Jonathan C. Stillerman, PhD, CGP
Licensed Psychologist and Certified Group Psychotherapist
2000 P Street NW, Suite 503
Washington, DC 20036

Psychotherapy Services Agreement

Provider
All psychotherapy services are provided by Dr. Jonathan Stillerman, a licensed psychologist in the District of Columbia. All sessions are conducted in-person; if it is unsafe to do so, sessions will take place virtually through Zoom or by phone.

Session Frequency, Length and Location
Individual sessions - 50 minutes; Couples sessions - 60-90 minutes; Group sessions - 75 minutes.
Individuals and couples are usually seen once or twice weekly. Groups meet once a week.

Fees
Individual therapy - $225; Couples therapy - $265-395; Group therapy - $100-120 (reduced fees may be negotiated in cases of need). Clients agree to pay at each individual or couple session or monthly for group treatment. I accept payment by check (payable to Jonathan Stillerman), cash, Venmo (@Jonathan-Stillerman-1) or Zelle (jstillerman@hotmail.com).

Cancellation Policy
With prior notice, a client may cancel up to 4 sessions in a calendar year without being charged. Any cancellation that can be rescheduled within one week will not count toward the 4 session annual limit. Beyond the 4 allowed, cancellations for any reason that cannot be rescheduled will be charged (this includes cancellations resulting from work responsibilities, vacations, etc.). In addition, clients will be charged for any individual or couple session missed without notice (aka "no show").
Please note: charges for missed or cancelled sessions are not insurance reimbursable.

Holidays and "Snow Days"
Sessions will NOT occur on: New Year's Day, MLK, Jr. Day, Memorial Day, July 4th, Labor Day, Thanksgiving, and Christmas. Even when the federal government closes due to weather, the office will remain open unless otherwise notified.

Using Insurance
I am not affiliated with any insurance provider. Clients who wish to use insurance should check with their provider to determine coverage for "out-of-network" outpatient mental health services. When using insurance, clients agree to pay the fee up front and then seek reimbursement from the insurance provider. Clients are responsible for tracking insurance claims. Regardless of whether one uses insurance, each client is ultimately responsible for all fees incurred.

Confidentiality
Confidentiality is an ethical and legal requirement of the therapeutic relationship. However, confidentiality may be limited by law under certain circumstances: 1) when it is clear that a client is in imminent danger of physically harming him/herself or an identified other and 2) when the therapist learns of the past or current physical or sexual abuse and/or neglect of minors (under 18 years old), non-competent adults, or the elderly in the District of Columbia or elsewhere. In all other cases, clients must give their written consent for the therapist to share any information about them with anyone else.

Email, Phone Contact and Emergencies
I limit communication by text (202-699-2779) or email (jstillerman@hotmail.com) to administrative issues. Clients may leave a confidential voicemail anytime at 202-699-2779. You may also use this number in an emergency or call 911.

Your signature below indicates that you have reviewed, understand and will abide by this Therapy Services Agreement. It also serves as an acknowledgement that you have received the HIPAA notice form "Notice of Policies and Practices to Protect the Privacy of Your Health Information."

_____	_____	_____
Client Signature	**Print Name**	**Date**

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Informed Consent for Teletherapy

This Informed Consent for Teletherapy contains important information about doing psychotherapy using the phone or the internet. Signing this document, represents an agreement between us.

Benefits and Risks of Teletherapy

Teletherapy refers to providing psychotherapy services remotely using telecommunications technologies, such as video conferencing or telephone. One of the benefits of teletherapy is that the patient and clinician can engage in services without being in the same physical location. This can be helpful in ensuring continuity of care under certain circumstances, as detailed below. There are also some differences between in-person psychotherapy and teletherapy, and some risks:

- Risks to confidentiality. Because teletherapy sessions take place outside of the therapist's office, there is potential for others to overhear sessions if you are not in a private place during the session. On my end, I will take reasonable steps to ensure your privacy. It is important for you to find a location for our session where you will not be overheard or interrupted.

- Issues related to technology. There are many ways that technology issues might impact teletherapy. For example, technology may fail during a session, other people could get access to our conversation, or stored data could be accessed by unauthorized people or companies.

- Crisis management and intervention. Usually, I will not engage in teletherapy with patients who are currently in a crisis situation requiring high levels of support and intervention. Before engaging in teletherapy, we will develop an emergency response plan to address potential crisis situations that may arise during the course of our teletherapy work.

- Efficacy. I believe that the therapeutic relationship relies on a personal connection that is best sustained in person. As such, I only offer teletherapy services in the event that you may need to miss a session due to unexpected necessary travel, transportation issues, inclement weather, or health concerns, AND it is clinically indicated that we keep our appointment.

