WELCOME AND INFORMATION ABOUT SYNCHROSAIC LLC

Welcome to Synchrosaic 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 Synchrosaic 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 - Synchrosaic LLC

NICOLE L. BRESLEND, PH.D.
Rostered Psychotherapist #097.0134529
Synchrosaic NPI #1326401670

Phone: (802) 676-1570
email: Nicole.Breslend@therapysecure.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 — Burlington, VT
Ph.D. May 2017

UNIVERSITY OF VERMONT — Burlington, VT

Master of Arts, March 2015

UNIVERSITY OF VERMONT — Burlington, VT

Bachelor of Arts, May 2012

Background Information

I am a rostered psychotherapist at Essex Pediatrics under the supervision of Licensed Clinical Psychologist-Doctorate, Cath Burns. I received my doctorate at the University of Vermont with a focus upon Developmental Psychology. I am currently completing the supervised practice hours required to be licensed as a clinical psychologist in the State of

Vermont. I have served as a pre-doctoral clinician at the University of Vermont, a supervised psychological trainee at Vermont Psychological Services (since fall 2020), and psychological trainee at Essex Pediatrics (since fall 2020). I have provided comprehensive assessments and treatment for children, adolescents, and young adults. My work with these individuals addressed a variety of emotional, behavioral, and developmental concerns experienced by children, youth and their families using predominantly behavioral and cognitive behavioral approaches. In addition, I have taught graduate classes in clinical and developmental psychology in the UVM Clinical Psychology Doctorate Program and in UVM's undergraduate psychology program.

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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, 3rd 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
Acupuncture
Architects
Athletic Trainers
Auctioneers
Audiologists
Barbers & Cosmetologists
Boxing Control
Chiropractic
Dental Examiners
Dietitians
Drug and Alcohol Counselor
Electrolysis
Professional Engineering
Funeral Service
Hearing Aid Dispensers
Land Surveyors
Landscape Architects
Marriage & Family Therapists
Clinical Mental Health Counselors
Midwives, Licensed
Motor Vehicle Racing
Naturopaths
Nursing
Nursing Home Administrators
Occupational Therapists
Opticians
Optometry
Osteopathic Physicians and Surgeons
Pharmacy
Physical Therapists
Private Investigative & Security Services
Property Inspectors
Psychoanalyst
Psychology
Psychotherapist, Non-licensed
Radiologic Technology
Real Estate Appraisers
Real Estate
Respiratory Care
Social Workers, Clinical
Tattooists
Veterinary

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.

The Vermont Statutes Online

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.

(e) 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.)

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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 Name:

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 Synchrosaic 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 Synchrosaic 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 Synchrosaic LLC professional services and business practices. Please read this carefully. If you have any questions, it is important that you clarify them with your Synchrosaic 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 Synchrosaic 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:

Synchrosaic 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. Synchrosaic typically bills the insurance company directly, and the client is responsible for deductibles and co-payments at the time of service. In certain situations, Synchrosaic 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 Synchrosaic provide written updates of your treatment on a periodic basis in order for services to be covered. It is understood that Synchrosaic 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 day 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 Synchrosaic 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 Synchrosaic LLC clinician. I understand that I am consenting and agreeing only to those services that the Synchrosaic 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 Synchrosaic 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 Synchrosaic 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 Synchrosaic 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 Synchrosaic 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 hard, 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 Synchrosaic Clinician, Synchrosaic'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 Synchrosaic 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: _____

Synchrosaic Clinician Name: _____

Synchrosaic Clinician Signature: _____

Date: _____

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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 Synchrosaic 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: _____ Date: _____
(if under 18)

Witness: _____ Date: _____

TELETHERAPY INFORMED CONSENT

Client Name: _____

Client DOB: _____

I, _____ hereby consent to engage in teletherapy/coaching with a Synchrosaic 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 Synchrosaic 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 Synchrosaic 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 Synchrosaic 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 Synchrosaic clinician, confidentiality of emails cannot be guaranteed.

10. I understand that while text may be used to communicate with the Synchrosaic clinician, confidentially 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 Synchrosaic, 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: _____

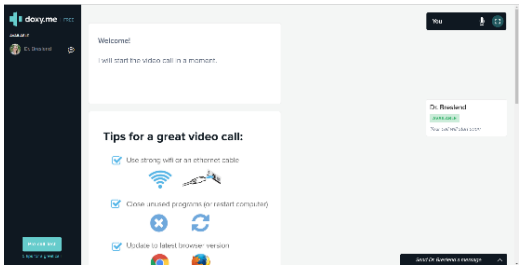
synchrosaic

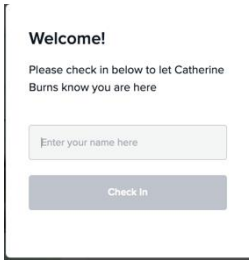
facilitating positive outcomes.

Preparing for Your Telemedicine Appointment

Step 1

Enter Nicole's virtual waiting room by visiting www.doxy.me/NicoleBreslend on a Google Chrome or Microsoft Firefox web browser. For your first visit, make sure to sign on at least 10-15 minutes early to allow sufficient time to troubleshoot any technical problems.



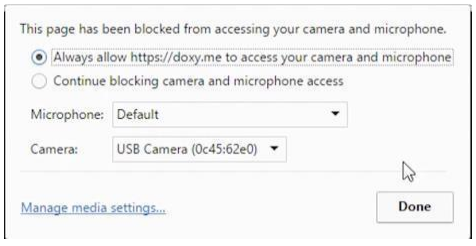


Step 2

Type in your name and click "check in" when prompted.

Step 3

Give your browser permission to access your camera and microphone. Ensure you have a strong internet connection and that you are in a comfortable, private, location for your call. If you run into issues connecting, try restarting your computer or check out www.help.doxy.me.com. You can also select "pre-call test" in the bottom left corner to ensure you have a good connection.



Step 4

Nicole will be alerted that you are waiting and will sign on at your appointment time. She will ask you for identification and for a number to call in case you are disconnected.

To reach Nicole directly you can leave a confidential voicemail at 802-676-1570 or email at Nicole.Breslend@therapysecure.com

04/07/2003

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 Synchrosaic, 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 Synchrosaic 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
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.