



## WELCOME AND INFORMATION ABOUT SYNCHROSAIC LLC

Welcome to Synchronosaic LLC, an independent group of mental health clinicians who work in collaboration with Essex Pediatrics to provide you, your child, and/or your family with mental health services and support. All services provided by your clinician are billed by Synchronosaic LLC.

**Please complete the following intake paperwork in its entirety prior to your first appointment:**

- Release of Information
- Policies
- Intake Information
- Informed Consent
- Telehealth Consent Form
- Text and Email Policy

***Included in this intake packet is information about your clinician. Please review this disclosure so that you know about your clinician, their background, training, and the best way to contact them in between sessions.***

You will also find the "Notice of Psychologists' Policies and Practices to Protect the Privacy of Your Health Information" and, "Preparing for Your Telehealth Appointment". Please review these prior to your appointment.

Your clinician will be happy to review any and all of this information with you at your first appointment.

If you have any questions, please don't hesitate to contact us at the address, email, or phone number above.

Thank you,

Catherine E. Burns, PHD  
Licensed Psychologist Doctorate  
Proprietor - Synchronosaic LLC



**CATHERINE E. BURNS, PH.D.**

**Vermont Licensed Psychologist - Doctorate #48.0000857**

**Individual NPI #1295910206**

**Synchronsaic NPI #1326401670**

**Phone: (802) 922-1612**

**email: [cath.burns@synchronsaic.com](mailto:cath.burns@synchronsaic.com)**

### **DISCLOSURE OF INFORMATION**

As mandated by Vermont State Law and the Rules of the Board of Psychological Examiners (January 15, 2015), Part 6.8, the following information about my professional qualifications and a copy of the statutory definitions of unprofessional conduct (26 V.S.A. 3016 and 3 V.S.A. 129a), and information for making a consumer inquiry or filing a complaint is herein provided to you.

#### **Professional and Educational Qualifications**

UNIVERSITY OF VERMONT Ph.D. October 2001	Burlington, VT
UNIVERSITY OF VERMONT Master of Arts, October 1998	Burlington, VT
UNIVERSITY OF COLORADO Master of Arts, August 1992	Boulder, CO
SKIDMORE COLLEGE Bachelor of Arts, May 1986	Saratoga Springs, NY

#### **Background Information**

I am a Licensed Psychologist – Doctorate in the State of Vermont. I was trained as a School Psychologist in Colorado, and completed my Doctorate at the University of Vermont with a focus upon Developmental Psychology. I currently am a psychologist in independent private practice and am the sole proprietor of Synchronsaic LLC.

Prior to starting my private practice, I worked in Vermont in Community Mental Health agencies serving children, youth and their families predominately in their homes and schools. My clinical work in these settings addressed a variety of emotional, behavioral, and developmental concerns experienced by children, youth and their families using predominantly behavioral and cognitive behavioral approaches. I also have a background in assessment both as a school psychologist in school settings, as well as with families whose children and youth have complex diagnostic presentations as part of an interdisciplinary team. I continue to provide clinical supervision to masters and doctoral level clinicians seeking licensure.

Other relevant experiences include directing a program for youth with Autism and as the Children's Clinical Director for a Community Mental Health Agency. I have taught graduate classes in Developmental Psychology and Applied Behavioral Analysis for Johnson State College, SNHU's program in Community Mental Health, and undergraduate classes at UVM in Adolescent Development. I also have worked in quality assurance and outcomes in community mental health, and continue to spend part of my professional career working in policy as it relates to the evaluation and promotion of community mental health.

## Office of Professional Regulation Notice

The Office of Professional Regulation provides Vermont licenses, certifications, and registrations for over 56,000 practitioners and businesses. Forty-six professions and occupations are supported and managed by this office. A list of professions regulated is found below.

Each profession or occupation is governed by laws defining professional conduct. Consumers who have inquiries or wish to obtain a form to register a complaint may do so by calling (802) 828-1505, or by writing to the Director of the Office, Secretary of State's Office, 89 Main Street, 3<sup>rd</sup> Floor, Montpelier, VT 05620-3402.

Upon receipt of a complaint, an administrative review determines if the issues raised are covered by the applicable professional conduct statute. If so, a committee is assigned to investigate, collect information, and recommend action or closure to the appropriate governing body.

All complaint investigations are confidential. Should the investigation conclude with a decision for disciplinary action against a professional's license and ability to practice, the name of the license holder will then be made public.

Complaint investigations focus on licensure and fitness of the licensee to practice. Disciplinary action, when warranted, ranges from warning to revocation of license, based on the circumstances. You should not expect a return of fees paid or additional unpaid services as part of the results of this process. If you seek restitution of this nature, consider consulting with the Consumer Protection Division of the Office of the Attorney General, retaining an attorney, or filing a case in Small Claims Court.

