Amy Sparks, PhD
Licensed Clinical Psychologist | PSY17514

OFFICE POLICIES INFORMATION SHEET

Welcome to the psychology offices of Amy Sparks, Ph.D. This office currently offers adult individual psychotherapy. In response to frequently asked questions and to insure your understanding of our office policies, we ask that you read the following information and sign your name to indicate your understanding. Should you have any questions, please feel free to ask your doctor.

1. Therapy sessions are by appointment and are 45-50 minutes in length. The time and length of evaluation sessions are arranged on an individual basis.
2. The fee for the initial therapy session and individual sessions are $200.00. We are not able to accept insurance at this time. A sliding scale fee can be arranged, as needed.
3. Full payment for each session is due at the time services is to be rendered unless prior arrangements have been made. Pre-payments are accepted. A $35 fee will be charged for any returned checks.
4. Your session time is reserved for you. If you are unable to attend your appointment, you are asked to notify our office at least 24 hours in advance so that someone else may utilize this time. In the absence of your notification, you will be billed for the missed session at the standard rate. Further, if you miss a session and do not call to reschedule, we will assume that you have terminated therapy.
5. If you are filing for reimbursement with your insurance and would like a receipt for payment or a super-bill, please let us know.
6. No outstanding fees over $200 for which arrangements for payment have not been made will be allowed. You are responsible for prompt payment. If your financial status prohibits further treatment with us, we will be happy to refer you to alternate agencies.
7. All delinquent accounts for which full payment has not been received (nor alternate arrangements for payments have been made) may be turned over to a collection agency. Persons who fall into this category will be responsible to pay all costs incurred in the collection process.
8. The benefits obtained from psychological services are dependent on many factors, and no guarantees regarding the effectiveness or outcome of these services are offered. The therapeutic process involves both the commitments of you as the patient and your doctor.
9. Psychological services are confidential in most circumstances. Please be aware, however, that your records are NOT confidential in the following circumstances: child custody disputes, civil law suits where psychological functioning is part of the claim, criminal lawsuits where records are subpoenaed, situations where child or elderly safety is of concern, or an impending act is planned by you or a family member that could cause harm to persons known or unknown. Please ask your doctor any questions you might have about this information.
10. All patients give consent for the psychologists and staff in this office to consult with each other as needed to provide the best possible services. In an emergency, the psychologists and staff in this office have permission to contact you as needed.

I have read, understand, and agree to abide by the above Office Policies Information Sheet.

Patient Name_____

Signature_____ Date_____

Amy Sparks, PhD | Phone (858) 480-9595 | dramysparks@gmail.com

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INFORMED CONSENT FOR TELE-PSYCHOLOGICAL SERVICES

Prior to starting tele-psychological services, we discussed and agreed to the following:

- There are potential benefits and risks of phone and/or video-conferencing (e.g. limits to patient confidentiality) that differ from in-person sessions.
- Confidentiality still applies for tele-psychology services, and the session will not be recorded without mutual agreement and permission from the client and Dr. Sparks.
- We agree to use the video-conferencing platform selected for our virtual sessions, and the psychologist will explain how to use it.
- You need to use a webcam or smartphone during the session.
- It is important to be in a quiet, private space that is free of distractions (including cell phone or other devices) during the session.
- It is important to use a secure internet connection rather than public/free Wi-Fi.
- It is important to be on time. If you need to cancel or change your tele-appointment, you must notify the psychologist 24 hours in advance by phone or email.
- We will arrange for a back-up plan (e.g., phone number where you can be reached) to restart the session or to reschedule it, in the event of technical problems.
- We will establish a safety plan that includes at least one emergency contact and the closest ER to your location, in the event of a crisis situation.

Patient Name_____

Signature_____ Date_____

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ADDENDUM: EMAIL CONFIDENTIALITY NOTICE

It is important to be aware that e-mail communication can be relatively easy to access by unauthorized people, and therefore can compromise the privacy and confidentiality of such communication. E-mails, in particular, are vulnerable to unauthorized access due to the fact that servers have unlimited and direct access to all e-mail messages that go through them. Unencrypted e-mails are even more vulnerable to unauthorized access. Please be aware that all email communication with Dr. Sparks is unencrypted.

Please notify Dr. Sparks immediately if you decide to avoid or limit in any way the use of e-mail. Please do NOT use e-mail for emergencies.

It is important that you understand Dr. Sparks does not provide professional advice through e-mail. If you choose to send personal information via e-mail that you feel relates to your therapy or that you believe is important for Dr. Sparks to know, it will be discussed in your next therapy session, not through e-mail.

By signing below, I acknowledge that I have read and understood this e-mail confidentiality notice. I give consent for Dr. Sparks to contact me through e-mail.

