

PRACTICE POLICIES - TELEHEALTH INFORMED CONSENT CLIENT AGREEMENT

This document is intended to inform you of our practice policies, state and federal laws, your rights, as well as serve as your informed consent. This document serves as an agreement between you, the client and Depressionexam.com. If you have other questions or concerns, please ask us and we will do our best to give you the information you need.

Depressionexam.com is an organization that helps qualified people obtain their California State Disability (SDI) Benefits. We specialize in the diagnosis of depression, and work with a network of psychologists and mental health professionals who can evaluate you for disability based on your diagnosis, as well as offer unique treatment options to address depression.

This agreement is made by and between _____,

(hereinafter "client"), whose permanent address is

and Depressionexam.com, and is effective as of _____

Pursuant to the terms of this agreement, Depressionexam.com shall provide services designed to assist clients with obtaining disability evaluations for the State of California and receiving supportive therapeutic services to address depression.

STATE DISABILITY EVALUATIONS

Disability evaluations are conducted by California state licensed clinical psychologists. You will meet with your doctor who will review your history of depression, and how it impacts your daily functioning. If you are found to have a diagnosis of depression which impacts your abilities to the point of disability, you can apply for State Disability Insurance through the California Employment Development Department (EDD).

Client's Initials

THERAPY

Our therapeutic services are specifically designed to address depression. Our goal is to guide you towards an overall improvement of your wellbeing. We offer structured and streamlined, 25-minute telehealth sessions designed to evaluate your condition and progress, and provide feedback. Sessions are conducted online through videoconferencing (telehealth) and are designed to help you reduce symptoms of depression, and improve the quality of your daily functioning as you obtain your Disability Insurance..

Client's Initials

INSURANCE / FINANCIAL

The undersigned agrees, whether he/she signs as agent or client, that in consideration of the services being rendered to the client by Depressionexam.com, he/she hereby individually obligates him/herself to pay the account of Depressionexam.com in accordance with their customary fees and terms. Depressionexam.com does not accept insurance as payment for any part of its services.

Client's Initials

PROGRAM DESCRIPTION AND FEES

Depressionexam.com specializes in offering disability evaluations for individuals with depression. We work with clients throughout California, and offer telehealth sessions. Clients will be seen by a California State licensed psychologist who will evaluate your condition over two to four weeks. WE DO NOT ACCEPT INSURANCE FOR ANY PORTION OF OUR SERVICES.

Our program is based on the success of your application to EDD, and Depressionexam.com does not ask for fees upfront. Though our usual and customary rates for services are **\$100.00 per session**, we ONLY collect after the state grants you your disability. **We will not ask for compensation if the EDD denies your application.** In order to process payments for your fees, we will require a credit card on file. You will NOT be charged on your credit card until after the EDD grants disability benefits or you have missed appointment fees. YOU CAN CONTINUE TO BE RE-EVALUATED AS LONG AS YOU ARE UNABLE TO PERFORM YOUR REGULAR AND CUSTOMARY DUTIES FOR YOUR JOB.

SESSIONS:

- **INTAKE ASSESSMENT (IA1):** An initial interview to collect clinical data that will be sent to your psychologist. \$0.00
- **INITIAL MEETING WITH PSYCHOLOGIST (EV1):** Your psychologist will review your case and assess your depression \$33.33
- **FOLLOWUP MEETING (EV2):** Your psychologist will continue to assess your depression and evaluate your depression \$33.33
- **FINAL SESSION (EV3):** Your psychologist will evaluate you and make a final recommendation regarding a disability diagnosis. \$33.33
- **CASE SUBMITAL TO EDD (CS1):** If directed to open up a case, you will furnish us the case number. We will then update the physician sections on form 2501-D and submit. (* - may be waived) \$25.00
- **TREATMENT MEETINGS (TM1):** On going treatment session with your doctor. \$100.00
- **CASE EXTENSION (CE1):** Updating of form 2501-D for benefits extension \$25.00
- **MISSED APPOINTMENT FEE (MA1):** (cancellations with less than 48 hours advance notice) \$100.00

In addition to the above services, should you require continued mental health care independent to your disability claim, arrangements can be made for you to continue seeing your psychologist. For further information, discuss them with a Depressionexam.com representative. Any such services will require a separate consent and contract.

Client's Initials

DISABILITY INSURANCE CLAIM PROCESS

For your information, the following is from the state of California EDD website. VISIT THEIR WEBSITE AND FOLLOW THEIR DIRECTIONS when submitting your claim. www.edd.ca.gov/disability

The California State Disability Insurance (SDI) program provides short-term Disability Insurance (DI) benefits to eligible workers. Workers who are unable to work due to their own non-work-related illness, injury, or pregnancy, and are losing wages may be eligible for DI benefits.

1. Review Eligibility Information for DI

You must be eligible in order to receive DI benefits. Some requirements include being unable to do your regular work for at least eight consecutive days, having lost wages because of your disability, and being either employed or actively looking for work at the time your disability began.