Accountancy	Naturopaths
Acupuncture	Nursing
Architects	Nursing Home Administrators
Athletic Trainers	Occupational Therapists
Auctioneers	Opticians
Audiologists	Optometry
Barbers & Cosmetologists	Osteopathic Physicians and Surgeons
Boxing Control	Pharmacy
Chiropractic	Physical Therapists
Dental Examiners	Private Investigative & Security Services
Dietitians	Property Inspectors
Drug and Alcohol Counselor	Psychoanalyst
Electrolysis	Psychology
Professional Engineering	Psychotherapist, Non-licensed
Funeral Service	Radiologic Technology
Hearing Aid Dispensers	Real Estate Appraisers
Land Surveyors	Real Estate
Landscape Architects	Respiratory Care
Marriage & Family Therapists	Social Workers, Clinical
Clinical Mental Health Counselors	Tattooists
Midwives, Licensed	Veterinary
Motor Vehicle Racing	

### Chapter 78: Roster of Psychotherapists Who Are Nonlicensed

#### § 4090. Disclosure of Information

The board shall adopt rules requiring persons entered on the roster to disclose to each client the psychotherapist's professional qualifications and experience, those actions that constitute unprofessional conduct, and the method for filing a complaint or making a consumer inquiry, and provisions relating to the manner in which the information shall be displayed and signed by both the rostered psychotherapist and the client. The rules may include provisions for applying or modifying these requirements in cases involving institutionalized clients, minors and adults under the supervision of a guardian.

**Title 3: Executive**

**Chapter 5: SECRETARY OF STATE**

**Sub-Chapter 3: Professional Regulation**

**3 V.S.A. § 129a. Unprofessional conduct**

(a) In addition to any other provision of law, the following conduct by a licensee constitutes unprofessional conduct. When that conduct is by an applicant or person who later becomes an applicant, it may constitute grounds for denial of a license or other disciplinary action. Any one of the following items or any combination of items, whether the conduct at issue was committed within or outside the State, shall constitute unprofessional conduct:

- (1) Fraudulent or deceptive procurement or use of a license.
- (2) Advertising that is intended or has a tendency to deceive.
- (3) Failing to comply with provisions of federal or State statutes or rules governing the practice of the profession.
- (4) Failing to comply with an order of the board or violating any term or condition of a license restricted by the board.
- (5) Practicing the profession when medically or psychologically unfit to do so.
- (6) Delegating professional responsibilities to a person whom the licensed professional knows, or has reason to know, is not qualified by training, experience, education, or licensing credentials to perform them, or knowingly providing professional supervision or serving as a preceptor to a person who has not been licensed or registered as required by the laws of that person's profession.
- (7) Willfully making or filing false reports or records in the practice of the profession, willfully impeding or obstructing the proper making or filing of reports or records, or willfully failing to file the proper reports or records.
- (8) Failing to make available promptly to a person using professional health care services, that person's representative, or succeeding health care professionals or institutions, upon written request and direction of the person using professional health care services, copies of that person's records in the possession or under the control of the licensed practitioner, or failing to notify patients or clients how to obtain their records when a practice closes.
- (9) Failing to retain client records for a period of seven years, unless laws specific to the profession allow for a shorter retention period. When other laws or agency rules require retention for a longer period of time, the longer retention period shall apply.
- (10) Conviction of a crime related to the practice of the profession or conviction of a felony, whether or not related to the practice of the profession.
- (11) Failing to report to the Office a conviction of any felony or misdemeanor offense in a Vermont District Court, a Vermont Superior Court, a federal court, or a court outside Vermont within 30 days.
- (12) Exercising undue influence on or taking improper advantage of a person using professional services, or promoting the sale of services or goods in a manner that exploits a person for the financial gain of the practitioner or a third party.
- (13) Performing treatments or providing services that the licensee is not qualified to perform or that are beyond the scope of the licensee's education, training, capabilities, experience, or scope of practice.
- (14) Failing to report to the Office within 30 days a change of name, e-mail, or mailing address.
- (15) Failing to exercise independent professional judgment in the performance of licensed activities when that judgment is necessary to avoid action repugnant to the obligations of the profession.
- (16)(A) Impeding an investigation under this chapter or unreasonably failing to reply, cooperate, or produce lawfully requested records in relation to such investigation.

(B) The patient privilege set forth in 12 V.S.A. § 1612 shall not bar the licensee's obligations under this subsection (a) and a confidentiality agreement entered into in concluding a settlement of a civil claim shall not exempt the licensee from fulfilling his or her obligations under this subdivision (16).

(17) Advertising, promoting, or recommending a therapy or treatment in a manner tending to deceive the public or to suggest a degree of reliability or efficacy unsupported by competent evidence and professional judgment.