Patient Name_____

Signature_____ Date_____

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CONFIDENTIAL PERSONAL INFORMATION (Please Print)

Today's Date _____ Patient's Legal Name_____

Chosen Name _____ Pronouns_____

Mobile Phone _____ Preference ___ Text ___ Voicemail Email _____

Street Address _____ City _____ State _____ Zip _____

Birthdate/Age _____ Place of Birth (City/State/Country) _____ Social Security # _____

Gender Identity ___Female ___Male ___Non-Binary ___ Prefer not to say

Occupation/Grade_____ Business/School Phone _____

Employer/School _____

Employer/School Address _____

City _____ State _____ Zip _____

Marital Status: ____Single ____Married ____Separated ____Divorced ____Widowed

Responsible Party (RP)_____ Relationship ____Parent ____Spouse ____Partner

RP Occupation/Grade_____ Business/School Phone _____

RP Employer/School _____

RP Employer/School Address _____

City _____ State _____ Zip _____

In case of emergency, please notify_____ Relationship _____

Address _____ Phone _____

Family Medical Care Provider _____

Address_____ Phone _____

Referred by ___ Headway ___ TFSS ___ Friend/Family ___ Internet Search ___Other_____

AUTHORIZATION TO TREAT:

I authorize and direct Amy Sparks, PhD to perform such therapeutic procedures that in her professional judgment may be advisable for the well being of myself, my child and/or my family. I understand that no warranty or guarantee is made as to the results of this treatment. I agree to assume financial responsibility for the full regular fee charged for a failed appointment canceled with less than 24 hours notice.

Signature _____ Date_____

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INTAKE SHEET

Brief statement of problem or services requested:_____

_____

_____

_____

_____

_____

_____

_____

For each person currently living with the client (INCLUDING THE CLIENT), please list the following information:

Name	Birthdate/ Age	Client/Relation to Client	Years of Education	Occupation	Marital Status/Years Married

For the CLIENT ONLY, please list all prescription and nonprescription medications:

Medication	Dosage	Condition Being Treated	Doctor	Length of Time	Any Other Relevant Info.

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HIPAA REGULATIONS PERTAINING TO USE AND DISCLOSURE OF YOUR PHI

This form is an agreement between you, _____, and Dr. Sparks. If you are signing on behalf of someone else as their personal representative, that person's name is _____ _____.

When working together for an assessment, psychotherapy, or counseling, the forms you fill out and the information collected is what HIPAA law calls Protected Health Information (PHI). The NOTICE OF PRIVACY PRACTICES or NPP form explains your rights to privacy and how HIPAA regulations allow use and disclosure of your PHI. As stated in the NPP, with the exception of emergencies and special circumstances where the law requires acting without authorization, Dr. Sparks will continue to seek your specific written authorization when disclosing PHI about treatment, payment, or healthcare operations. You are entitled to request limits on the use or disclosure of information and there is a place on the authorization form for this. You have the right, after consenting, to revoke your consent in writing. In the future, if privacy laws and regulations change you will be notified. Revisions will be available to you at your request. A copy can be emailed upon request. Signing below indicates the understanding and acceptance of Dr. Sparks's NPP.

_____
Name of Client (Please Print)

_____
Signature of Client, Parent or Personal Representative

_____
Relationship to the Client

_____
Date

____ Copy given to the Client, Parent or Personal Representative

Effective date of NPP: April 14, 2003

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NOTICE OF PRIVACY PRACTICES

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) enacts sweeping changes in how the healthcare professions handle the administrative details of their practices, and contains a broad and stringent framework for the privacy and confidentiality of personally identifiable health information. This Federal statute was enacted as Public Law 104-191. You can find the text of PL 104-191 at the Department of Health and Human Services website www.aspe.hhs.gov/admnsimp/pl104191.htm. The HIPAA Privacy Rule establishes patients' rights and requires that health professionals implement various policies and procedures regarding the use of and access to health care information. It is extremely important to note that the HIPAA privacy rule provides a "floor" of protection. When state law provides the patient with a higher level of protection, state law will prevail. This means that HIPAA will have less effect in California than in many other states because while California law does not appear to require patient consent when information is shared with another provider for treatment purposes, the great majority of psychologists request such consent and thus this constitutes the current standard of care. *I will not disclose your* ***Protected Health Information (PHI)*** *without your consent, except under the following conditions: Your confidentiality is waived in situations where psychologists are mandated by law to report, including: suspected child abuse or neglect; suspected elder abuse; and threats to harm yourself or others. Confidentiality is also subject to waiver when treatment is court-ordered or if you are involved in litigation that calls your mental health into question. If you are using health insurance to cover your therapy expenses, they often require information regarding assessment, diagnosis, treatment goals, and treatment progress. I will, however, inform you of any requests for your records or information about you from third parties.*

