

INSTRUCTIONS

Enclosed in this document you will find the following information:

1. Private Practice Policies for Three Hour Initial Couples Session
2. Private Practice Policies for Couples
3. Informed Consent to Couple or Family Psychotherapy
4. HIPAA Privacy Policy

Please carefully read all of the information enclosed in this document. You will be required to print and complete all of the signature forms associated with this information and bring them to your first session with Dr. Berry.

All of this information needs the attention of both partners in the couple.

Karen W. Berry, Ph.D.
Licensed Psychologist

Private Practice Policies for Three Hour
Initial Couple's Session

PRIVATE PRACTICE POLICIES FOR THREE HOUR INITIAL COUPLE'S SESSION

To maintain smooth business relationships, here are several points to keep in mind and heart:

- A one day couple's intensive psychotherapy session is three hours in duration. I require payment within 48 hours of your session. Go to the Payment page on my website to make a payment online. <http://www.drkarenberry.com/payment/>
- If you need to cancel or reschedule an appointment, please do so at least 48 hours in advance of your appointment to avoid being charged for the full session. Any cancellation must be made through the "Manage Booking" link of your confirmation or reminder email, or through direct contact with me or my office.
- I often require more than one day to return your telephone outreach. Emergencies always have priority; if you have one, please say so. Always leave your telephone number on the voice mail.
- Return telephone calls fewer than 10 minutes will not be billed. Those professional contacts of 10 minutes or more will be billed at session rates.

If you have any questions or concerns regarding any of the above, please do not hesitate to address them with me.

Please sign the Private Practice Policies For Three Hour Initial Couple's Session Form to indicate that you have read this document carefully and you understand and agree to comply with the policies.

Sincerely,
Dr. Karen W. Berry

PRIVATE PRACTICE POLICIES FOR COUPLES

To maintain smooth business relationships, here are several points to keep in mind and heart:

- My experience has taught me, when working with couples, it is in their best interest, financially and emotionally, to meet for no shorter than an hour and a half block of time. Plan on some time (usually no more than 10 minutes) for waiting. Please be advised that there are restroom facilities available in the office, although there is no access to them from the waiting room. If I am delayed, your session will not be compromised. Sessions will end 5 minutes early to allow for the completion of session notes.
- Please pay at least 48 hours in advance of your appointment. Go to the Payment page on my website to make a payment online. <http://www.drkarenberry.com/payment/>
- Scheduling of all appointments is done at the beginning or end of each session, online via my website at <http://www.drkarenberry.com> or by phone. To reserve your appointments at your most preferred times, it is best to schedule for the entire month...at least two weeks prior.
- If you need to cancel or reschedule an appointment, please do so 48 hours in advance of your appointment to avoid being charged for the missed session. Any cancellation must be made through the “Manage Booking” link of your confirmation or reminder email, or through direct contact with me or my office.
- I often require more than one day to return your telephone outreach. Emergencies always have priority; if you have one, please say so. Always leave your telephone number on the voice mail.
- Return telephone calls fewer than 10 minutes will not be billed. Those professional contacts of 10 minutes or more will be billed at session rates.
- Telephone sessions for clients who are out of town, ill, or unavailable in person are encouraged and must be scheduled in advance through this office. Billing rate is the same as session rate

If you have any questions or concerns regarding any of the above, please do not hesitate to address them with me. I welcome your contact.

Please sign the Private Practice Policies For Couples Form to indicate that you have read this document carefully and you understand and agree to comply with the policies.

Sincerely,
Dr. Karen W. Berry

INFORMED CONSENT TO COUPLE OR FAMILY PSYCHOTHERAPY

This form documents that we give our consent to Dr. Karen W. Berry, Ph.D. (the "psychologist") to provide psychotherapeutic treatment to us.

While we expect benefits from this treatment, we fully understand that no particular outcome can be guaranteed. We understand that we are free to discontinue treatment at any time but that it would be best to discuss with the psychologist any plans to end therapy before doing so.