Electronic Communications

For virtual therapy sessions, I use Zoom, a HIPAA-compliant video platform. You are solely responsible for the cost to obtain equipment, accessories, or software necessary to use Zoom.

Confidentiality

I have a legal and ethical responsibility to make my best efforts to protect all communications that are a part of our teletherapy. I will try my best to use updated security measures and systems to keep your information private, but there is a risk that our electronic communications may be compromised, unsecured, or accessed by others. You should also take reasonable steps to ensure the security of our communications (e.g., only using secure networks for teletherapy sessions and having passwords to protect the device you use for teletherapy). The extent of confidentiality and exceptions to it outlined in the Psychotherapy Services Agreement still apply to teletherapy.

Emergencies and Technology

Assessing and evaluating threats and other emergencies can be more difficult when conducting teletherapy rather than in-person therapy. To help address this, we ask you to identify an emergency contact person who is near your location and who we will contact in the event of a crisis or emergency to assist in addressing the situation. In signing this agreement, you authorize us to contact your emergency contact person as needed during such a crisis or emergency.

Technical Difficulties or Failures in Non-Emergency Situations

Because some technological failures are common and to be expected when engaging in teletherapy, we will not be able to prorate the session fee related to such expected momentary disconnections or low-quality video/phone connections. These instances are considered part of the noted limitations of this particular treatment modality.

Fees

The same fees apply for teletherapy as for in-person psychotherapy. However, insurance providers may not cover sessions that are conducted via telecommunication. If your insurance provider does not cover teletherapy sessions, **you will remain responsible for the session fee**.

Records

The teletherapy sessions shall not be recorded. I will maintain a record of our session in the same way I maintain records of in-person sessions in accordance with my policies.

Informed Consent

This agreement is intended as a supplement to the general informed consent that we agreed to at the outset of our clinical work together and does not amend any of the terms of that agreement. Your signature below indicates agreement with its terms and conditions.

_____
Patient Name (print)

_____
Emergency Contact

_____
Patient Signature Date

_____
Therapist Signature Date

Client Information Form

Name:_____ **DOB:** ____/____/____

Address:

_____

_____

Phone: (home)_____ (work)_____ (cell)_____

Email:_____ **Soc Security #**:_____

Occupation: _____ **Highest Level of Education**:_____

Relationship Status (circle all that apply):

single married divorced engaged separated

widowed partnered polyamorous

Living Situation (circle one):

by myself with partner with roommate(s) other_____

Name of Spouse/Partner: _____ Age: _____

Children (name/age):

1)_____ 2)_____

3)_____ 4)_____

Parents (name/age/occupation):

1)_____ 2)_____

3)_____ 4)_____

Siblings (name/age):

1)_____ 2)_____

3)_____ 4)_____

Identities (optional):

Gender:_____ **Preferred Pronoun**:_____

Sexual Orientation: _____ **Race/Ethnicity**: _____

Country of Origin:_____ **Religion/Faith**: _____

Other:_____

Have you ever been in therapy before (circle one): yes no

If yes, with whom, when and for how long?

_____

Significant medical conditions AND medications you take:

_____

Primary issues/struggles that you want to address in therapy:

1)_____

2)_____

3)_____

4)_____

Emergency Contact:

Name:_____ Phone Number:_____

Relationship to you:_____

Notice of Psychologist's Policies and Practices to Protect the Privacy of Your Health Information

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

I. Uses and Disclosures for Treatment, Payment, and Health Care Operations

I may *use* or *disclose* your *protected health information* (*PHI*), for *treatment, payment, and health care operations* purposes with your *written authorization*. To help clarify these terms, here are some definitions:

- "*PHI*" refers to information in your health record that could identify you.
- "*Treatment, Payment and Health Care Operations*"
  – *Treatment* is when I provide, coordinate or manage your health care and other services related to your health care. An example of treatment would be when I consult with another health care provider, such as your family physician or another psychologist.
  – *Payment* is when I obtain reimbursement for your healthcare. Examples of payment are when I disclose your PHI to your health insurer to obtain reimbursement for your health care or to determine eligibility or coverage.
  – *Health Care Operations* are activities that relate to the performance and operation of my practice. Examples of health care operations are quality assessment and improvement activities, business-related matters such as audits and administrative services, and case management and care coordination.
- "*Use*" applies only to activities within my [office, clinic, practice group, etc.] such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.
- "*Disclosure*" applies to activities outside of my [office, clinic, practice group, etc.], such as releasing, transferring, or providing access to information about you to other parties.
- "*Authorization*" is your written permission to disclose confidential mental health information. All authorizations to disclose must be on a specific legally required form.