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

II. I HAVE LEGAL DUTY TO SAFEGUARD YOUR PHI. I am legally required to protect the privacy of you PHI, which includes information that can be used to identify you that I've created or received about your past, present, or future health or condition, the provision of health care to you, or the payment of this health care. I must provide you with the Notice of Privacy Practices (NPP), and such NPP must explain, how, when, and why I will "use" and "disclose" your PHI. A "use" of PHI occurs when I share, examine, utilize, apply, or analyze such information within my practice; PHI is "disclosed" when it is released, transferred, has been given to, or is otherwise divulged to a third party outside of my practice. With some exceptions, I may not use or disclose any more of your PHI than necessary to accomplish the purpose for which the use or disclosure is made. And, I am legally required to follow the NPP. However, I reserve the right to change the terms of this NPP at any time. Any changes will apply to PHI on file with me already. Before I make any important changes to my NPP, I will promptly change this NPP and post a new copy of it in my office. You can also request a copy of this NPP from me, or you can view a copy of it in my office.

III. HOW I MAY USE AND DISCLOSE YOUR PHI. I will use and disclose you PHI for many different reasons. For some of these uses or disclosures, I will need your prior authorization; for others, however, I do not. Listed below are the different categories of my uses and disclosures along with some examples of each category.

   A. Uses and Disclosures Relating to Treatment, Payment, or Health Care Operations Do Not Require Your Prior Written Consent. I can use and disclose you PHI without your consent for the following reasons:

      1. For treatment I can disclose your PHI to physicians, psychiatrists, psychologists, and other licensed health care providers who provide you with health care services or are involved in your care. For example, if you are being treated by a psychiatrist, I can disclose your PHI to the psychiatrist to coordinate care.

2. To obtain payment for treatment I can use and disclose your PHI to bill and collect payment of the treatment and services provided by me to you (e.g., I might send your PHI to your insurance company or health plan to be paid for the services provided). I may also provide your PHI to my business associates, such as billing companies, claims processing companies, and others that process my health care claims.
3. For health care operations I can use and disclose your PHI to operate my practice (e.g., I might use your PHI to evaluate the quality of health care services you received or to evaluate the performance of the health care professionals providing such services to you). I may also provide you PHI to our accountants, attorneys, consultants, and other to make sure I'm complying with applicable laws.
4. Other disclosures: disclosing your PHI to others without your consent in certain situations (e.g., your consent isn't required if you need emergency treatment, as long as I try to get your consent after treatment is rendered, or if you are unable to communicate due to unconsciousness or severe pain and I think that you would consent to such treatment if you were able to do so).

B. Certain Uses and Disclosures Do Not Require Your Consent. I can use and disclose your PHI without your consent or authorization for the following reasons:
   1. When disclosure is required by federal, state, or local law; judicial or administrative proceedings; or law enforcement (e.g., disclosure to applicable officials when a law requires me to report information to government agencies and law enforcement personnel about victims of abuse or neglect; or when ordered in a judicial or administrative proceeding).
   2. For public health activities (e.g., reporting information about you to the county coroner).
   3. For health oversight activities (e.g., providing information to assist the government when it conducts and investigation or inspection of a health care provider or organization).
   4. For research purposes I may provide PHI in order to conduct medical research.
   5. To avoid harm or serious threat I may disclose your PHI to law enforcement personnel or persons able to prevent or lessen such harm.
   6. For specific government functions. I may disclose PHI of military personnel and veterans in certain situations. And I may disclose your PHI for national security purposes, such as protecting the President of the United States or conducting intelligence operations.
   7. Workers' compensation purposes—provide PHI to comply with workers' compensation laws.
   8. Appointment reminders and health related benefits/services: using PHI for appointment reminders or information about treatment alternatives, or other health care services/benefits.

C. Certain Uses and Disclosures Require You to Have the Opportunity to Object
   1. Disclosures of PHI to a family member, friend, or other person you indicate is involved in your care or payment for your care, unless you object in whole or in part. Consent may be obtained retroactively in emergency situations.

D. Other Uses and Disclosures Require Your Prior Written Authorization. In any other situation not described in Sections III A, B, and C above, I will ask for your written authorization before using or disclosing any of your PHI. If you choose to sign an authorization to disclose your PHI, you can later revoke such authorization in writing to stop any future uses and disclosures (to the extent that I haven't taken any action in reliance on such authorization) of your PHI by me.

IV. WHAT RIGHTS YOU HAVE REGARDING YOUR PHI You have the right to ask that I limit how I use and disclose you PHI. I will consider your request, but I am not legally required to accept it. If I accept your request, I will put any limits in writing and abide by them except in emergency situations. You may not limit the uses and disclosures that I am legally required or allowed to make.