We have fully discussed with the psychologist what is involved in psychotherapy and we understand and agree to the policies about scheduling, fees and missed appointments. Our discussion about therapy has included the psychologist's evaluation and diagnostic formulation of our problems, the method of treatment, goals and length of treatment, and information about record-keeping. We have been informed about and understand the extent of treatment, its foreseeable benefits and risks, and possible alternative methods of treatment. We understand that therapy can sometimes cause upsetting feelings to emerge, that we may feel worse temporarily before feeling better, and that we may experience distress caused by changes we may decide to make in our lives.

We understand that the psychologist cannot provide emergency service. The psychologist has told us whom to call if an emergency arises and the psychologist is unavailable. In any case, we understand that in any emergency, we may call 911 or go to the nearest hospital emergency room.

We have each received a HIPAA Notice of Privacy Practices from the psychologist. We understand that information about psychotherapy is almost always kept confidential by the psychologist and not revealed to others unless we give our consent. There are a few exceptions as noted in the HIPAA Notice of Privacy Practices. Details about certain of those exceptions follows:

1. The psychologist is required by law to report suspected child abuse or neglect to the authorities.
2. If one of us tells the psychologist of an intention to harm another person, the psychologist must try to protect that person, including by telling the police or the person or other health care providers. Similarly, if one of us threatens to harm ourselves, or our life or health is in any immediate danger, the psychologist will try to protect us, including by telling others such as relatives or the police or other health care providers, who can assist in protecting us.
3. If we are involved in certain court proceedings the psychologist may be required by law to reveal information about our treatment. These situations include child custody disputes, cases where a patient's psychological condition is an issue, lawsuits or formal complaints against the psychologist, civil commitment hearings, and court ordered treatment.
4. If our health insurance or managed care plan will be reimbursing us or paying the psychologist directly, they will require that we waive confidentiality and that the psychologist give them information about our treatment.
5. The psychologist may consult with other psychologists about our treatment, but in doing so will not reveal our names or other information that might identify us unless specific consent to do so is obtained. Further, when the psychologist is away or unavailable, another psychologist might answer calls and so

will need to have some information about our treatment.

6. If our account with the psychologist becomes overdue and we do not work out a payment plan, the psychologist will have to reveal a limited amount of information about our treatment in taking legal measures to be paid. This would include our names, social security number, address, dates and type of treatment and the amount due.

In all of the situations described above we understand that the psychologist will try to discuss the situation with us before any confidential information is revealed, and will reveal only the least amount of information that is necessary.

We understand that, except in exceptional circumstances, the psychologist cannot keep secrets from other family members who are involved in the therapy because this might harm the person who does not know.

We agree that each of us has and shall continue to have the right to information about our individual and conjoint treatment sessions, and to the treatment records of the psychologist regarding our individual and conjoint treatment sessions. We each agree that the psychologist may release such information or records to either or all of us without any additional authorization(s) of the other(s). We understand that each of us will not, however, have any right of access to information or records regarding individual treatment sessions of other family members.

We agree that if marriage or parenting problems lead to legal disputes over child custody or visitation, neither of us will ask nor require that the psychologist testify regarding custody or visitation. If a custody or visitation proceeding does occur, we agree that the psychologist's role will be limited to providing to a mental health professional appointed to perform a forensic evaluation, and/or to the attorneys, law guardian, if any, and the judge involved in the legal proceeding, written information regarding, and/or the record of, our treatment; the psychologist will provide these either as required by law or upon our authorization.

