

**GENERAL POLICIES AND PROCEDURES FOR CYBERTHERAPY**  
**And**  
**PATIENT'S INFORMED CONSENT**

**D. Craig Kerley, Psy.D.**  
3949 Holcomb Bridge Road  
Suite 202  
Norcross, Georgia 30092  
Phone 770-449-0082

This document's intent is to introduce you to the general policies, procedures, and conditions for obtaining psychological services from Dr. Kerley, and obtain your informed consent for the provision of and conditions under which such services are provided.

**1. Practice Location, and Professional Responsibility/Liability:** Dr. Kerley practices psychology in the physical location (3949 Holcomb Bridge Road, Suite 202, Norcross, GA 30092) as a completely independent practitioner. You agree that our cybertherapy exchange, including email-based consultation, video-conference therapy, and avatar-based therapy occurs in the state of Georgia, (USA) and is governed by the laws of that state. You agree that you are using the internet to visit Dr. Kerley in his Georgia office, where you will meet with him to do your work. Dr. Kerley has his own patient load, skills, fees, schedules, billing procedures, etc., according to his patient's and his needs, as do the other practitioners at this location. As independent practitioners, each professional at this location is responsible for his/her own practice and the liability of her/his actions, but are not responsible, nor liable, for the professional conduct (acts of omissions) of other practitioners.

**2. Limits of Confidentiality:** Information obtained during the provision of psychological services remains confidential in accordance with the American Psychological Association (APA) ethics and Georgia state law. APA ethics and Georgia state law require exception to confidentiality in the following circumstances:

- (a) When a patient is believed to be a danger to himself or herself.
- (b) When a patient is believed to be a danger to someone else.
- (c) When a minor is believed to be experiencing physical and/or sexual abuse, a report must be made to the Department of Family and Children's Services.

**3. Consultation and Supervision:** In order to provide the best possible services, supervision and/or consultation, which provides for professional accountability and growth, is obtained on a regular basis. All information communicated to another mental health practitioner is covered by the same laws regarding confidentiality that govern Dr. Kerley.

**4. Initial Interview, Assessment, and Possible Referral:** This first appointment is an assessment interview in which your needs and expectations are discussed and a determination is made as to what services would be most beneficial to you. On occasion, this may require more than one interview. If the services provided by Dr. Kerley will not meet your needs, he will refer you to a more appropriate resource. Full payment is expected prior to the time of this service.

**5. Appointments and Scheduling:** Daytime as well as some evening appointments are available, according to the patients' needs and Dr. Kerley's time. Appointment times are scheduled directly with Dr. Kerley, either by leaving a confidential voice mail message at 678-697-4853, or with regular patients, at the conclusion of each session.

**6. Fees and Payment for Therapy or Assessment:** You, the patient or your legal representative (in the case of a minor, etc.), are financially responsible for the total cost of services rendered. Full payment (credit card, cash, or check) is expected prior to the time services are rendered, unless prior arrangements have been made with Dr. Kerley. His fees for cybertherapy are \$100 per 50 minutes for the first session (the diagnostic interview) and for psychotherapy sessions thereafter. In the case of email-based consultation, his rates are \$50 per half-hour of service. Billable time for email-based consultation includes reading and responding to client emails. Dr. Kerley will gladly provide the necessary information for you to file with your insurance company. However, be aware that very few insurance companies will reimburse for cybertherapy. A \$20 fee will be charged for bank-returned checks. If an account becomes delinquent (i.e., payment is not made within 30 days of services or agreed schedule), service charges will accrue at a rate of 1.5% per month. Following efforts by this office to rectify the situation, including notification of the delinquency, professional services will be discontinued and the account, along with only necessary personal/financial information, will be turned over to a collection agency for the amount owed.

**7. Missed Appointments:** You are encouraged to notify Dr. Kerley (at 770-449-0082 or info@drkerley.com) as early as possible when you need to cancel/reschedule an appointment, since your appointment time is reserved exclusively for you. In the case of avatar-based and videoconference therapy, payment is expected 24-hours prior to your appointment. If payment is not received at least 24 hours prior to your appointment, the appointment will be cancelled and the time-slot will be rescheduled for another client. Cancellation of appointments occurring with at least 24 hours of notice will receive a refund of their payment within two weeks of the cancellation, less expenses incurred for the refund (e.g., credit card refund charges, postage, etc.). Clients who fail to attend their appointments without notifying Dr. Kerley, or Clients who cancel or reschedule their appointment with less than 24 hours of notice to Dr. Kerley, will forfeit their payment for that session. It is highly recommended that all cancellations be made via telephone. If you choose to use email to cancel an appointment, be sure to check that you would like to receive a delivery receipt when the email has been read by Dr. Kerley. This suggestion is for your protection. In the case of email-based consultation, services will begin within 24 hours of receipt of your payment.