2. File a Claim for DI

Submit a Claim for Disability Insurance (DI) Benefits (DE 2501) using SDI Online or by mail.

If you need a paper version of the Claim for Disability Insurance Benefits (DE 2501), you can order the form through the Online Forms and Publications section.

Important Information About the Start of Your Claim

The day you became unable to work due to your disability is the day or date your disability begins. You will need to include that date when you submit your claim. *This date can be determined with your Psychologist.*

You may not change the beginning date of your claim or adjust a base period after establishing a valid claim. If you have any questions about your claim start date, please contact DI at 1-800-480-3287 before filing your claim.

Your claim cannot be submitted any earlier than the ninth day from the date your disability begins and must be submitted no later than 49 days after the first date of your disability or the claim is considered to be a late claim and you may lose benefits.

3. Physician/Practitioner Completes a Medical Certification.

Your psychologist must certify to your disability by completing and submitting the medical certification portion (either through SDI Online or DE 2501 Part B – Physician/Practitioner's Certificate of the paper claim form). It is your responsibility to have your psychologist complete and sign the form and submit it to the Employment Development Department (EDD) within 49 days from the date your disability begins or you may lose benefits. Your claim is not complete until a physician/practitioner completes a medical certification.

4. The EDD Reviews Your Claim.

Once a properly completed claim form is received, the EDD usually determines whether or not you are eligible to receive DI benefits within 14 days.

The EDD will send you the Notice of Computation (DE 429D) to inform you of your potential weekly benefit amount. Receiving this notice does NOT confirm that you have been found eligible to receive DI benefits.

5. If You are Found Eligible for Benefits

Before you receive benefits, you must first serve an unpaid seven-day waiting period (calendar days). The first payable day is the eighth day of the claim.

Benefit payments are normally issued within two weeks of the EDD receiving a properly completed claim; however, if they need additional information, more time may be needed to process your claim.

Benefit Payments and the EDD Debit CardSM

For claims beginning on or after January 1, 2018, weekly benefits range from \$50 to a maximum of \$1,216. To qualify for the maximum weekly benefit amount (\$1,216), you must earn at least \$27,701.83 in a calendar quarter during the base period. For more information, review Calculating Disability Benefit Payment Amounts.

You will receive benefit payments on an EDD Debit Card issued by Bank of America. Once you receive your debit card, all authorized benefit payments are deposited to the EDD Debit Card account. The same EDD Debit Card is used to issue DI, Paid Family Leave (PFL), and Unemployment Insurance (UI) payments and is valid for three years.

If you have received benefits in the last three years from any one of the EDD programs (UI, DI, or PFL benefits), your benefits will be deposited on the previously issued card.

6. If You are Found Ineligible for Benefits

If you are found ineligible, a Notice of Determination (DE 2517) will be mailed to you. An Appeal Form (DE 1000A) will also be mailed with your disqualification notice. You have the right to appeal any decision in writing within 20 days of the mailing date of the disqualification notice. For more information, visit Appeals. *Please submit this notice of determination to us if you are found to be ineligible so you will not be charged for our service*

7. If You Need to Certify for Continued Benefits

If your claim is on automatic payment, after 10 weeks of payment, you will receive a Disability Claim Continuing Eligibility Certification (DE 2593). You must return this form to the EDD to certify that your disability continues. If you do not return the DE 2593, your benefits will stop.

If you are not on automatic payment, you will receive a Claim for Continued Disability Benefits (DE 2500A) every two weeks to certify that your disability continues. If you do not return the DE 2500A, your benefits will stop.

The quickest way to submit the DE 2593 or DE 2500A is through SDI Online.

8. If You Need to Extend or Discontinue Your Benefits

If you have not recovered:

You are eligible to receive benefits until the date your physician/practitioner provides to the EDD. With your final payment you will receive a Physician/Practitioner's Supplementary Certificate (DE 2525XX) by mail.

If you have not fully recovered and want to extend your disability period to continue benefits, you must have your psychologist complete the DE 2525XX and return the form to the EDD to certify your continuing disability. The DE 2525XX may also be completed by your psychologist and submitted using SDI Online.

If you have recovered or returned to work:

If you recover or return to work on the date your psychologist provided to the EDD, no further action is required to discontinue your claim.

If you previously recovered or returned to work and became ill or injured again, immediately file a new claim form (DE 2501) and report the dates you worked.

CREDIT CARD

Depressionexam.com keeps a copy of your credit card on file to be used for billing against your appointments, therapy, fee's, etc.

The credit card is only used against those types of charges. When your treatments come to an end, your credit card will no longer be billed against, assuming your account is current and paid in full.

Client's Initials

FINANCIAL POLICY

FINANCIAL AGREEMENT: In consideration of the care and services to be rendered by Depressionexam.com, the undersigned hereby agrees to pay the applicable fees as indicated above for the selected service. Any special financial considerations applicable to charges and payments for the client shall be specified in writing in a Supplemental Financial Addendum, which shall be attached to this Agreement.