(18) Promotion by a treatment provider of the sale of drugs, devices, appliances, or goods provided for a patient or client in such a manner as to exploit the patient or client for the financial gain of the treatment provider, or selling, prescribing, giving away, or administering drugs for other than legal and legitimate therapeutic purposes.

(19) Willful misrepresentation in treatments or therapies.

(20) Offering, undertaking, or agreeing to cure or treat a disease or disorder by a secret method, procedure, treatment, or medicine.

(21) Permitting one's name or license to be used by a person, group, or corporation when not actually in charge of or responsible for the professional services provided.

(22) Prescribing, selling, administering, distributing, ordering, or dispensing any drug legally classified as a controlled substance for the licensee's own use or to an immediate family member as defined by rule.

(23) For any professional with prescribing authority, signing a blank or undated prescription form or negligently failing to secure electronic means of prescribing.

(24) For any mental health care provider, use of conversion therapy as defined in 18 V.S.A. § 8351 on a client younger than 18 years of age.

(25) For providers of clinical care to patients, failing to have in place a plan for responsible disposition of patient health records in the event the licensee should become incapacitated or unexpectedly discontinue practice.

(26) Sexually harassing or exploiting a patient, client, or consumer, or doing so to a coworker in a manner that threatens the health, safety, or welfare of patients, clients, or consumers; failing to maintain professional boundaries; or violating a patient, client, or consumer's reasonable expectation of privacy.

(b) Failure to practice competently by reason of any cause on a single occasion or on multiple occasions may constitute unprofessional conduct, whether actual injury to a client, patient, or customer has occurred. Failure to practice competently includes:

(1) performance of unsafe or unacceptable patient or client care; or

(2) failure to conform to the essential standards of acceptable and prevailing practice.

(c) The burden of proof in a disciplinary action shall be on the State to show by a preponderance of the evidence that the person has engaged in unprofessional conduct.

(d)(1) After hearing, and upon a finding of unprofessional conduct, a board or an administrative law officer may take disciplinary action against a licensee or applicant, including imposing an administrative penalty not to exceed \$5,000.00 for each unprofessional conduct violation.

(2)(A) Any money received under this subsection shall be deposited in the Professional Regulatory Fee Fund established in section 124 of this chapter for the purpose of providing education and training for board members and advisor appointees.

(B) The Director shall detail in the annual report receipts and expenses from money received under this subsection.

(c) In the case where a standard of unprofessional conduct as set forth in this section conflicts with a standard set forth in a specific board's statute or rule, the standard that is most protective of the public shall govern. (Added 1997, No. 40, § 5; amended 2001, No. 151 (Adj. Sess.), § 2, eff. June 27, 2002; 2003, No. 60, § 2; 2005, No. 27, § 5; 2005, No. 148 (Adj. Sess.), § 4; 2009, No. 35, § 2; 2011, No. 66, § 3, eff. June 1, 2011; 2011, No. 116 (Adj. Sess.), § 5; 2017, No. 48, § 4; 2017, No. 144 (Adj. Sess.), § 6, eff. July 1, 2019; 2019, No. 30, § 4.)

### **§ 3016. Unprofessional conduct**

Unprofessional conduct means the conduct listed in this section and in 3 V.S.A. § 129a:

(1) Failing to make available, upon written request of a person using psychological services to succeeding health care professionals or institutions, copies of that person's records in the possession or under the control of the licensee.

(2) Failing to use a complete title in professional activity.

(3) Conduct which evidences moral unfitness to practice psychology.

(4) Engaging in any sexual conduct with a client, or with the immediate family member of a client, with whom the licensee has had a professional relationship within the previous two years.

(5) Harassing, intimidating, or abusing a client or patient.

(6) Entering into an additional relationship with a client, supervisee, research participant, or student that might impair the psychologist's objectivity or otherwise interfere with the psychologist's professional obligations.

(7) Practicing outside or beyond a psychologist's area of training or competence without appropriate supervision.

(8) In the course of practice, failure to use and exercise that degree of care, skill, and proficiency which is commonly exercised by the ordinary skillful, careful, and prudent psychologist engaged in similar practice under the same or similar conditions, whether or not actual injury to a client or patient has occurred.

(9) Conduct which violates the "Ethical Principles of Psychologists and Code of Conduct" of the American Psychological Association, effective December 1, 1992, or its successor principles and code.

(10) Conduct which violates the "ASPPB Code of Conduct-1990" of the Association of State and Provincial Psychology Boards, or its successor code. (Added 1975, No. 228 (Adj. Sess.), § 2; amended 1981, No. 241 (Adj. Sess.), § 1; 1993, No. 98, § 7; 1993, No. 222 (Adj. Sess.), § 3; 1997, No. 145 (Adj. Sess.), § 50; 1999, No. 52, § 26; 1999, No. 133 (Adj. Sess.), § 24; 2013, No. 27, § 34.)