**8. Non-Emergency and Emergency Phone Contact:** To reach Dr. Kerley, you may phone him directly at 770-449-0082. If he is in session or away from his desk, you may leave a confidential message on his voice mail at the above listed number. He will make every attempt to return your call either the same day or at least by the next business day. **If you are experiencing a crisis** (i.e., life-threatening scenario/emergency) and must reach Dr. Kerley right away, please call (678) 697-4853 where specific directions are listed on how to reach him, or one of his colleagues should he be unavailable. If you are unable to reach Dr. Kerley or one of his colleagues, due to telephone system failure or other unavoidable circumstances, and you need help immediately, call Summit Ridge Center for Behavioral Health at 678-442-5800, which is accessible 24 hours per day.

**9. Release of Information and Records:** Oftentimes, patients, or their legal guardians, request that Dr. Kerley obtain patient information from and/or share patient information with other professionals (e.g., primary care physician, other health care professionals, insurance company). A patient's, or his/her legal guardian's, written permission must be obtained prior to the sharing of any patient information (with the exceptions that are noted under #2, #3, and #6). If you would like for Dr. Kerley to obtain from and/or share patient information with such professionals, you will need to complete the attached Authorization for Release of Information and Records for each professional/agency that you wish for him to contact.

**INFORMED CONSENT (ADULT PATIENTS)**

I, \_\_\_\_\_ (print patient's name), have read and understand the attached information, and accept the conditions for receiving services from Dr. Kerley.

Signature \_\_\_\_\_ Date \_\_\_\_\_

-----  
**INFORMED CONSENT  
(CHILD, ADOLESCENT OR OTHERS WITH LEGAL GUARDIANS)**

If you are signing this Informed Consent as it relates to seeking services for a minor child, adolescent, or other with legal guardian, please answer the following questions (providing names and relationship of each with the child, adolescent, or other):

With whom (both parents, one parent, others) does the child/adolescent/other reside?

\_\_\_\_\_

Who (both parents, one parent, others) has legal custody of the child/adolescent/other?

\_\_\_\_\_

I (We), \_\_\_\_\_, parents(s)/legal guardian of \_\_\_\_\_ (print identified patient's name), have read and understand the attached information, and accept the conditions for receiving services from Dr. Kerley.

Parent(s)/Legal Guardian Signature(s):

\_\_\_\_\_ Date \_\_\_\_\_

\_\_\_\_\_ Date \_\_\_\_\_

Identified Patient's Signature \_\_\_\_\_ Date \_\_\_\_\_

# Notice of Privacy Practices – Short Version

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

## **My Commitment to your Privacy**

My practice is dedicated to maintaining the privacy of your personal health information. I am required also by law to do this. These laws are complicated, but I must provide you with important information. This pamphlet is a shorter version of the full, legally required Notice of Privacy Practices (NPP), which will be provided to you on request. Please refer to the NPP for more information. Also, feel free to take a personal copy from the binder. However, we cannot cover all possible situations, so please talk with me about any questions or problems.

I will use the information about your health that I get from you or from others, mainly to provide you or your child with treatment, to arrange payment for my services or for some other business activities, which are called in the law, health care operations. After you have read this NPP, I will ask you to sign a consent form to let me use and share your information. If you do not consent and sign this form, I cannot treat you or your child.

If you or I want to use or disclose (send, share, release) your information for any other purpose, I will discuss this with you and ask you to sign an authorization to allow this.

Of course I will keep your health information private, but there are some times when the laws require me to use or share it, such as the following:

1. When there is a serious threat to you or your child's health and/or safety, or the health and/or safety of another individual and/or the public. I will only share information with a person or organization who is able to help prevent or reduce the threat.
2. Some lawsuits and legal or court proceedings.
3. If a law enforcement official legally requires me to do so.
4. For workers compensation and similar benefit programs.

There are some other situations like these that do not happen very often. They are described in the longer version of the NPP.