Client's Initials

PAYMENT SCHEDULE: Depressionexam.com does not ask for fees upfront. Though our usual and customary rates for services are \$100.00 per session, **we ONLY collect after the state grants you your disability.** In order to process payments for your fees, we will require a valid credit card on file prior to the intake session. You will be charged on your credit card only after the state grants disability. Your total fee after receiving your first payment of disability benefits will be \$250.00 **minus any security deposit payments** (1 intake assessment and 3 sessions with your psychologist at \$33.33 each). Spaced over 1 payments.

- | | | |
|--|---|--|
| <input type="checkbox"/> Intake Assessment | } | 4 telehealth sessions:
TOTAL : \$100.00 |
| <input type="checkbox"/> Initial meeting with Psychologist | | |
| <input type="checkbox"/> Follow-up session with Psychologist | | |
| <input type="checkbox"/> Final session with Psychologist | | |

All subsequent follow up treatment meetings (TM1) are 100.00 payable on the day of the session by credit card on file. Unless otherwise specified, all fees for services are payable when services are rendered. All payments are due at the time of service. In the event of any overpayment, refunds will be issued directly to the responsible party of the bill. Depressionexam.com accepts cash, checks, Visa/MasterCard, and American Express and other forms of payment.

Client's Initials

CREDIT CARD AUTHORIZATION: Clients are required to complete a credit card authorization prior to any services, to cover fees for any services rendered, and for any no-show/missed appointments. If the client/responsible party elect to pay service fees by credit card, the following provisions shall apply. By initialing below, the undersigned, authorize Depressionexam.com or its designee to charge the credit card listed ("the credit card") for services rendered in accordance with the terms and conditions of this Agreement. Any charges made to the credit card under this agreement will constitute a "final sale" and an agreement that services were rendered and received. The amount to be charged to the credit card shall be determined in accordance with the payment terms of the Agreement. Undersigned acknowledges and agrees that the refund policy set forth in the Agreement shall apply to services paid by the credit card. Furthermore, undersigned authorizes Depressionexam.com to maintain the credit card number and authorizing signature on file, and to charge all fees to such credit card for services rendered. By initialing below, client/responsible party authorizes and approves all charges assessed against the credit card by Depressionexam.com for each of the services identified in this Agreement. It is understood that the nature, quality and/or results of each individual service may vary from time to time, and cannot be guaranteed. Client/responsible party further acknowledges and agrees that upon receiving any services, the credit card charge is valid and legitimate, and the responsible party is precluded from disputing any charge on such credit card, and is further precluded from seeking a chargeback or adjustment on any basis, including without limitation quality or non-receipt of services. Client/responsible party are liable and financially responsible for any and all fees and charges due for each and every treatment service, notwithstanding any rejection or declination of the credit card for any reason. Undersigned acknowledges and agrees to waive any rights or privileges to dispute any charge under the credit card as to any individual service, if rendered while being a client of Depressionexam.com. In the event of any credit card dispute, Depressionexam.com may immediately suspend acceptance of the credit card and demand payment in full of all amounts due in cash, by electronic transfer or by certified check. If the credit card is declined for any reason at any time, Depressionexam.com may also suspend acceptance of the credit card, and assess a declination charge. The foregoing agreement in this section can only be cancelled in writing; however, any such cancellation shall not affect any prior, pending or future charges against the credit card for any services rendered on or before the cancellation date.

Client's Initials

CREDIT CARD PAYMENT AUTHORIZATION

- By authorizing charges to your credit card, you will be charged the amount indicated below. A receipt for each payment will be emailed to you and the charge will appear on your bank statement as an "ACH Debit." You agree that no prior-notification will be provided unless the date or amount changes, in which case you will receive notice from us at least 10 days prior to the payment being collected.

By signing below, I the undersigned authorize Depressionexam.com or its designee to charge the credit card listed ("the credit card").

I, _____ AUTHORIZE **Depressionexam.com** TO CHARGE MY CREDIT CARD

(CLIENT/RESPONSIBLE PARTY FULL NAME)

INDICATED BELOW, THE AMOUNT OF \$100.00 PER SESSION AS MY PAYMENT FOR ONGOING SESSIONS RENDERED IN ACCORDANCE WITH THE TERMS AND CONDITIONS OF THIS AGREEMENT.

- By authorizing credit card payment for missed appointments (less than 48 hours in advance), you will be charged the amount indicated below for each instance of a late cancellation or no show.

I, _____ AUTHORIZE **Depressionexam.com** TO CHARGE MY CREDIT CARD

(CLIENT/RESPONSIBLE PARTY FULL NAME)

INDICATED BELOW, THE AMOUNT OF \$100 FOR ANY NO-SHOW/MISSED APPOINTMENTS.