You may bump into someone you know leaving the office or encounter myself out in the community. It is my procedure to follow my client's lead, if you nod - I will nod, if you say hello - I will say hello. If you choose not to acknowledge me that is perfectly fine. I suggest that you do not engage in conversation with me because it makes it more challenging for me to protect your confidentiality. I will never acknowledge working with you or anyone else without that person's written permission. Many clients chose to work with me as their therapist because they knew me before entering into therapy and/or were aware of my stance on the topics of interest. Nevertheless, I will discuss with you the often-existing complexities, potential benefits and difficulties that may be involved in such relationships. Dual or multiple relationships can enhance therapeutic effectiveness but can also detract from it, and often it is impossible to know that ahead of time. Therapy never involves sexual or any other dual relationship that impairs my objectivity, clinical judgment or therapeutic effectiveness or can be exploitative in nature. I will assess carefully before entering into non-sexual and non-exploitive dual relationships with clients. It is your, the client's, responsibility to communicate to me if the dual relationship becomes uncomfortable for you in any way. I will always listen carefully and respond according to your feedback. I will discontinue the dual relationship if I find it interfering with the effectiveness of the therapeutic process or the welfare of the client, and of course, you can do the same at any time.

If we are participating in a managed care plan, we have discussed with the psychologist our financial responsibility for any co-payment, and the plan's limits on the number of therapy sessions. We have discussed with the psychologist our options for continuation of treatment when our managed care benefits end. If we are not participating in a managed care program, we understand that we are fully financially responsible for treatment, including any portion of the fees not reimbursed by our health insurance.

Karen W. Berry, Ph.D.
Licensed Psychologist

Informed Consent to Couple or Family Psychotherapy

We understand that we have a right to ask the psychologist about the psychologist's training and qualifications and about where to file complaints about the psychologist's professional conduct.

Please sign the Informed Consent to Couple or Family Psychotherapy Form to indicate that you have read this document carefully and you understand and agree to comply with the policies.

Sincerely,
Dr. Karen W. Berry

Karen W. Berry, Ph.D.
Licensed Psychologist

HIPAA Privacy Policy

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE READ IT CAREFULLY.

NOTICE OF PRIVACY PRACTICES

Effective April 15, 2005

The following is the Notice of Privacy Practices of Dr. Karen W. Berry, Ph.D. HIPAA is a federal law that requires me to maintain the privacy of your protected health information and to provide you with notice of my legal duties and privacy policies with respect to your protected health information. I am required by law to abide by the terms of this Notice of Privacy Practices.

Your Protected Health Information

Your "protected health information" (PHI) broadly includes any health information, oral, written or recorded, that is created or received by me, other healthcare providers, and health insurance companies or plans, that contains data, such as your name, address, social security number, and other information, that could be used to identify you as the individual patient who is associated with that health information.

Uses or Disclosures of Your Protected Health Information

Generally, I may not "use" or "disclose" your PHI without your permission, and must use or disclose your PHI in accordance with the terms of your permission. "Use" refers generally to activities within my office. "Disclosure" refers generally to activities involving parties outside of my office. The following are the circumstances under which I am permitted or required to use or disclose your PHI. In all cases, I am required to limit such uses or disclosures to the minimal amount of PHI that is reasonably required.

Without Your Written Authorization

Without your written authorization, I may use within my office, or disclose to those outside my office, your PHI in order to provide you with the treatment you require or request, to collect payment for my services, and to conduct other related health care operations as follows:

Treatment activities include: (a) use within my office by my professional staff for the provision, coordination, or management of your health care at my office; and (b) my contacting you to provide appointment reminders or information about treatment alternatives or other health-related services that may be of interest to you.

Payment activities include: (a) if you initially consent to treatment using the benefits of your contract with your health insurance plan, I will disclose to your health plans or plan administrators, or their appointed agents, PHI for such plans or administrators to determine coverage, for their medical necessity reviews, for their appropriateness of care reviews, for their utilization review activities, and for adjudication of health benefit claims; (b) disclosures for billing for which I may utilize the services of outside billing companies and claims processing companies with which I have Business Associate Agreements that protect the privacy of your PHI; and (c) disclosures to attorneys, courts, collection agencies and consumer reporting agencies, of information as necessary for the collection of my unpaid fees, provided that I notify you in writing prior to my making collection efforts that require disclosure of your PHI.

Health care operations include: (a) use within my office for training of my professional staff and for internal quality control and auditing functions (b) use within my office for general administrative activities such as filing, typing, etc.; and (c) disclosures to my attorney, accountant, bookkeeper and similar consultants to my healthcare operations, provided that I shall have entered into Business Associate Agreements with such consultants for the protection of your PHI.