A. The Right to Choose How I Send PHI to You. You have the right to ask that I send information to you to at an alternate address (e.g., sending information to you work address rather than you home address) or by alternate means (e.g., by e-mail instead of the postal service) I must agree to your request so long as I can easily provide the PHI to you in the format you requested.
B. The Right to See and Get Copies of Your PHI. In most case, you have the right to look at or get copies of your PHI that I have, but you must make the request in writing. If I don't have your PHI, but I know who does, I will tell you how to get it. I will respond to you within 30 days of receiving your written request. In certain situations, I may deny your request. If I do, I will tell you, in writing, my reasons for the denial and explain your right to have my denial reviewed. If you request copies of you PHI, I will charge you not more than $.25 for each page. Instead of providing the PHI you requested, I may provide you with a summary or explanation of the PHI as long as you agree to that and to the cost in advance.
C. The Right to Get a List of the Disclosures I Have Made. You have the right to get a list of instance in which I have disclosed your PHI. The list will not include uses or disclosures that you have already consented to, such as those made for treatment, payment, or health care operations, directly to you, or to your family. The list also won't include uses and disclosures made for national security purposes, to corrections or law enforcement personnel, or disclosures made before April 15, 2003. I will respond to your request for an accounting of uses and disclosures within 60 days of receiving your request. The list I will give you will include disclosures made in the last six years unless you request a shorter time. The list will include the date of the disclosure, to whom PHI was disclosed (including their address, if known), a description of the information disclosed, and the reason for the disclosure. I will provide the list to you at no charge, but if you made more than one request in the same year, I will charge you a reasonable cost based fee for each additional request.
D. The Right to Correct or Update Your PHI. If you believe that there is a mistake in your PHI or that a piece of important information is missing, you have the right to request that I correct the existing information or add the missing information. You must provide the request and your reason for the request in writing. I will respond within 60 days of receiving your request to correct or update you PHI. I may deny your request in wiring if the PHI is (a) correct and complete, (b) not created by me, (c) not allowed to be disclosed, or (d) not part of my records. My written denial will state the reasons for the denial and explain your right to file a written statement of disagreement with the denial. If you don't file one, you have the right to request that your request and my denial be attached to all future disclosures of your PHI. If I approve your request, I will make the change to your PHI, tell you that I have done it, and tell others that need to know about the change to your PHI.
E. You have the right to get a copy of this notice by e-mail or regular mail.

V. HOW TO FILE A COMPLAINT REGARDING MY NPP If you think that I may have violated your privacy rights, or you disagree with a decision I made about access to your PHI, you may file a complaint with the person listed in Section VI below. You also may send a written complaint to the Secretary of the Department of Health and Human Services at 200 Independence Avenue S. W., Washington, D.C. 20201. I will take no retaliatory action against you if you file a complaint about my privacy practices.
VI. PERSON TO CONTACT FOR INFORMATION ABOUT THE NOTICE OR TO FILE A COMPLAINT ABOUT MY NPP If you have any questions about this NPP or any complaints about these NPP, or would like to know how to file a complaint with the Secretary of the Department of Health and Human Services, please contact Dr. Amy Sparks at: dramysparks@gmail.com
VII. EFFECTIVE DATE OF THIS NOTICE April 14, 2003.

KEEP THIS FORM FOR YOUR RECORDS

Amy Sparks , PhD
Licensed Clinical Psychologist | PSY17514

KEEP THIS FORM FOR YOUR RECORDS

PATIENT BILL OF RIGHTS

You have the right to:

- To be free from discrimination because of age, color, culture, disability, ethnicity, national origin, gender expression or identify, race, religion, sexual orientation, marital status, relationship status, linguistic status, immigration status, or socioeconomic status.
- Request and receive full information about the therapist's professional capabilities, including licensure, education, training, experience, professional association membership, specialization, and limitations.
- Have written information about fees, method of payment, insurance reimbursement, number of sessions, substitutions (in cases of vacation and emergencies), and cancellation policies before beginning treatment.
    - Receive respectful treatment that will be helpful to you.
    - A safe environment free from sexual, physical, and emotional abuse.
    - Ask questions about your therapy.
- Refuse to answer any question or disclose any information you choose not to reveal.
- Request that the therapist inform you of your progress.
- Know the limits of confidentiality and the circumstances in which a therapist is legally required to disclose information to others.
- Refuse a particular type of treatment or end treatment without obligation or harassment.
- Request and (in most cases) receive a summary of your file, including the diagnosis, your progress, and type of treatment.
- Report unethical and illegal behavior by a therapist.
- Receive a second opinion at any time about your therapy or therapist's methods.
- Request the transfer of a copy of your file to any therapist or agency you choose.

(Source – https://www.psychology.ca.gov/forms_pubs/consumer_guide.pdf)

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