Billing Address _____ Phone# _____

City, State, Zip _____ Email _____

Credit Card Visa MasterCard AmEx

Cardholder Name _____

Account Number _____

Exp. Date _____ CVV (3 or 4 digit security number) _____

SIGNATURE _____ DATE _____

I understand that **this authorization will remain in effect until I cancel it in writing**, and I agree to notify Depressionexam.com in writing of any changes in my account information or termination of this authorization at least 15 days prior to the next service date. I certify that I am an authorized user of this credit card and will not dispute these scheduled transactions with my bank or credit card company; so long as the transactions correspond to the terms indicated in this authorization form.

REFUND POLICY

In the event that client terminates the services of Depressionexam.com, any and all monies paid for treatment will be held non-refundable. Client is not entitled to any refund either in whole or in part.

Client's Initials

NO WARRANTY OR GUARANTEE

The client acknowledges and agrees that Depressionexam.com is not making any warranty, representation or guaranty with respect to the provision of the services to the client or the results thereof, and that notwithstanding the provision of the services, Depressionexam.com has absolutely no ability to ensure that client will receive SDI benefits after applying to the EDD. Regarding the evaluation for disability, it is the psychologist's sole determination whether your symptoms and other factors constitute a clinical diagnosis. It is the EDD's sole discretion to offer disability based upon the psychologist's recommendation. In regards to supportive therapeutic services, all forms of counseling and therapy can be intensely personal processes which can bring unpleasant memories or emotions to the surface. There are no guarantees that these services will work for the client, or that their depression will be cured. Some clients who make improvements go backwards after a time. Progress may happen slowly, and the complete participation of the client is needed. It is the client's responsibility to follow the recommendations of the psychologist during the support sessions. Depressionexam.com does not warrant or agree to affect a cure but does agree to accord the client such care and mental health treatment as to provide him/her the opportunity for improved functioning.

Client's Initials

NON-COVERED EXPENSES

Any psychiatric and/or medical needs outside of our scope of services that arise while the client is at Depressionexam.com are not covered by us. Clients will need to make individual, separate arrangements for any such medical services. Depressionexam.com will neither pay for nor bill the client for medical services given by any outside provider. Services that are outside the Depressionexam.com's scope of services, including additional physicals, laboratory fees, drug testing, and pharmacy expenses are not covered by Depressionexam.com and the client is solely responsible to pay for these ancillary fees. Such fees will be paid directly to the supplier of service and not through Depressionexam.com.

Client's Initials

COLLECTIONS / FEES

Depressionexam.com reserves the right to charge a fee for accounts that are turned over to a collection agency. If your account is turned over to a collection agency, take note that your account will be charged a fee of 33% of the account balance. It is in your best interest to avoid these negative financial events and pay any outstanding balances before your account is turned over to a collection agency.

Depressionexam.com reserves the right to charge a \$55.00 Insufficient Funds (ISF) Fee for any returned or declined items (checks and/or credit/debit card transactions).

Client's Initials

NON MEDICAL ORGANIZATION

Depressionexam.com IS A NON MEDICAL ORGANIZATION. Any client requiring higher level care for psychiatric or medical services will be provided with a list of community resources for medical/ psychiatric referrals. A written list of referrals will be provided to the client and a notation placed in the client's EHR.

Client's Initials

RELEASE OF INFORMATION

Depressionexam.com shall obtain client's consent and his/her written authorization to release information, except in those circumstances when permitted or required by law to release information. The undersigned agrees that, to the extent necessary to determine liability for payment and to obtain reimbursement, Depressionexam.com may disclose minimally necessary portions of the client's records to any person or entity which is or may be liable for all or any portion of Depressionexam.com charges. This includes, but is not limited to California Employment Development Department, health care service plans, employers, or worker's compensation carriers.

It is understood by the undersigned that Depressionexam.com maintains a right of access to the treatment file, treatment notes, therapy plan, etc., by the undersigned. Furthermore undersigned acknowledges that patients doctor and Depressionexam.com staff and contracted staff of Depressionexam.com may collaborate and share information with each other concerning clients counseling, progress, treatment plan, etc.

Without limiting any of the foregoing, if payment is made by credit card, client further agrees as follows: in the event of any credit card dispute as to any services rendered at Depressionexam.com, its staff or representatives are authorized to submit to the applicable credit card company, this Agreement or any other agreement or documents Depressionexam.com or its staff deems reasonably necessary to establish that services were rendered and that client agreed to be responsible for payment. Depressionexam.com shall submit only minimally necessary portions of any client identifying information/records and that if further information is required to establish the provision of services, client agrees to provide any necessary authorizations in an expeditious manner.

Client's Initials

NON-LIABILITY OF PROFESSIONAL SERVICES

Client understands that certain services provided at Depressionexam.com may be provided by contracted professionals. I also understand that although Depressionexam.com retains responsibility for services performed by contracted agencies, Depressionexam.com does not assume liability for the acts of such contracted professionals, and therefore, the client releases Depressionexam.com, its owners and employees, from any and all liability for the acts and omissions of all contracted professionals providing services.

