events, feelings, or thoughts can result in you experiencing considerable discomfort. Attempting to resolve issues that brought you to therapy in the first place, such as personal or interpersonal relationships, may result in changes that were not originally intended. There is no guarantee that psychotherapy will yield positive or intended results. During the course of therapy, the therapist is likely to draw on various psychological approaches according, in part, to the problem that is being treated and his/her assessment of what will best benefit you. The therapist provides neither custody evaluation recommendation nor

Client's Initials _____

medication or prescription recommendation nor legal advice, as these activities do not fall within his/her scope of practice.

Phone and Videoconference Appointments: Consulting with clients exclusively over the phone rather than in person in the therapist's office brings additional complexities and potential disadvantages to the therapeutic process. When appropriate, the therapist may recommend that the client find a local therapist with whom the client can meet face to face. Treating clients exclusively via phone may put therapists at a disadvantage because they cannot detect nonverbal cues, may not be able to accurately diagnose, may not always be aware of the resources available locally, and may not be able to intervene as effectively as necessary in emergency situations. If the therapist assesses, at any point, that s/he is not effective in helping you reach the therapeutic goals via the telephone sessions, s/he is obligated to discuss it with you and, if appropriate, to terminate treatment. Similar disadvantages apply to videoconference appointments. Secure Foundations uses VSee as a HIPAA compliant platform when videoconferencing is the best means for therapy.

Complaints: If you have any complaints or questions regarding these policies or procedures, please contact Dr. Malinoski. He will get back to you in a timely manner. You may also submit a complaint to the U.S. Dept. of Health and Human Services and/or the Indiana State Board of Psychology. If you file a complaint we will not retaliate in any way.

I have read the above informed consent and privacy of information policies. I understand them and agree to comply with them. I understand that a copy of this form is available upon my request.

Client's Name (print) _____

Signature _____ Date _____

Psychotherapist's Name (print) _____

Signature _____ Date _____

SECURE FOUNDATIONS

Rights & Responsibilities

Your Rights as a Client:

- Complaints: Dr. Malinoski will carefully consider your complaints. The majority of client complaints can be resolved with good will and open communication.
- Suggestions: You are invited to suggest changes in any aspect of the services Secure Foundations provides.
- Civil Rights: Your civil rights are protected by federal and state laws.
- Treatment: You have the right to take part in formulating your treatment plan.
- Denial of Services: You may refuse services offered to you and be informed of any potential consequences.
- Record Restrictions: You may request restrictions on the use of your protected health information; however, the therapist is not required to agree with the request.
- Availability of Records: You have the right to obtain a copy and/or inspect your protected health information; however, in rare cases the therapist may deny access to certain records. If he/she chooses to do so, he/she will discuss this decision with you.
- Amendment of Records: You have the right to request an amendment in your records; however, this request could be denied. If denied, your request will be kept in the records.
- Medical/Legal/Spiritual Advice: You may discuss your treatment with your physician, attorney, clergy, spiritual director and others you choose.
- Disclosures: You have the right to receive an accounting of disclosures of your protected health information that you have not authorized.

Therapist's Ethical Obligations:

- He/she dedicates him/herself to serving the best interest of each client.
- He/she will not discriminate between clients based on age, race, creed, disabilities, or handicaps.
- He/she maintains a professional relationship and holds professional boundaries with each client.
- He/she will end services or refer clients to other programs when appropriate.
- He/she will evaluate his/her personal limitations, strengths, biases, and effectiveness on an ongoing basis for the purpose of self-improvement. He/she will continually attain further education and training.

Client's Initials _____

SECURE FOUNDATIONS

Your Responsibilities as a Client:

- You are responsible for your financial obligations to Secure Foundations as outlined in the Payment Contract for Services.
- You are responsible for following the policies and procedures detailed above in the Informed Consent & Privacy of Information form.
- You are responsible to treat the therapist and fellow clients in a manner in which their rights are not violated.