II. Other Uses and Disclosures Requiring Authorization

I may use or disclose PHI for purposes outside of treatment, payment, or health care operations when your appropriate authorization is obtained. In those instances when I am asked for information for purposes outside of treatment, payment, or health care operations, I will obtain an authorization from you before releasing this information. I will also need to obtain an authorization before releasing your Psychotherapy Notes. "*Psychotherapy Notes*" are notes I have made about our conversation during a private, group, joint, or family counseling session, which I have kept separate from the rest of your record. These notes are given a greater degree of protection than PHI.

You may revoke all such authorizations (of PHI or Psychotherapy Notes) at any time, provided each revocation is in writing. You may not revoke an authorization to the extent that (1) I have relied on that authorization; or (2) if the authorization was obtained as a condition of obtaining insurance coverage, law provides the insurer the right to contest the claim under the policy.

III. Uses and Disclosures without Authorization

I may use or disclose PHI without your consent or authorization in the following circumstances:

- *Child Abuse* – If I know or have reasonable cause to suspect that a child known to me in my professional capacity has been or is in immediate danger of being a mentally or physically abused or neglected child, I must immediately report such knowledge or suspicion to the appropriate authority.

- *Adult and Domestic Abuse* – If I believe that an adult is in need of protective services because of abuse or neglect by another person, I must immediately report this belief to the appropriate authorities.

- *Health Oversight Activities* – If the D.C. Board of Psychology is investigating me or my practice, I may be required to disclose PHI to the Board.

- *Judicial and Administrative Proceedings* – If you are involved in a court proceeding and a request is made for information about the professional services I provided you and/or the records thereof, such information is privileged under D.C. law, and I will not release information without the written authorization of you or your legally appointed representative or a court order. The privilege does not apply when you are being evaluated for a third party or where the evaluation is court ordered. You will be informed in advance if this is the case.

- *Serious Threat to Health or Safety* – If I believe disclosure of PHI is necessary to protect you or another individual from a substantial risk of imminent and serious physical injury, I may disclose the PHI to the appropriate individuals.

- *Worker's Compensation* – If I am treating you for Worker's Compensation purposes, I must provide periodic progress reports, treatment records, and bills upon request to you, the D.C. Office of Hearings and Adjudication, your employer, or your insurer, or their representatives.

IV. Patient's Rights and Psychologist's Duties

<u>Patient's Rights:</u>

- *Right to Request Restrictions* – You have the right to request restrictions on certain uses and disclosures of protected health information. However, I am not required to agree to a restriction you request.
- *Right to Receive Confidential Communications by Alternative Means and at Alternative Locations* – You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations. (For example, you may not want a family member to know that you are seeing me. On your request, I will send your bills to another address.)

- *Right to Inspect and Copy* – You have the right to inspect or obtain a copy (or both) of PHI in my mental health and billing records used to make decisions about you for as long as the PHI is maintained in the record. I may deny your access to PHI under certain circumstances, but in some cases you may have this decision reviewed. You may be denied access to Psychotherapy Notes if I believe that a limitation of access is necessary to protect you from a substantial risk of imminent psychological impairment or to protect you or another individual from a substantial risk of imminent and serious physical injury. I shall notify you or your representative if I do not grant complete access. On your request, I will discuss with you the details of the request and denial process.

- *Right to Amend* – You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. I may deny your request. On your request, I will discuss with you the details of the amendment process.

- *Right to an Accounting* – You generally have the right to receive an accounting of disclosures of PHI. On your request, I will discuss with you the details of the accounting process.

- *Right to a Paper Copy* – You have the right to obtain a paper copy of the notice from me upon request, even if you have agreed to receive the notice electronically.

Psychologist's Duties:

- I am required by law to maintain the privacy of PHI and to provide you with a notice of my legal duties and privacy practices with respect to PHI.

- I reserve the right to change the privacy policies and practices described in this notice. Unless I notify you of such changes, however, I am required to abide by the terms currently in effect.

- If I revise my policies and procedures, I will notify you either by mail or in person.

V. Complaints

If you are concerned that I have violated your privacy rights, or you disagree with a decision I made about access to your records, I request that you raise the issue with me so that we may have the opportunity to come to a mutually agreed resolution. However, if we cannot resolve the situation to your satisfaction, you may contact the DC Health Professing Licensing Administration - Board of Psychology at 202-442-4766.

You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services. The person listed above can provide you with the appropriate address upon request.

VI. Effective Date, Restrictions and Changes to Privacy Policy

This notice went into effect on 4/14/03.

I reserve the right to change the terms of this notice and to make the new notice provisions effective for all PHI that I maintain. I will provide you with a revised notice by mail or in person.