Client's Initials

NO SHOW POLICY/MISSED APPOINTMENTS

Client understands that it is his/her responsibility to notify Depressionexam.com at least 48 hours in advance to cancel and/or reschedule any appointment. Missed appointments will be charged \$100.00 unless documented 48-hour notice of cancellation is given.

Client's Initials

ACTIVITIES EXPECTED OF PARTICIPANTS

Clients are expected to participate in their treatment and follow the recommendations of their treating psychologist. Clients are expected to be on time for sessions. Clients are required to attend a minimum of 2 (two) follow up counseling sessions with their doctor each calendar month.

Client's Initials

ATTORNEY FEES AND COSTS

If any party institutes any action or proceeding based upon or arising out of this agreement, the prevailing party in any such action shall be entitled to receive from the non-prevailing party all costs and expenses of prosecuting or defending the action or proceeding, including reasonable attorney's fees.

Client's Initials

MISCELLANEOUS

Neither party may assign this Agreement or delegate any right or duty hereunder without the prior written consent of the other party. Subject to the foregoing, this Agreement shall be binding on and shall inure to the benefit of the parties and their respective successors and assigns. This Agreement shall be construed and governed by the laws of the State of California and invalidity and unenforceability of any provision hereof shall in no way affect the validity or enforceability of any of the other provisions. All notices which any party is required, or may desire, to give to another party under this Agreement shall be in writing, and shall be given by addressing the same to such other party or parties at Depressionexam.com address, and by depositing the same so addressed, postage prepaid, certified mail, return receipt requested, in the United States mail, or by delivering the same personally to such other party or parties. No waiver by either of the parties hereto of any failure by the other party to keep or perform any provision, covenant, or condition of this Agreement shall be deemed to be a waiver of any preceding or succeeding breach of the same, or of any other provision, covenant or condition. This Agreement, and all attachments, exhibits and other agreements referenced herein or contemplated hereby, constitute the complete understanding of the parties regarding the subject matter herein and supersede any prior or contemporaneous oral or written agreements, representations, understandings or discussions between the parties. The exhibits and attachments to this agreement are incorporated herein by this reference as though fully set forth herein. This Agreement shall not be modified or amended except by a written document executed by both parties to this Agreement, and such written modifications shall be attached hereto.

Client's Initials

CONFIDENTIALITY AND EMERGENCY SITUATIONS

During the course of treatment, it may be necessary to communicate with other providers and staff at Depressionexam.com. Client hereby understands that all information shared with the staff is confidential and no information will be released without client consent. While written authorization will not be requested, prior to any discussion with other providers and staff, understand that client will be informed of such communications. In all other circumstances, consent to release information is given through written authorization. Verbal consent for limited release of information may be necessary in special circumstances. Further, understand that there are specific and limited exceptions to this confidentiality which include the following:

1. When there is risk of imminent danger to the client or another person, we are ethically bound to take necessary steps to prevent such danger.
2. When there is suspicion that a child or elder is being sexually or physically abused or is at risk of such abuse, we are legally required to take steps to protect the elder or child, and to inform the proper authorities.
3. When a valid court order is issued for medical records, we are bound by law to comply with such requests.

If an emergency situation occurs where immediate attention is necessary, client is to contact the local emergency services (911) for assistance. Client shall contact us as well as his/her primary care physician to follow up on those emergency services.

Client's Initials

YOUR RIGHTS

You have the right to:

- Request and receive information about your therapist's professional capabilities, including license status, education, training, experience, professional association membership, specialization and specific areas of competence.
- Verify the status of the therapist's credentials license with the appropriate board and receive information about any disciplinary actions.
- Have a discussion with a representative from Depressionexam.com about fees, billing arrangements, and the nature and anticipated course of sessions.
- Be provided a safe environment, free from sexual, physical or emotional abuse, when in the care of the therapist.
- Expect that your therapist should not involve you or anyone who is a close relative, guardian, or significant other in sexual intimacies.
- Ask questions about your sessions or assessments.
- Refuse to answer any question or disclose any information you choose not to reveal.
- Request that the therapist inform you of your progress.
- Know if there are supervisors, consultants, students, assistants or others with whom your therapist will discuss your case.
- Refuse a particular type of treatment or end treatment at any time without obligation or harassment.
- Refuse or request electronic recording of your sessions.
- Request and (in most cases) receive a copy of your records, including the diagnosis, treatment plan, your progress and type of treatment.
- Report unprofessional behavior by a therapist to the appropriate overseeing body.
- Receive a second opinion at any time about your therapy or about your therapist's methods.
- Receive referral names, addresses and telephone numbers in the event that your therapy needs to be transferred to someone else and to request that a copy or a summary of your records be sent to any therapist or agency you choose.