Karen W. Berry, Ph.D.
Licensed Psychologist

HIPAA Privacy Policy

PLEASE NOTE THAT UNLESS YOU REQUEST OTHERWISE, AND I AGREE TO YOUR REQUEST, I WILL USE OR DISCLOSE YOUR PERSONAL HEALTH INFORMATION FOR TREATMENT ACTIVITIES, PAYMENT ACTIVITIES, AND HEALTHCARE OPERATIONS AS SPECIFIED ABOVE, WITHOUT WRITTEN AUTHORIZATION FROM YOU.

As Required By Law

I may use or disclose your PHI to the extent that such use or disclosure is required by law. *Examples of instances in which I am required to disclose your PHI include:* (a) disclosures regarding reports of child abuse or neglect, including reporting to social service or child protective services agencies; (b) health oversight activities including audits, civil, administrative, or criminal investigations, inspections, licensure or disciplinary actions, or civil, administrative, or criminal proceedings or actions, or other activities necessary for appropriate oversight of government benefit programs; (c) judicial and administrative proceedings in response to an order of a court or administrative tribunal, or other lawful process; (d) to the extent necessary to protect you or others from a serious imminent risk of danger presented by you; (e) for worker's compensation claims, and (f) as required by the Secretary of Health and Human Services to investigate or determine my compliance with federal regulations, including those regarding government programs providing public benefits.

All Other Situations, With Your Specific Written Authorization

Except as otherwise permitted or required as described above, I may not use or disclose your PHI without your written authorization. Further, I am required to use or disclose your PHI consistent with the terms of your authorization. You may revoke your authorization to use or disclose any PHI at any time, except to the extent that I have taken action in reliance on such authorization, or, if you provided the authorization as a condition of obtaining insurance coverage, other law provides the insurer with the right to contest a claim under the policy.

Special Handling of Psychotherapy Notes

"Psychotherapy Notes" are defined as records of communications during individual or family counseling which may be maintained in addition to and separate from medical or healthcare records. Psychotherapy Notes are only released with your specific written authorization except in limited instances, including: (a) if you sue me or place a complaint, I may use Psychotherapy Notes in my defense; (b) to the United States Department of Health and Human Services in an investigation of my compliance with HIPAA; (c) to health oversight agencies for a lawful purpose related to oversight of my practice; and (d) to the extent necessary to protect you or others from a serious imminent risk of danger presented by you. Health insurers may not condition treatment, payment, enrollment, or eligibility for benefits on obtaining authorization to review, or on reviewing, Psychotherapy Notes.

Your Rights With Respect to Your Protected Health Information

Under HIPAA, you have certain rights with respect to your PHI. The following is an overview of your rights and my duties with respect to enforcing those rights.

Right To Request Restrictions On Use Or Disclosure

You have the right to request restrictions on certain uses and disclosures of your PHI. While I am not required to agree to any requested restriction, if I agree to a restriction, I am bound not to use or disclose your protected healthcare information in violation of such restriction, except in certain emergency situations. I will not accept a request to restrict uses or disclosures that are otherwise required by law. I require that all requests for restrictions be in writing and that you state a reason for the request.

Right To Receive Confidential Communications by Alternative Means and at Alternative Locations

I must permit you to request and must accommodate reasonable requests by you to receive communications of PHI from me by alternative means or at alternative locations. I will ask you how you wish me to communicate with you.

Right To Inspect And Copy Your Protected Health Information

You have the right of access in order to inspect, and to obtain a copy of your PHI, *except for* (a) personal notes and observations of the treating provider, (b) information compiled in reasonable anticipation of, or for use in, a civil, criminal, or administrative action or proceeding, (c) health information maintained by me to the extent to which the provision of access to you is at my discretion, and I exercise my professional judgment to deny you access, and (d) health information maintained by me to the extent to which the provision of access to you would be prohibited by law.