If you believe that your rights have been violated please discuss this with your therapist and/or Dr. Malinoski. If this does not resolve the issue, you may contact the Indiana State Board of Psychology for information on lodging a formal complaint.

I certify that I have read and understand these rights and responsibilities and that I can receive a copy of this notice upon request.

Client's Name (print) _____

Signature _____ Date _____

Psychotherapist's Name (print) _____

Signature _____ Date _____

Payment Contract for Services

Name _____ DOB_____

Address _____

City _____ State _____ Zip _____

Bill to (if different from above):

Name _____

Address _____

City _____ State _____ Zip _____

I (we) agree to pay Secure Foundations a rate of $_____ for the 90- minute initial intake evaluation.

I (we) agree to pay Secure Foundations a rate of $_____ per clinical unit (defined as 45 minutes) for:

- ☐ Long-term Individual Psychotherapy at _____ clinical units per week
- ☐ Family Consultation
- ☐ Other _____

Payment will be made ☐ at the time of service; ☐ weekly; or ☐ monthly, by the ___ of each month for that month's provided and anticipated services .

A fee of $ _____ per clinical unit is charged for missed appointments or cancellations with less than 24 hours' notice. Exceptions can be made for cancellations or missed appointments caused by medical emergencies, severe weather, car accidents, etc.

Financial contracts for clients on sliding fee scales are reviewed at least quarterly and whenever session frequency changes or the client's financial situation changes significantly. An addendum signed by the client and therapist will indicate any changes to the fee structure and supplement this contract. Payments are due at the time of service unless otherwise agreed upon in writing. A 1½% per month (18% Annual Percentage Rate) interest charge may be applied to all accounts that are not paid within 60 days of the billing date. Delinquent accounts may be sent to a collections agency. There will be a $35 charge for checks returned for insufficient funds ("bounced checks"). Secure Foundations does not file claims for insurance, Medicare, Medicaid, or other third-party reimbursement, but may choose to provide limited information for clients to do so (e.g. HCFA forms).

Client's Initials _____

I certify that I have read and agree to the conditions and I understand that I can receive a copy of this Payment Contract for Services upon request.

Client's Name (print) _____

Signature _____ Date _____

Psychotherapist's Name (print) _____

Signature _____ Date _____

SECURE FOUNDATIONS

Policies & Procedures for Elizabeth Hofmeister

Student Status: Elizabeth Hofmeister is a student in the Master of Science in Counseling Program at Marian University and works under the license of clinical psychologist Peter Malinoski, Ph.D., who oversees her work via weekly supervision sessions.

Psychological Emergencies: In the event of a psychological emergency, take the following steps:

1. Call Elizabeth Hofmeister at 317-886-8339.
2. If Ms. Hofmeister is not available, call Dr. Malinoski on his cell phone at 317-473-5765 and leave a voice mail
3. If Dr. Malinoski does not return your call quickly enough, call the National Crisis Hotline at 800-273-8255 or go directly to the nearest hospital emergency department.

Ms. Hofmeister and Dr. Malinoski make a concerted effort to respond to calls as soon as is reasonably possible. However, it is important to understand that they do not interrupt psychotherapy sessions to respond to calls. Thus, because therapy sessions can be up to 1 ½ hours long, it may be as long as two hours before they will call you back. Also, their cell phones may not be able to receive signals in all locations at all times and technological failures are possible; thus, it is important to leave a voicemail with the office phone, as a backup. Dr. Malinoski usually checks his voicemail several times per day.

Cancellations and Failed Appointments: Secure Foundations requires a 24-hour cancellation notice. You may cancel an appointment by leaving a voicemail or text message at 317-886-8339 at any time. Ms. Hofmeister's phone has a time and date stamp on it. You will be charged for cancellations made less than 24 hours in advance at the rate agreed upon in the Payment Contract, which is usually the regular clinical rate for the appointment. Failed appointments are also charged at the rate agreed upon. If it appears that you will not be able to make it in to the office for your appointment, you may request to have your session by phone at the designated appointment time. Exceptions to the cancellation policy can be made for sudden illnesses, car accidents, severe weather, emergencies, etc.