Client's Initials

Effective Date: 03/04/2017

This notice describes how health information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Our Pledge Regarding Your Medical Information

This Notice tells you about the ways in which Depressionexam.com may use and disclose health information about you. It also describes your rights and certain obligations we have regarding the use and disclosure of your medical information.

We are required by law to:

- make sure that your medical information is protected;
- give you this Notice describing our legal duties and privacy practices with respect to medical information about you; and follow the terms of the Notice that is currently in effect.

How We May Use and Disclose Medical Information About You

NOTICE OF PRIVACY PRACTICES

The following sections describe different ways that we may use and disclose your medical information. For each category of uses or disclosures we will describe them and give some examples. Some information such as certain drug and alcohol information, HIV information and mental health information is entitled to special restrictions related to its use and disclosure. Depressionexam.com abides by all applicable state and federal laws related to the protection of this information. Not every use or disclosure will be listed. All of the ways we are permitted to use and disclose information, however, will fall within one of the following categories:

For Treatment. We may use medical information about you to provide you with the best treatment or services. For example, we may disclose or receive medical information about you to/from clinicians/therapists in order to assist you with finding the appropriate therapist for your specific needs and treatments for your needs.

For Payment. We may use and disclose medical information about you so that the treatment and services you receive from your clinician/therapist may be billed to and payment may be collected from you, an insurance company or a third party. Other personnel, to whom we may disclose personal information during your treatment, may include the cashier for credit card processing.

Appointment Reminders. We may contact you to remind you that you have an appointment with your clinician/therapist at depressionexam.com.

Individuals Involved in Your Care or Payment for Your Care. We may release medical information to anyone involved in your medical care, e.g., a friend, family member, personal representative, or any individual you identify. We may also give information to someone who helps pay for your care.

To Avert a Serious Threat to Health or Safety. We may use and disclose medical information about you when necessary to prevent or lessen a serious and imminent threat to your health and safety or the health and safety of the public or another person. Any disclosure would be to someone able to help stop or reduce the threat.

Public Health Disclosures. We may disclose medical information about you for public health purposes. These purposes generally include the following:

- preventing or controlling disease (such as cancer and tuberculosis), injury or disability;
- reporting vital events such as births and deaths;
- reporting child abuse or neglect; reporting adverse events or observations related to food, medications or defects or problems with products;
- notifying persons of recalls, repairs or replacements of products they may be using;
- notifying a person who may have been exposed to a disease or may be at risk of contracting or spreading a disease or condition;
- reporting to the employer findings concerning a work-related illness or injury or workplace-related medical observation;
- notifying the appropriate government authority if we believe a patient has been the victim of abuse, neglect or domestic violence and make this disclosure as authorized or required by law.

As Required By Law. We will disclose medical information about you when required to do so by federal or state law.

Health Oversight Activities. We may disclose medical information to governmental, licensing, auditing, and accrediting agencies as authorized or required by law.

Lawsuits and Other Legal Actions. In connection with lawsuits or other legal proceedings, we may disclose medical information about you in response to a court or administrative order, or in response to a subpoena, discovery request, warrant, summons or other lawful process.

Law Enforcement. If asked to do so by law enforcement, and as authorized or required by law, we may release medical information:

- to identify or locate a suspect, fugitive, material witness, or missing person;
- about a suspected victim of a crime if, under certain limited circumstances, we are unable to obtain the person's agreement;
- about a death suspected to be the result of criminal conduct;
- in case of a medical emergency, to report a crime; the location of the crime or victims; or the identity, description or location of the person who committed the crime.

National Security and Intelligence Activities. As authorized or required by law, we may disclose medical information about you to authorized federal officials for intelligence, counterintelligence, and other national security activities.

Protective Services for the President and Others. As authorized or required by law, we may disclose medical information about you to authorized federal officials so they may conduct special investigations or provide protection to the President, other authorized persons or foreign heads of state.

NEED FOR AUTHORIZATION: We will not make any uses or disclosures other than those mentioned above without your permission. You may withdraw such permission in writing.

Your Rights Regarding Medical Information About You

Your medical information/records are the property of your clinician/therapist. You have the following rights, however, regarding the medical information your clinician/therapist maintains about you:

FEDERAL LAW PROVIDES YOU WITH THE RIGHT TO INSPECT AND COPY PROTECTED HEALTH INFORMATION: You have the right to inspect and copy your information, except for any psychotherapy notes, certain information relating to civil, criminal, or administrative proceedings, and certain information prohibited by law from disclosure.

FEDERAL LAW PROVIDES YOU WITH THE RIGHT TO AN ACCOUNTING OF DISCLOSURES: You have the right to receive an accounting from us of disclosures of your information made for up to the six (6) years prior to your request. This right does not apply to: disclosures made to carry out treatment, payment, or health care operations; disclosures made with your permission; disclosures made for police purposes; disclosures allowed by law; or disclosures made before August 1, 2014.

FEDERAL LAW PROVIDES YOU WITH THE RIGHT TO REQUEST RESTRICTIONS: You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment or payment.

