Dr. Daniel Chorney & Associates
Psychological Services

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Client Information and Consent to Services

Services

Psychologists at Chorney & Associates provide a range of psychological services which may be customized to meet your specific needs or the needs of your family. We provide services to children, adolescents, adults, and families. Please note that no psychologist at this practice specializes in custody evaluations, parental alienation concerns, or parental capacity assessments. To provide the best quality of care to our clients, parents in legal/divorce/custody proceedings should be aware that we would not provide any legal opinions about the capabilities of either parent unless required by law. Emergency psychological services are not provided and should be addressed by your local emergency department, the Mental Health Mobile Crisis Team (902-429-8167) or by calling police, ambulance, or emergency services (e.g., 9-1-1). We reserve the right to refuse service at our discretion if we believe you are seeking services that fall outside our areas of service or competency areas.

Fees

Psychological services are billed at the rate of $220.00 per therapy hour (50-minute session, with 10 minutes devoted to chart review and progress notes). Additional time and other services pertinent to your care are charged on a prorated basis. This includes longer session times (e.g., if 1.5hrs is needed or desired), report/letter writing, attendance at meetings or school visits, extended correspondence via email, and/or phone calls longer than 15 minutes. The Initial Evaluation is typically 1.5 hours in length ($330) given the time to review your records and background, review confidentiality and consent, discuss your current situation in detail, and establish goals for treatment. We accept the following payment options: VISA or MasterCard. Credit card information is stored on our online practice management software ("JANE"). Cheques are not accepted. Upon payment for your session, a receipt will be provided to you for reimbursement/tax purposes.

Insurance

Psychologist's fees are not covered under the Nova Scotia's MSI Plan. Many private extended health care plans cover part, or a significant portion of psychological services. Please talk to your insurance provider directly to see what your specific plan covers. We do **not** offer direct billing to insurance companies, therefore, regardless of third-party coverage we require payment in full prior to beginning each session.

Cancellation/Late/No-Show Policy

Appointment times are reserved exclusively for you, and without sufficient notice we can not provide that time to other individuals and families who may benefit from that time. Our online booking software can send reminder emails and text messages that allow for multiple opportunities to cancel or reschedule your appointment if necessary. We require **48hrs (two full business days) of notice** for no administrative fees to be charged for cancelled/missed appointments.

Appointments cancelled with **less than 48hrs (two business days) notice** will be charged 50% of the session rate of the time reserved for you. This will be charged regardless of the reason for cancellation. Appointments cancelled with **less than 24hrs (one business day)** of notice or "no-show" appointments will be charged the full session fee ($220 for recurring appointments, $330 for initial appointment), regardless of reason for cancellation. All receipts issued for missed appointments will state "Missed Appointment."

Telepsychology / Telehealth (Online services)

For all appointments of individuals aged 18 or below, we require the presence of at least one adult parent/caregiver to be present for the initial appointment to review consent, safety, and security concerns.

Confidentiality: With any transmission of data over the internet, a risk of possible access by third parties exists. Potential threats to the security and transmission of client/patient data and information include (but are not limited to): computer viruses, hackers, theft of technology devices, damage to hard drives or portable drives, failure of security systems, flawed software, ease of accessibility to unsecured electronic files, or outdated technology. Other threats may include policies and practices of technology companies and vendors (Guidelines for the Practice of Telepsychology, APA 2013).

Security: In accordance with Model Standards for Telepsychology Service Delivery (ACPRO June 2011), clients may be asked to provide some form of verifiable identification to minimize the possibility of impersonating a client and gaining access to confidential health information. Sessions will **not** be recorded by your treatment provider and you are asked to refrain from taping, recording, or sharing/streaming sessions without first obtaining clear written consent from your treatment provider.

Technology: Please ensure you and your treatment provider have discussed what will happen in the event of a technological failure or disruption in service. Options include: a) calling our office at (902) 444-1160 and leaving a voicemail at the extension of your provider or b) emailing your provider to discuss options (all email addresses can be found on our website Contacts page – chorneyandassociates.com). Please note that session fees will apply in full if service interruption is due to technology failures or other issues encountered outside our office (e.g., poor internet connection, computer failure due to low battery, etc).