Client's Initials _____

Confidentiality: Your contact with Ms. Hofmeister and Secure Foundations is kept confidential with the exceptions provided for by law. See the Privacy of Information form for more details. Dr. Malinoski's wife, Pamela Malinoski, has access to client files to aid in the management of the office, as does Patty Ellenberger, the Secure Foundations office manager. Others working in a professional capacity (e.g. transcriptionists, psychological testing assistants) may also have some limited access. Please indicate any special instructions or limitations on Ms. Hofmeister writing to you at your home address or calling you at home, work or cell phone numbers on the Screening Information form.

Financial Responsibility: You are ultimately financially responsible for your treatment. Secure Foundations is a fee-for-service practice. The practice does not file claims for insurance, Medicare, Medicaid, or other third-party reimbursement. If you experience problems in paying for your services at the agreed-upon rate, it is very important that you discuss this with Ms. Hofmeister as soon as is reasonably possible. Financial need is not a reason for discontinuing services at Secure Foundations, as a sliding fee scale is available to clients with financial need. Secure Foundations does not accept credit or debit cards or electronic payments. Cash, personal checks, and money orders are all acceptable forms of payment. Delinquent accounts are subject to interest as detailed in the Payment Contract and may be sent to a collections agency. Bounced checks are subject to a $35 charge.

Termination of Services: Clients at Secure Foundations come for assessment and/or treatment voluntarily. Thus, they may end their assessment or treatment at any time. The following are grounds for Ms. Hofmeister to end treatment with a client:

- Safety Concerns: In order to maintain a secure environment for the therapeutic work, clients may not make threats against the personal safety of Ms. Hofmeister, her coworkers, or other clients. Failure to follow this policy is grounds for the termination of the professional relationship.
- Failure to Participate in Treatment: If a client routinely fails to come for appointments, cancels appointments, does not schedule appointments, or insists on a session frequency that is insufficient for therapeutic progress, Ms. Hofmeister will raise these issues with the client. If the situation cannot be resolved, a client's failure to adequately participate in treatment is a reason for termination.
- Failure to Improve: If it appears that the treatment Ms. Hofmeister offers is not helpful in addressing the clinical problem, she has an ethical obligation to refer the client for services that seem likely to be of greater benefit.

Philosophical Basis of Practice: All psychological treatment is based on underlying assumptions or beliefs about what is good, true, beautiful and meaningful in life. Ms. Hofmeister bases her treatment on a Catholic understanding of philosophy, anthropology, and theology. She believes that respect for individual conscience and the client's personal search for truth, goodness, beauty and meaning are of the highest importance and she does not impose her beliefs on her clients. Thus, her

clients do not have to be Catholic or subscribe to the teachings of the Catholic Church to receive treatment. You may request services from someone with training or experiences from a specific cultural or spiritual orientation. If Ms. Hofmeister cannot provide these services, she will help you in the referral process.

I hereby attest that I have voluntarily entered into treatment, or give my consent for the minor or person under my legal guardianship mentioned above to receive treatment, with Elizabeth Hofmeister at Secure Foundations. I understand that I am consenting and agreeing only to those mental health services that Ms. Hofmeister is qualified to provide.

The rights, risks and benefits associated with the treatment have been explained to me. I understand that I may discontinue treatment at any time. I also understand the informed consent procedures and limits to confidentiality. I understand and agree to abide by the above stated policies and agreements with Elizabeth Hofmeister and Secure Foundations. I understand that I can receive a copy of these Policies and Procedures for my own records upon request.

Client's Name (print) _____

Signature _____ Date _____

Practicum Student Psychotherapist: Elizabeth Hofmeister

Signature _____ Date _____