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CONSENT FOR TREATMENT & PATIENT AGREEMENT

Welcome to the Integrative Insomnia & Sleep Health Center (IISHC). Your therapy is an important joint venture in which you and I will work together to understand the problems that you are having and to explore your options and obstacles in resolving those problems. This document contains information about my professional services and business policies. Should you have any questions about these at any time, I will be pleased to answer them.

COGNITIVE BEHAVIORAL TREATMENT (CBT) SERVICES

Cognitive Behavior Therapy (CBT) is the primary therapeutic modality that I use. CBT involves assisting a person in modifying their behaviors, beliefs, and attitudes about a particular problem area in their life with the goal of reducing the symptoms and distress which accompany the problem. When applied to the area of insomnia treatment, CBT is referred to as "CBT-I" for "Insomnia". CBTI is aimed at improving sleep and reducing one's concern and anxiety about sleep in general. CBTI does not involve the use of sleep medication but instead entails the use of a small number of non-drug strategies shown to be clinically effective at reducing the time to fall asleep at night, reducing the frequency of night-time awakenings, reducing the total amount of time spent awake at night, improving sleep quality, and reducing sleep-related anxiety. In head to head controlled clinical trials, CBTI has been shown to be as effective as sleep medication after about five weeks of treatment. Moreover, individuals treated with CBTI maintain their improvement up to a year after treatment, whereas those using sleep medication are much more prone to relapse.

The CBTI program at the IISHC is offered in multiple formats. I conduct the CBTI program in both individual and small group (4 to 6) formats. An additional option for patients engaged in individual treatment is 24-hour actigraphy monitoring of home sleep-wake pattern, which is carried out for a week at a time. Individual treatment allows for one-one-one interaction and a greater degree of tailoring of the CBTI strategies to the individual. Group treatment allows for the sharing of one's perspectives with other individuals dealing with similar issues.

For patients who have not been seen previously either by me or my colleague, Dr. Mindy Cetel, an initial 60 minute consultation is required to obtain a proper sleep and medical history and to determine your suitability for CBTI. This is because CBTI is not a good fit for everybody. If it is determined that CBTI is not an appropriate treatment option in your case or if you prefer not to undertake CBTI, other suitable treatment recommendations will be made at the consultation visit.

The CBTI program consists of four core sessions (occurring over a five week period) followed by a 45 minute follow up session scheduled approximately four weeks after completion of the core program. The approximate durations of each core session is 60 minutes for individual therapy, 75 minutes for individual therapy with actigraphy, and 90 minutes for group. You will be required to maintain a daily sleep-wake diary throughout the duration of the program and bring it with you to each visit.

CBTI AND SLEEP MEDICATIONS

If you are presently using prescription or over-the-counter sleep aids, either regularly or occasionally, it is not necessary to discontinue them in order to participate in the CBTI program. If reducing or discontinuing sleep medication is a desirable goal of yours, this aspect may be incorporated into your CBTI regimen. It is important that we discuss the issue of sleep medication use, if applicable, at the outset of treatment. I am not a physician and therefore cannot recommend or over see any changes in your use of prescription medications. This component of your care will need to be managed by my physician colleague, Dr. Mindy Cetel, and may require a medication consultation with her. NOTE: YOU SHOULD NOT ALTER OR DISCONTINUE THE USE OFANY PRESCIPTION MEDICATION WITHOUT FIRST CONSULTING A PHYSICIAN.

ENDING TREATMENT

You have the right to stop treatment at any time. Also, if at any point during treatment I determine that I am not effective in helping/treating you, I am obligated to discuss it with you and, if appropriate, to terminate treatment. In such a case, I would give you a number of referrals that may be of help to you.

MY EDUCATION AND TRAINING

I am a licensed Clinical Psychologist in the state of California. I received my Doctorate in Psychology from the University of Ottawa, Canada in 1996. I completed my Post-Doctoral Research Fellowship at the University of Arizona in 1999 and my Fellowship in Sleep Medicine at Stanford University in 2001 during which time I co-founded the CBTI program at the Stanford Sleep Disorders Center. I am also a board certified Behavioral Sleep Specialist. If you have questions about the specifics of my training, experience, and/or license please ask for clarification at any time.

APPOINTMENTS
Our appointments are usually scheduled at least one week in advance. An appointment is a commitment to our work. We agree to meet here and to be on time. If I am ever unable to start on time, I ask for your understanding, and I assure you that you will receive the full time agreed to. If you are late, we may not be able to meet for the full time. I will provide one month's notice of my planned absences. For short absences and therapist illness, I will attempt to reschedule your appointment as soon as possible.

CANCELLATION POLICY
Because the scheduling of an appointment involves the reservation of time set aside specifically for you, a minimum of 48 business hours notice is required for rescheduling or canceling an appointment. The full session fee will be charged for sessions missed without such notification. The phone number for leaving a cancellation message is (858) 657-0550.