Communication Policy

By choosing to communicate with any of our providers/staff by e-mail, you are agreeing that you understand there are risks when using email to communicate with your healthcare providers. You understand that e-mail is not 100% secure and that confidentiality and security cannot be guaranteed. **You understand that email relevant to patient care will be placed on the patient's health record.** Given the high risk of miscommunication or misunderstanding when using email, you understand that email sent to your healthcare provider is a) for non-urgent communication only and b) is **not** used for soliciting/providing clinical advice between sessions. Email use should be limited to scheduling issues, billing matters, or other administrative issues. Please note we may ask you to verify your identify when emailing for security/privacy reasons.

Note that **email is not checked outside of regular business hours or during holidays**. **If this is an emergency, please call 911 or visit a local hospital Emergency Department.** Response times for most emails can range from two business days (for intakes/bookings) to five business days (for psychologists returning client emails).

You consent to our staff and healthcare providers communicating with you by email about your care (e.g., your provider may email you session notes or handouts/worksheets as a follow-up to your session). You understand that you are responsible for telling your healthcare providers if you do not want to communicate by email. Our online practice software (jane.app) uses automated email and text reminders sent prior to your scheduled appointment. You consent to our office using Google Mail ("Gmail") for communication/email. All contact via social media or other outlets will not be responded to, including direct messages or friend/follow requests.

Confidentiality and Privacy

Please note that the use of our online practice management, charting, and scheduling software (Jane | janeapp.com) results in your treatment chart and Personally Identifiable Information/Protected Health Information (PII/PHI) being stored in secured Canadian based data storage servers.

All discussions with a psychologist are strictly confidential and your privacy is important to us. No information will be released to third parties without your explicit consent, except where required by law or in situations where the psychologist is ethically and legally required to disclose information to others without your consent. The following are examples of when your information may be released **without** written consent:

1. When an individual poses potential or **threatened harm to themselves OR to others** (in this circumstance the psychologist will act to protect the person(s) in danger by informing police, medical personnel, parents/caregivers, or other relevant individuals who may assist).
2. Suspicion of or risk of **child abuse** (psychologists are mandated reporters and required to report relevant information the Department of Children's Services) or sharing/possession of sexually explicit images of minors.
3. Suspicion of **adult/elder abuse** (physical, sexual, and/or mental cruelty to anyone over 16 at risk of being abused due to physical or mental disability that impedes their ability to care for themselves).
4. In the event your information is **subpoenaed by a judge** or court of law in the case of legal proceedings.
5. If services are **being paid by a third-party** (e.g., insurance), certain information may be disclosed (e.g. dates/time of service, who was present, fees charged).
6. Internal **consultation** amongst psychologists within Chorney & Associates Psychological Services.

If you are the parent/guardian of a mature minor (a minor who is consenting to their own treatment services) please note we require their written permission to speak with you regarding any aspect of their care, including billing and scheduling issues.

Consent to Treatment

In order to voluntarily provide consent to treatment, an individual should understand **1)** the nature of the assessment and treatment, **2)** the potential benefits, risks, and side effects of treatment, and **3)** any reasonable alternatives to treatment (including refusal). It is important to note that consent is an ongoing process, and you have the right at any time to ask questions about your treatment or terminate your treatment at this clinic.

> ***Adolescents.*** In the case the individual consenting to treatment is an adolescent, consent to treatment is obtained on a case-by-case basis and the consent/signature of a legal guardian or parent may be required depending on the ability of the adolescent to understand the points listed above. In most cases, privacy is protected to ensure the adolescent feels able to share confidential information (including drug use, lying, or sexual behavior) and this information will remain confidential unless a significant risk of harm to themselves or to others is revealed.

By signing below, I agree that I have read (or had read to me) and agree to **all items** with the Client Information & Consent form. I have discussed and asked questions about any portion of the form I find unclear or unacceptable, and have had my questions, if any, answered. I agree to act in accordance with the points and information listed above, and by signing I consent to taking part in both assessment and treatment with the provider named below.

_____ _____

(**Client** Signature) (**Client** Printed Name)

_____ _____

(**Clinician** Signature) (**Clinician** Printed Name)

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(**Date**)