FEDERAL LAW PROVIDES YOU WITH THE RIGHT TO ALTERNATIVE CONFIDENTIAL COMMUNICATION OF PROTECTED HEALTH INFORMATION. You have the right to request that we communicate with you in a certain way or at a certain location. For example, you may ask that we call you only on your cell, or whether or not to leave messages.

FEDERAL LAW PROVIDES YOU WITH THE RIGHT TO AMEND PROTECTED HEALTH INFORMATION: You have the right to request that we amend your information kept in our records. We are allowed to deny your request if we did not create the information in the record. We will review your request and respond to you in writing

FEDERAL LAW PROVIDES YOU WITH THE RIGHT TO A PAPER COPY OF THIS NOTICE. You have the right to a paper copy of this Notice. You may ask us to give you a copy of this Notice at any time. *Copies of this Notice are available at our office reception.*

FEDERAL LAW PROVIDES YOU WITH THE RIGHT TO FILE A COMPLAINT. If you believe your privacy rights have been violated, you have the right to complain to us by writing to the contact listed at the end of this Notice or to the federal Secretary of the Department of Health and Human Services, Hubert H. Humphrey Building, 200 Independence Avenue, Washington, D.C., 20201. Federal law prohibits retaliation against you for filing such a complaint. The contact listed at the end of this Notice is available to provide you information regarding questions you have or other information concerning this Notice.

Changes to Depressionexam.com’s Privacy Practices and This Notice

We reserve the right to change the Depressionexam.com’s privacy practices and this Notice. We reserve the right to make the revised or changed Notice effective for medical information we already have about you as well as any information we receive in the future. We will post a copy of the current Notice. The Notice will contain the effective date on the first page at the top, right-hand corner. In addition, at any time you may request a copy of the current Notice in effect.

Other Uses of Medical Information

Other uses and disclosures of medical information not covered by this Notice will be made only with your written permission. If you provide us permission to use or disclose medical information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose medical information about you for the reasons covered by your written permission. You understand that we are unable to take back any disclosures we have already made with your permission, and that we will retain our records of the care provided to you as required by law.

If you have any questions about this Notice, please contact:

Depressionexam.com
Attn: Administration
P.O. Box 342
Escondido, CA 92033
Phone: 213-716-2364

Department of Health and Human Services
Hubert H. Humphrey Building 200
Independence Avenue
Washington, D.C., 20201

TERMINATION OF SERVICES

Upon termination of services, client will be provided with a list of community resources for medical/ psychiatric referrals. A written list of referrals will be provided to the client and a notation placed in the client's EHR.

Client's Initials

MONITORING / TRACKING / RECORDING

Undersigned client acknowledges that they may be requested to install applications specific to treatment onto their phone, computer device, wearable device, IOT device, etc.

It is noted that said applications specifically interact with client via phone / tablet, device, etc and have the capability to report activity, gps location, etc.

Undersigned client also acknowledges that they may be requested to wear, interact, with electronic devices.

Client's Initials

SECURITY DEPOSITS

You may be required to place a security deposit down prior to beginning sessions with your doctor.

Security deposits are NON-REFUNDABLE.

Security deposits will be applied against the initial charge for intake services if the State grants your benefits. If the State does not grant benefits security deposit will remain the property of Depressionexam.com

Client's Initials

LEGAL ENGAGEMENT AGREEMENT

Fees: Fees and disbursements for service shall include, but not be limited to, charges for legal and professional consultations, interviews, evaluation appointments, collateral appointments, reviewing documents and other evidence, preparing and providing reports, affidavits, and testimony, and assistant time and effort, where applicable.

The doctors usual and customary fee is \$350 per hour or portion thereof for all services including but not limited to evaluation, collaborative interviews, attorney consultation, review of records, depositions, affidavits, declarations, and travel time (door to door).

Court and deposition testimony is billed in full and half-day increments at the hourly rate of \$400 – that is, \$1600 per half-day and \$3200 per full-day.

Fees for photocopying and other staff-related activities are billed at \$50 per hour.

Disbursements, which will also be billed, include actual costs associated with psychological services, as well as travel expenses and other reasonable expenses incurred.

The financially responsible party shall be the law firm by whom the doctor is retained. The responsible party shall pay the fees and disbursements for all time and services provided by the doctor to depressionexam.com. The doctor will not accept payment from the litigant directly. If the litigant fails to attend the evaluation, fails to provide more than 48 hours notice of cancellation, or fails to cooperate with the evaluation, the financially responsible party shall be responsible for full payment for time allotted for the evaluation.

Retainer or Court Order. A retainer of \$3500 is due at least 48 hours before the first consultation or evaluation session with the doctor and before the doctor may be identified to opposing counsel or to the court as having been retained by the law firm. The retainer shall be applied to the final billing statement, and the doctor shall return any unused remaining portion of the retainer to the payer.