## INTAKE INFORMATION

### **Client's Information:**

Last Name:

First Name:

M. I.:

Street:

City:

State:

Zip:

Phone:

Date of Birth:

Marital Status:

S M D W CU

Gender:

Pronouns:

Employer:

Occupation:

### **Person to Contact In Case of an Emergency:**

Name:

Relationship:

Tel:

### **Contact Information for Clients under 18 years of Age:**

*Parent/Guardian:*

Home Phone:

May I leave a message at this number? Yes No

Cell Phone:

May I leave a message at this number? Yes No

Work Phone:

May I leave a message at this number? Yes No



Email:

*Additional Parent Guardian:*

Home Phone: May I leave a message at this number? Yes No

Cell Phone: May I leave a message at this number? Yes No

Work Phone: May I leave a message at this number? Yes No

Email:

**School Information:**

School: Grade: \_\_\_\_\_ Teacher:

Classroom Setting:

IEP: Yes No

Interventionist: Yes No

504 Plan: Yes No

**Referring Physician:**

**Reason for Referral**

Please take a moment to explain the reasons you are seeking psychological support. What concern is bringing you and/or your child into care?

**Goals for Treatment:**

Please explain what you and/or your child are hoping to gain from treatment.

1.

2.

3.

4.

**Person Completing Form:**

**Date:**



**INFORMED CONSENT  
FOR RELEASE OF INFORMATION**

Client Name:

Date of Birth: \_\_\_/\_\_\_/\_\_\_

In order to facilitate psychological evaluation and/or treatment, I authorize Synchronsaic LLC to disclose protected health information, as specified below, to and request protected health information from:

Name: \_\_\_\_\_

Organization/Primary Care Practice: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

Phone: \_\_\_\_\_

**Please release the following protected health information:**

**Date Range:**

**Description of Records:**

Release all records for this timeframe

**OR**

Other (please describe):

Restrictions, if any:

I also authorize the Synchronsaic clinician to use the Electronic Health Record at Essex Pediatrics to maintain all records related to my, or my child's, care. I understand that this means all

therapy notes and other records will be contained in the Essex Pediatrics Electronic Health Record where they can be reviewed by Essex Pediatrics medical staff.

I agree to and understand the following:

- I may revoke this consent at any time by notifying the above named clinician in writing, except to the extent that action has already been taken based on my previous consent. This consent will be effective unless and until I revoke it in writing.
- The information released in response to this consent may be disclosed by the recipient and may no longer be protected by federal or state law.
- I am not required to sign this consent. My treatment cannot be conditioned on the signing of this consent.

I have read this form and certify that I understand its contents.

This authorization will expire one year from the date of this signature.

Signature of parent/guardian (if client is under 18): \_\_\_\_\_

Date: \_\_\_\_\_



## POLICIES

*The information described below is offered to anticipate the most frequently asked questions about Synchronsaic LLC professional services and business practices. Please read this carefully. If you have any questions, it is important that you clarify them with your Synchronsaic clinician prior to signing the consent and disclosure of information form.*

### **Session Information:**

Individual therapy sessions are by appointment only and are customarily 45 - 55 minutes in length with children and 55 minutes with adults. Longer sessions (usually 80 minutes) will occasionally be scheduled in consultation with the client. Group therapy sessions range from 60 to 90 minutes depending upon the group topic and age of the participants.

Psychotherapy has both benefits and risks. Since treatment often involves discussing difficult aspects of your life, you may experience uncomfortable feelings. However, therapy has many possible benefits, including the reduction in the symptoms that brought you to care. As we meet to conduct an initial evaluation and treatment plan, it will be important for you to evaluate how you feel about working with me. Successful therapy involves a large commitment of time and resources; you should choose your therapist with care. If you have any questions about my training, my methods, or my recommendations, please feel free to discuss them with me. If your doubts persist, I will be happy to provide you with a referral to another mental health professional.

### **Cancellations:**

The time agreed upon is reserved for you. **In the event that you must cancel a session, please call your Synchronsaic clinician at least 48 business hours in advance using their contact number.** If such notice is given, the client will not be charged for the sessions. **In the absence of such notice, except in extraordinary circumstances, the client will be charged for the session at the usual hourly rate.** It should be noted that insurance will not pay for missed sessions, so the client will be billed directly. In accordance with legal requirements, Medicaid patients will not be charged for missed sessions. However, in the case of all clients, if an appointment is not kept, subsequent scheduled appointments will be forfeited unless and until the client calls to reschedule. Additionally, I reserve the right to discontinue treatment with a client if session attendance becomes a regular problem.

### **Phone Calls:**

Synchronsaic clinicians are not often immediately available by phone and messages are received by their voicemail. Clinicians pick up these messages periodically throughout the day and will return calls as soon



as possible. Clinicians will make every effort to return your call within 24 hours. Please leave messages with your clinician using their confidential voicemail.