## **Your Rights Regarding Your Health Information**

1. You can ask me to communicate with you about your health and related issues in a particular way or at a certain place. For example, you can ask me to call you at home, and not a work, to schedule or cancel an appointment. I will try my best to do as you ask.
2. You have the right to ask me to limit what I tell certain individuals involved in your or your child's care, or in the payment of your care, such as family members and friends. While I do not have to agree to your request, if I do agree, I will keep our agreement except if it is against the law, or in an emergency, or when the information is necessary to treat you or your child.
3. You have the right to a copy of this notice. If I change this NPP, I will post it in the waiting area and you can always get a copy of the NPP from me.
4. You have the right to file a complaint if you believe your privacy rights have been violated. You can file a complaint with me and with the Secretary of the Department of Health and Human Services. All complaints must be in writing. Filing a complaint will not change the health care I provide to you in any way.

If you have any questions regarding this notice or my health information privacy policies, please let me know. I can be reached by phone at 678-697-4853 or by mail at 3400 McClure Bridge Road, Building E, Suite A, Duluth, Georgia 30096.

The effective date of this notice is April 14, 2003.

**D. Craig Kerley, Psy.D.**  
**3949 Holcomb Bridge Road**  
**Suite 202**  
**Norcross, GA 30092**  
**(770) 449-0082**

## **Consent to Use and Disclose your Health Information**

This form is an agreement between you, \_\_\_\_\_, and me, D. Craig Kerley, Psy.D. When we use the word 'you' below, it can mean you, your child, a relative, or other person if you have written his or her name here

\_\_\_\_\_.

When I examine, test, diagnose, treat, or refer you, I will be collecting what the law calls Protected Healthcare Information (PHI) about you. I need to use this information to determine what treatment is best for you, and to provide any treatment for you. I may also share this information with others who provide treatment to you or need it to arrange payment for your treatment or for other business or government functions.

By signing this form, you are agreeing to let me use your information here and send it to others. The Notice of Privacy Practices (NPP) explains in more detail your rights and how we can use and share your information. Please read this before you sign this Consent Form.

If you do not sign this consent form agreeing to what is in our NPP, I cannot treat you.

In the future, I may change how I use and share your information, and so may change my NPP. If I do change my NPP, you can get a copy from my office.

If you are concerned about some of your information, you have the right to ask me to not use or share some of your information for treatment, payment, or administrative purposes. You will have to tell me what you want in writing. Although I will try to respect your wishes, I am not required to agree to these limitations. However, if I do agree, I promise to do as you asked.

After you have signed this consent, you have the right to revoke it (by writing a letter to me telling me that you no longer consent) and I will comply with your wishes about using or sharing your information from that time on, but may already have used or shared some of your information and cannot change that.

\_\_\_\_\_  
Signature of client or his/her personal representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed name of client or personal representative

\_\_\_\_\_  
Relationship to client

\_\_\_\_\_  
Description of personal representative's authority

\_\_\_\_\_  
Signature of authorized representative of this office or practice

\_\_\_\_\_  
Date of NPP

:Copy given to the client/personal representative

# AUTHORIZATION FOR RELEASE OF INFORMATION AND RECORDS

I have been informed that under Georgia state law, communication between a patient and his/her psychologist are privileged and may not be disclosed by the psychologist unless the patient consents. I also have been informed that patient records maintained by a psychologist may not be disclosed to third parties except with the patient's consent or through legal process

I hereby request and authorize:

**D. Craig Kerley, Psy.D.**  
3949 Holcomb Bridge Road  
Suite 202  
Norcross, GA 30092  
Phone 770-449-0082

To obtain and/or release:

- All available information
- Results of psychological or educational testing
- Diagnosis
- Other \_\_\_\_\_

To and/or from:

\_\_\_\_\_  
(Name of Service Provider) (Telephone Number)

\_\_\_\_\_  
(Name of Agency) (Telephone Number)

\_\_\_\_\_  
(City) (State) (Zip Code)

In regards to:

\_\_\_\_\_  
(Patient's Name) (Date of Birth)

I understand that all information I authorize to be obtained from this person/agency will be held strictly confidential and cannot be released by the recipient without my written consent.

I understand that unless otherwise limited by state or federal regulation, and except to the extent that action has been taken which is based on my consent, I may withdraw this consent at any time. I understand that this request to withdraw consent must be presented in writing, and that this authorization shall remain in effect until revoked by me in writing

I hereby relieve and release the above mentioned from any and all damages, claims, and causes of action arising out of, or in connection with, the release of this information.

\_\_\_\_\_  
(Signature of Patient, or Parent, or Legal Guardian where applicable) (Date)