PROFESSIONAL FEES
The CBTI program is generally covered by Medicare and TriCare (an authorization may be required for TriCare). For those with private insurance, the initial consultation and CBTI program are "fee for service" meaning that payment is due in full at each visit in the form of cash, check, or credit card. Partial reimbursement may or may not be available from your carrier under your Mental Health Benefit. I will provide you with a bill/receipt with the diagnostic and treatment codes for you to submit to your insurance company to facilitate your potential reimbursement. However, you, and not your health insurance carrier, are ultimately responsible for full payment of my fees.

If a payment by check results in insufficient funds a $50 fee may be assessed. Please notify me if any problem arises during the course of therapy regarding your ability to make timely payments.

CONFIDENTIALITY
With certain specific exceptions described below, you have the absolute right to the confidentiality of your therapy. I cannot and will not tell anyone else what you have told me, or even that you are in therapy with me, without your prior written permission. The following are legal exceptions to your right to confidentiality. Should one of these situations occur, I will make every effort to discuss it with you fully before taking any action.

- If I reasonably suspect that a person under 18 or over 65, or a disabled person, is being abused or has been abused, I must file a report with the appropriate state agency.

- If a patient threatens to harm him/herself, I may be obligated to seek hospitalization for the patient, or to contact family members or others who can help provide protection.

- If a patient communicates a serious threat of physical violence against an identifiable victim, I must take protective actions, including notifying the potential victim and contacting the

police. I may also seek hospitalization of the patient, or contact others who can assist in protecting the victim.

- If you are involved in a court proceeding and a request is made for information about the services that I have provided you and/or the records of them, such information is protected by psychologist-patient privilege law. I cannot provide any information without your written authorization, a court order, or compulsory process (a subpoena) or discovery request from another party to the court proceeding where I do not have grounds for objecting under state law (or you have instructed me not to object). If you are involved in or contemplating litigation, you should consult with your attorney to determine whether a court would be likely to order me to disclose information.

- If a patient files a complaint or lawsuit against me, I may disclose relevant information regarding that patient in order to defend myself.

- If a patient files a worker's compensation claim, I must, upon appropriate request, disclose information relevant to the claimant's condition, to the worker's compensation insurer.

MINORS AND PARENTS

Unemancipated patients under 18 years of age and their parents should be aware that the law may allow parents to examine their child's treatment records unless I determine that access would have a detrimental effect on my professional relationship with the patient, or to his/her physical safety or psychological well-being. Because privacy in psychotherapy is often crucial to successful progress, particularly with adolescents, and parental involvement is also essential, it is usually my policy to request an agreement with minors and their parents about access to information.

PROFESSIONAL RECORDS

Except in unusual circumstances in which disclosure would physically endanger you and/or others or makes reference to another person (unless such other person is a health care provider), you may examine and/or receive a copy of your clinical record, if you request it in writing.

HEALTH INSURANCE & CONFIDENTIALITY OF RECORDS

If you choose to seek reimbursement from your health insurance carrier, the disclosure of confidential information may be required by your carrier in order to process the claims. Please refer to the Federal Health Insurance Portability and Accountability Act (HIPAA) form with regard to the use and disclosure of your Protected Health Information (PHI). Only the minimum necessary information will be communicated to the carrier. By signing this contract, you are consenting to a release of information about your case to your health plan for claims, certification and case management for the purposes of treatment and payment. You must be aware that submitting a mental health invoice for reimbursement carries a certain amount of risk to confidentiality, privacy or to future capacity to obtain health or life insurance.

CONTACTING ME & CRISIS NUMBERS:
I am often not immediately available by telephone. When I am unavailable, my telephone is answered by voicemail, which I check a few times per day, unless I am out of town. I will make every effort to return your call on the same day you make it, with the exception of calls on weekends and holidays. Also, I do not return telephone calls between 8:00 p.m. and 8:00 a.m. on weekdays, during weekends, and planned vacations. If you are unable to reach me and you are in crisis, you can contact the following: the emergency dispatcher at 911, your local physician/hospital, crisis line 1-800-479-3339**,** National Suicide Prevention Lifeline (800) 273-TALK (8255), or National Hopeline Network (800) 784-2433. If I am unavailable for an extended time, I will provide you with the name of a colleague whom you can contact if necessary.

By initialing here I attest that I have received a copy of the "Consent for Treatment and Patient Agreement" _____

Please sign below to acknowledge your informed consent to this agreement.
I have read the above information, received a copy of this form, and have had an opportunity to ask questions which clarify the conditions under which I consent to treatment. I give permission to **Derek Loewy, Ph.D. Clinical Psychologist** to provide psychotherapy, evaluation, consultation, and/or testing for myself or my child.

_____
Name of patient

_____ _____
Signature of patient Date

_____
Name of parent or guardian

_____ _____
Signature of parent or guardian Date