**Email and Text:**

Clinicians do not prefer to use text to communicate with clients as this is not a secure form of communication. It is best to communicate with them by phone and voice mail.

If you choose to use Email or text to communicate with your clinician, please be advised that this is not a secure form of communication. We require that you review risks and sign a separate release to authorize email or text communication.

**Fees:**

The regular fee for individual psychotherapy is \$165 for a 55 minute session. The regular fee for group psychotherapy is \$65 for an hour and \$90 for a 90-minute session. Payment of all fees due by the client, including co-payments, is required at the time of service, unless we have discussed your being billed for co-pays. **Please contact your provider to determine what your financial responsibility for therapy will be.** Telephone consultations of 10 minutes or longer and preparation of reports or letters will be billed at the usual rate, based upon time involved. Consultation to schools or other consultation will be billed at a rate determined prior to initiating services.

**Insurance:**

If insurance is to be used to pay for services, arrangements must be made in advance with me. Synchronsaic typically bills the insurance company directly, and the client is responsible for deductibles and co-payments at the time of service. In certain situations, Synchronsaic may arrange to bill the client with the understanding that they will apply for reimbursement from the insurance company themselves. **All insurance plans vary and you are responsible for learning the details about your plan.** Some require pre-authorization by your primary care provider or by the insurance company before they will pay for services. Some plans authorize a set number of sessions. The client is responsible for tracking this information. If your insurance coverage changes, it is your responsibility to inform me to avoid any lapse in coverage. Many insurance companies require that Synchronsaic provide written updates of your treatment on a periodic basis in order for services to be covered. It is understood that Synchronsaic will provide these updates to your insurance company as part of your care unless you request otherwise.

**Patient Rights:**

You have the right to be treated with dignity and respect. You have the right to necessary and available treatment regardless of race, religion, national origin, age, handicap, gender, or sexual orientation. You have the right to be informed about the services and treatment available for your needs. You have a right



to know your diagnosis, if you have one, and your treatment plan. You have the right to consent to treatment or to refuse treatment. You have the right to review your clinical records. You have the right to give or withhold access to your clinical record to others, such as a relative or lawyer. You have the right to complain if you believe your rights, or someone else's rights, have been violated.

**Confidentiality:**

Confidentiality is a very important part of psychological services. The release of confidential information to a third party requires client authorization through the signed, time-limited *Authorization to Disclose Protected Health Information* form for each party concerned. We will fulfill a client request to send records to a third-party without unreasonable delay and without undue burden to the client.

Under the following circumstances, information might be released without your written permission:

- The psychologist is mandated to act to minimize risk in the event that the client is assessed to be an imminent danger to themselves or others
- The psychologist is mandated to report actual or suspected abuse or neglect involving children and vulnerable adults
- The psychologist is required to respond to a court-ordered subpoena to testify in court or to provide records to the court
- The psychologist may be obligated to report to authorities situations which directly affect the health and safety of others

Further information about confidentiality is included in the Privacy Notice that has been provided to you.

**Emergencies:**

We will discuss crisis planning as part of your treatment. In the event of a mental health emergency requiring immediate attention, you can contact your clinician by calling their confidential phone, 24 hours a day. Clinicians return calls within a business day. Patients of Essex Pediatrics can call 802-879-6556 24 hours per day and ask for the physician on call. ***In a life-threatening situation, contact 911 immediately or go to the Emergency Department.***

My signature on the page authorizes Synchronsaic to provide psychological services to myself, my child, or a minor to whom I am the legal guardian. It also verifies I have read, understand, and agree to abide by the conditions and policies described above.

Signature of Client or Parent:

Date:



## INFORMED CONSENT AND CLIENT'S DISCLOSURE CONFIRMATION

### CHILD

Client's Name:

Date of Birth:

- A. I voluntarily consent to evaluation and/or treatment of the above named client by a Synchronsaic LLC clinician. I understand that I am consenting and agreeing only to those services that the Synchronsaic clinician is qualified to provide within the scope of her training. I acknowledge that no guarantees are being made to me as the result of the treatment. I also understand that Synchronsaic LLC is an independent contractor.
- B. I acknowledge that no guarantees have been made to me as to the result of the treatment or evaluation.
- C. I certify that I am the child's legal guardian or custodial parent and am legally authorized to initiate and consent for treatment on behalf of this individual.
- D. I understand that the Synchronsaic clinician may consult with other clinicians for the purposes of professional development and coverage and that such consultations are also bound by the rules of confidentiality. I understand that the Synchronsaic clinician may discuss my child's care in peer supervision and provide information to a covering clinician to facilitate continuity of care.
- E. I authorize the Synchronsaic clinician to communicate with my insurance company for care authorization and care coordination upon request from the insurance company.
- F. I understand that treatment is confidential with exceptions. These exceptions include, but are not limited to: disclosure to insurance companies and managed care companies for reimbursement purposes; disclosures required by law, such as suspicion of abuse or neglect of children, vulnerable adults, risk of imminent harm, or duty to warn; and disclosure to other health care professionals to facilitate my child's care and treatment or as described above. I understand that there may be other circumstances in which the law requires my therapist to disclose confidential information.
- G. I have been given the professional qualification and experiences of the Synchronsaic Clinician, Synchronsaic's professional policies, a listing of actions that constitute unprofessional conduct