I require written requests for copies of your PHI; they should be sent to me at the mailing address below. If you request a copy of your PHI, I will charge a fee for copying. I reserve the right to deny you access to and copies of all or certain PHI as permitted or required by law. Upon denial of a request for access or request for information, I will provide you with a written denial specifying the basis for denial, a statement of your rights, and a description of how you may file an appeal or complaint.

Right To Amend Your Protected Health Information

You have the right to request that I amend your PHI, for as long as your medical record is maintained by me. I have the right to deny your request for amendment. I require that you submit written requests and provide a reason to support the requested amendment.

If I deny your request, I will provide you with a written denial stating the basis of the denial, your right to submit a written statement disagreeing with the denial, and a description of how you may file a complaint with me and/or the Secretary of the U.S. Department of Health and Human Services (DHHS). If I accept your request for amendment, I will make reasonable efforts to provide the amendment within a reasonable time to persons identified by you as having received PHI of yours prior to amendment and persons that I know have the PHI that is the subject of the amendment and that may have relied, or could foreseeably rely, on such information to your detriment. All requests for amendments shall be sent to me at the mailing address below.

Right To Receive An Accounting Of Disclosures Of Your Protected Health Information

Beginning April 14, 2003, you have the right to receive a written accounting of all disclosures of your PHI for which you have not provided an authorization, that I have made within the six (6) year period immediately preceding the

Karen W. Berry, Ph.D.

HIPAA Privacy Policy

Licensed Psychologist

date on which the accounting is requested. You may request an accounting of such disclosures for a period of time less than six (6) years from the date of the request. I require that you request an accounting in writing on a form that I will provide to you.

The accounting of disclosures will include the date of each disclosure, the name and, if known, the address of the entity or person who received the information, a brief description of the information disclosed, and a brief statement of the purpose and basis of the disclosure or, instead of such statement, a copy of your written authorization or written request for disclosure pertaining to such information. *I am not required to provide accountings of disclosures for the following purposes:* (a) treatment, payment, and healthcare operations, (b) disclosures pursuant to your authorization, (c) disclosures to you, (d) to other healthcare providers involved in your care, (e) for national security or intelligence purposes, (f) to correctional institutions, and (g) with respect to disclosures occurring prior to 4/14/03. I reserve the right to temporarily suspend your right to receive an accounting of disclosures to health oversight agencies or law enforcement officials, as required by law. I will provide the first accounting to you in any twelve (12) month period without charge, but will impose a reasonable cost-based fee for responding to each subsequent request for accounting within that same twelve (12) month period. All requests for an accounting shall be sent to me at the mailing address below.

Complaints

You may file a complaint with me and with the Secretary of DHHS if you believe that your privacy rights have been violated. Please submit any complaint to me in writing by mail sent to the mailing address below. A complaint must name the subject of the complaint and describe the acts or omissions believed to be in violation of the applicable requirements of HIPAA or this Notice of Privacy Practices. A complaint must be received by me or filed with the Secretary of DHHS within 180 days of when you knew or should have known that the act or omission complained of occurred. You will not be retaliated against for filing any complaint.

Amendments to this Notice of Privacy Practices

I reserve the right to revise or amend this Notice of Privacy Practices at any time. These revisions or amendments may be made effective for all PHI I maintain even if created or received prior to the effective date of the revision or amendment. Upon your written request, I will provide you with notice of any revisions or amendments to this Notice of Privacy Practices, or changes in the law affecting this Notice of Privacy Practices, by mail or electronically within 60 days of receipt or your request.

Ongoing Access to Notice of Privacy Practices

I will provide you with a copy of the most recent version of this Notice of Privacy Practices at any time upon your written request sent to me at the mailing address below. For any other requests or for further information regarding the privacy of your PHI, and for information regarding the filing of a complaint, please contact me at the address or telephone number listed below.

Acknowledgment of Receipt of Notice of Privacy Practices of Karen W. Berry, Ph.D.

Please sign the Acknowledgment of Receipt of Notice of Privacy Practices of Karen W. Berry, Ph. D. Form to indicate that you have read this document carefully.