In lieu of a retainer, a court order or other document guaranteeing payment will be required.

The actual final cost of services varies widely depending on the amount of time spent by the doctor and the amount of contact with the parties and the attorneys, the amount of information to be read, and the degree of complexity of the matter. The doctors fees may substantially exceed the initial retainer in which case additional retainers shall be required. Additional retainers and fees shall be paid promptly when requested by the doctor.

Please be advised that should your doctor be requested to write a letter on any court related matter, they will NOT be stipulating in writing or in person as to an opinion. As your **therapist**, they may only provide observations and feedback. At no time will they make a recommendation in regards to custody or any other court related matter.

If a court order is served and is requesting that they be present in person and/or there is a request for records, your doctor will request your consent before turning over confidential information. They will discuss with you exactly what has been requested by court and there is no guarantee that the information will be kept confidential. This information includes mental health history, current status and inclusive records and may not be in your best interest.

The **therapist**-client relationship does not render your doctor as your advocate. They will withhold any opportunity to engage in a dual relationship in this way.

They will not be on-call at any time. Should a case be trailed, they will be paid in full for each day as well as an additional \$3200 per day as it hinders their ability to be available to other clients.

All court fees must be received by cashier's check 14 days prior to the court date. Should the court calendar the hearing for another date, you doctor must be re-issued a court order with the new court hearing date.

Should the doctor be on vacation, the party initiating the court order must take reasonable steps to avoid imposing undue burden or expense on a person subject to the subpoena.

Client's Initials

TELEHEALTH CONSENT

I _____, hereby consent to engaging in telehealth, as part of my treatment through Depressionexam.com. I understand that “telehealth” includes the practice of health care delivery, diagnosis, consultation, treatment, transfer of medical data, and education using interactive audio, video, or data communications. I understand that telehealth also involves the communication of my medical/mental information, both orally and visually, to health care practitioners located in California or outside of California. I understand that I have the following rights with respect to telehealth:

(1) I have the right to withhold or withdraw consent at any time without affecting my right to future care or treatment or risking the loss or withdrawal of any program benefits to which I would otherwise be entitled.

(2) The laws that protect the confidentiality of my medical information also apply to telehealth. As such, I understand that the information disclosed by me during the course of my therapy is generally confidential. However, there are both mandatory and permissive exceptions to confidentiality, including, but not limited to reporting child, elder, and dependent adult abuse; expressed threats of violence towards an ascertainable victim; and where I make my mental or emotional state an issue in a legal proceeding. I also understand that the dissemination of any personally identifiable images or information from the telehealth interaction to researchers or other entities shall not occur without my written consent.

(3) I understand that there are risks and consequences from telehealth, including, but not limited to, the possibility, despite reasonable efforts on the part of my therapist, that: the transmission of my medical information could be disrupted or distorted by technical failures; the transmission of my medical information could be interrupted by unauthorized persons; and/or the electronic storage of my medical information could be accessed by unauthorized persons. In addition, I understand that telehealth based services and care may not be as complete as face-to-face services. I also understand that if my therapist believes I would be better served by another form of therapeutic services (e.g. face-to-face services) I will be referred to a therapist who can provide such services in my area. Finally, I understand that there are potential risks and benefits associated with any form of therapy, and that despite my efforts and the efforts of my therapist, my condition may not improve, and in some cases may even get worse.

(4) I understand that I may benefit from telehealth, but that results cannot be guaranteed or assured.

(5) I understand that I have a right to access my medical information and copies of medical records in accordance with California law. I have read and understand the information provided above. I have discussed it with my therapist, and all of my questions have been answered to my satisfaction.

Signature of Client

Date

**ACKNOWLEDGEMENT OF RECEIPT OF
NOTICE OF PRIVACY PRACTICES**

Client Name: _____ DOB: _____

I, _____ hereby acknowledge that I have received a copy
(PLEASE PRINT)

of the Depressionexam.com Notice of Privacy Practices, with an effective date of March 04, 2017.

Client Signature

Date

CONSENT TO SERVICES

By accepting the conditions outlined in this document, the client consents to evaluations and services provided by the psychologists and staff at Depressionexam.com, and acknowledges that no guarantees have been made to client about what will be experienced as a result of participating in these services.

Client's Initials

If any provision or article of this contract is held invalid, such invalidity shall not affect other articles or provision of this contract, which will be given effect without the invalid provision or articles, and to this end the articles and provision of this contract are servable. This agreement (unless expressly revoked by the client sooner) expires upon discharge by the treating psychologist. The undersigned client certifies that he/she has read the foregoing, accepts and agrees to comply with and be bound by its terms and received a signed copy of this Agreement. The following conditions and provisions shall govern the services, care and accommodations provided to all clients at the program. Depressionexam.com reserves the right to modify, change or revise any of these conditions and provisions with notification to client.

Client's Name (Please Print)

Client's Signature

Date

Depressionexam.com Name (Please Print)

Depressionexam.com Signature

Date