according to Vermont statutes, and the methods for making a consumer inquiry or filing a complaint with the Office of Professional Regulation.

- H. In addition, I have received and been informed of client privacy rights as outlined under state and federal law. These rights include:
  - a. The right to be informed of the various steps and activities involved in receiving services.
  - b. The right to confidentiality under federal and state laws related to the receipt of services.
  - c. The right to humane care and protection from harm, abuse and neglect.
  - d. The right to make an informed decision about whether to accept or refuse treatment.
  - e. The right to contact and consult with counsel and select practitioners of my choice at my expense.
- I. I understand that I may revoke this consent at any time except to the extent that treatment has already been rendered or that action has been taken in reliance on this consent, and that if I do not revoke this consent, it will automatically expire one year after all claims for treatment have been paid as provided in the benefit plan.
- J. I understand that the Synchronsaic clinician will be using the Essex Pediatric Medical Record for all documentation of treatment. I understand that this means all therapy notes are contained in the medical record and can be reviewed by medical staff.
- K. I have read this document and understand and consent with the content.

Parent or Guardian Signature:

Date:

Synchronsaic Clinician Name:

Synchronsaic Clinician Signature:

Date:



## EMAIL AND TEXT COMMUNICATION POLICY

Patient name:

DOB:

I understand that email, texts and similar communications may not be secure through encryption and other safeguards and, even if encrypted, raise security risks that threaten confidentiality.

- By requesting email and text communication, I represent that I am the person legally responsible for use of the cell phone number provided, that I am at least 18 years of age.
- I understand that texting over cellular devices carries security risks because text messages from my device may not be encrypted. This means that information received or sent by text message could be intercepted or viewed by an unintended recipient, or by my cell phone carrier.
- I understand that my provider does not charge for this service, but standard text messaging rates may apply as provided in my wireless plan (contact your carrier for pricing plans and details).
- I understand that text and email messages are not a substitute for professional or medical attention.

I nonetheless wish to use one or more of these modalities to communicate with my provider. I understand that I may change my mind and, if I notify my provider of this, she/he/they will no longer communicate with me in that way.

I understand that email, texts, and similar forms of communication are to be used only for scheduling or as otherwise agreed upon with my provider. If a matter is urgent, I should contact my Synchronosaic Clinician on their cell phone, or after hours, *Essex Pediatrics* at (802) 879-6556. If I have a medical emergency, I understand I should call 911.

Phone Number:

Email address:

Signature of patient:

Date:

Signature of parent/guardian:  
(if under 18)

Date:

Witness:

Date:

Synchronosaic LLC • P. O. Box 345 • Richmond, VT 05477 • Phone: (802) 922-1612 • <https://www.synchronosaic.com>



## TELETERAPY INFORMED CONSENT

Client Name:

Client DOB:

I, \_\_\_\_\_ hereby consent to engage in teletherapy/coaching with a Synchronsaic LLC Clinician. I understand that "teletherapy" includes consultation, treatment, transfer of medical data, emails, telephone conversations and education using interactive audio, video, or data communications. I understand that teletherapy/coaching also involves the communication of my medical/mental information, both orally and visually.

I understand that I have the following rights with respect to teletherapy:

1. I have the right to withhold or withdraw consent at any time without affecting my right to future care or treatment.
2. The laws that protect the confidentiality of my medical information also apply to teletherapy. As such, I understand that the information disclosed by me during the course of my therapy or consultation is generally confidential. However, there are both mandatory and permissive exceptions to confidentiality, which are discussed in detail in the other consent forms for treatment I received with this consent form.
3. I understand that there are risks and consequences from teletherapy, including, but not limited to, the possibility, despite reasonable efforts on the part of the Synchronsaic clinician, that: the transmission of my information could be disrupted or distorted by technical failures; the transmission of my information could be interrupted by unauthorized persons; that people who are nearby when I participate in a teletherapy session may overhear my discussion; and/or the electronic storage of my medical information could be accessed by unauthorized persons.
4. In addition, I understand that teletherapy based services and care may not be as complete as face- to-face services. I also understand that if the Synchronsaic clinician believes I would be better served by another form of therapeutic services (e.g. face-to-face services) I will be referred to a professional who can provide such services in my area. Finally, I understand that there are potential risks and benefits associated with any form of psychotherapy, and that despite my efforts and the efforts of my psychologist, my condition may not be improve, and in some cases may even get worse
5. I understand that I may benefit from teletherapy, but that results cannot be guaranteed or assured.
6. I accept that teletherapy does not provide emergency services. During our first session, the Synchronsaic clinician and I will discuss an emergency response plan. If I am experiencing an emergency situation, I understand that I can call 911 or proceed to the nearest hospital emergency room for help. If I am having suicidal thoughts or making plans to harm myself, I can call the National Suicide Prevention Lifeline at 1.800.273.TALK (8255) for free 24 hour hotline support or use the National Crisis Text line 741741 24 hours per day.
7. I understand that I am responsible for (1) providing the necessary computer, telecommunications equipment and internet access for my teletherapy sessions, (2) the information security on my computer, and (3) arranging a location with sufficient lighting and privacy that is free from distractions or intrusions for my teletherapy session.
8. I understand that I have the right to choose to receive services by audio-only telephone, in person, or by teletherapy, to the extent clinically appropriate.

9. I understand that while email may be used to communicate with the Synchronsaic clinician, confidentiality of emails cannot be guaranteed.
10. I understand that while text may be used to communicate with the Synchronsaic clinician, confidentiality of texts cannot be guaranteed.
11. I understand that I have a right to access my medical information and copies of medical records in accordance with HIPAA privacy rules and applicable state law.

**Audio-only Teletherapy visit:**

- Audio-only telephone services are available if clinically appropriate.
- Consenting to receive services by audio-only telephone is voluntary and does not preclude access to in-person or teletherapy services.
- Less information is available to your provider in an audio-only visit and your provider will determine whether an audio-only visit is clinically appropriate.
- Using telephone services, only requires access to a phone line and eliminates the need for internet or devices that enable video services.
- Audio-only telephone services cannot be used for psychiatric examinations related to involuntary commitments.
- Not all audio-only services are covered by all health plans, some services may be billed out-of-pocket, please talk to your provider or the billing department for more information.

I have read, understood and agree to the information provided above.

**Client (or Guardian's) Signature:**

**Date of Birth:**

**Printed Name:**

**Date:**

To be completed by provider:

Patient is receiving audio-only telehealth visit due to:

Clinical indication, specify:

---



---

Other Indications (Check all below that apply):

- Broadband Access / Reliability of Internet Connection
- Other technical barrier, specify: \_\_\_\_\_
- Patient comfort / preference
- Other, specify: \_\_\_\_\_



## CREDIT CARD CONSENT FORM

***\*This form is VOLUNTARY.***

***If no credit card information is filed, you will be sent an invoice for your account balance.***

Name of Client:

Name on Credit Card:

Card type:

Card number:

Expiration date:

CCV:

I authorize Synchronsaic, LLC to charge my credit/debit/health account card for professional services. I understand that my information will be saved (in a HIPAA compliant format) for future transactions on my account.

I verify that my credit card information, provided above, is accurate to the best of my knowledge. If this information is incorrect or fraudulent or if my payment is declined, I understand that I am responsible for the entire amount owed and any interest or additional costs incurred if denied.

Client initials:

Cardholder initials:

Date:

Signature:

## **VERMONT NOTICE FORM**

### **Notice of Psychologists' 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**

We may use or disclose your protected health information (PHI), for treatment, payment, and health care operations purposes with your consent. 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 we provide, coordinate or manage your health care and other services related to your health care. An example of treatment would be when we consult with another health care provider, such as your family physician or another psychologist.
  - *Payment* is when we obtain reimbursement for your healthcare. Examples of payment are when we 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.

## **II. Uses and Disclosures Requiring Authorization**

We may use or disclose PHI for purposes outside of treatment, payment, and health care operations when your appropriate authorization is obtained. An "authorization" is written

permission above and beyond the general consent that permits specific disclosures. In those instances when we are asked for information for purposes outside of treatment, payment, and health care operations, we will obtain written authorization from you before releasing this information.

We will also need to obtain written authorization before releasing your **psychotherapy notes**. "Psychotherapy notes" are notes we have made about our conversation during a private, group, joint, or family counseling session, which we have kept separate from the rest of your medical record. These notes are given a greater degree of protection than PHI. Psychotherapy notes **do not include** medication prescription and monitoring, counseling session start and stop times, modalities and frequencies of treatment, the results of clinical tests, any summary of a diagnosis, functional status, treatment plans, symptoms, prognosis, or progress.

All requests for release of information should be directed to Synchronsaic, LLC or their representative for processing, we will respond to all requests without unreasonable delay.

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) We have relied on that authorization; or (2) if the authorization was obtained as a condition of obtaining insurance coverage, and the law provides the insurer the right to contest the claim under the policy.

### **Reasons for Denied or Delayed Release of Clinical Records**

- When the client's provider determines that releasing the information poses a threat of serious harm or threat to the life of the client or another person;
- After reasonable attempts, we are unable to reach the client due to an incomplete authorization or to verify a third-party request;
- If the request requires the requestor to pay a cost-based fee and no payment information is provided; NOTE: We will not charge fees that are prohibited by the HIPAA Privacy Rule or state law or based on electronic access that requires no manual effort to fulfill;

- If the request is for electronic health information (EHI) and one of the exceptions to the Information Blocking Rules applies (see Requests for Electronic PHI below);
- Notes taken in preparation for potential litigation or legal action; and
- Without express authorization or as determined by your provider, psychotherapy notes may be excluded from a request.

### **III. Requests for Electronic PHI**

We believe that we are better able to treat clients when they are actively engaged in their care. To be engaged, they must have timely access to their health information. Electronic Health Information (EHI) typically includes electronic medical records and billing records used, in whole or in part, by providers to make decisions about client care.

We will respond to EHI requests without unreasonable delay. Every effort will be made to respond to an EHI request in the manner requested but we may need to discuss alternatives if we are technically unable to provide EHI as requested.

We may deny or limit access to EHI under the following circumstances:

- To prevent harm to the life or physical safety of a patient or another person;
- To protect an individual's privacy;
- To protect the security of EHI;
- If it is infeasible\* to fulfill a request for EHI due to uncontrollable events or data that cannot be separated; or
- If the electronic health record is unavailable due to routine maintenance or in response to an emergency.

\*If responding to a request for EHI is infeasible, we will notify the requestor within ten (10) business days of the request with a written explanation.

### **IV. Uses and Disclosures with Neither Consent nor Authorization**

We may use or disclose PHI without your consent or authorization as required by law in the following circumstances:

- **Child Abuse:** If we have reasonable cause to believe that a child has been abused or neglected, we are required by law to report such information within 24 hours to the Commissioner of Social and Rehabilitation Services or its designee.



- **Adult and Domestic Abuse:** If we have reasonable cause to believe that an elderly or disabled adult has been abused, neglected, or exploited, we are required by law to report this information to the Commissioner of Aging and Disabilities.
- **Health Oversight:** If we receive a subpoena for records from the Vermont Board of Psychological Examiners in relation to a disciplinary action, we must submit such records to the Board.
- **Judicial or administrative proceedings:** If you are involved in a court proceeding and a request is made for information about the professional services that we have provided you and/or the records thereof, such information is privileged under state law, and we must not release this information without written authorization from you or your legally appointed representative, or a court order. This privilege does not apply when you are being evaluated for a third party or where the evaluation is court ordered. We will inform you in advance if this is the case.
- **Serious Threat to Health or Safety:** If we know that you pose a serious risk of danger to an identifiable victim, We are required by law to exercise reasonable care to protect such victim. This may include disclosing your relevant confidential information to those people necessary to address the problem. Also, we may disclose your confidential information if we judge disclosure is necessary to protect against a clear and substantial risk of imminent serious harm being inflicted by you on yourself or another person.

#### **V. Patient's Rights and Psychologist's Duties**

##### **Patient's Rights:**

- *Right to Request Restrictions* You have the right to request restrictions on certain uses and disclosures of protected health information about you. However, we are 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. Upon your request, we 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. On your request, we will discuss with you the details of the request 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. We may deny your request. On your request, we 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** regarding you. On your request, we 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:**

- We are 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**.
- We reserve the right to change the privacy policies and practices described in this notice. Unless we notify you of such changes, however, we are required to abide by the **terms** currently in effect.
- If we revise these policies and procedures, we will discuss this with you.

#### **VI. Complaints**

If you are concerned that we have violated your privacy rights, or you disagree with a decision we made about access to your records, you may contact the proprietor of Synchronsaic LLC or the Office of Professional Regulation at (802) 828-2367.

You may also send a complaint to the Secretary of the U.S. Department of Health and Human Services Office for Civil Rights:

Online: [www.hhs.gov/ocr/privacy/hipaa/complaints](http://www.hhs.gov/ocr/privacy/hipaa/complaints)

By Phone: (877) 696-6775

By Mail: U.S. Department of Health and Human Services Office for Civil Rights, 200 Independence Avenue, S.W., Washington, D.C. 20201

**VII. Effective Date, Restrictions and Changes to Privacy Policy**

This notice will go into effect on April 13, 2003

We will limit the uses or disclosures that we will make as follows: Disclosure of minimum information necessary to effect business with your insurance carrier.

We reserve the right to change the terms of this notice and to make the new notice provisions effective for all PHI that we maintain. If the terms of this notice are changed, we will provide you with a revised notice in writing.