Samuel Psychotherapy, Inc.
92 Argonaut, Suite 245
Aliso Viejo, CA 92656
(949) 887-8779

CONSENT FOR TREATMENT

Financial Terms:
Upon verification of health plan/insurance coverage and policy limit, we will bill your insurance carrier for you and your provider will be paid directly by the carrier. You (patient or guardian) will be responsible for any applicable deductibles and co-payments. If you are not eligible at the time services are rendered, you are responsible for payment. **Co-payments are required to be paid at time services are rendered**.

Cancelled and Missed Appointments:
A scheduled appointment means that times is reserved only for you. **If you miss or cancel an appointment with less than 24 hours notice, you will be charged $100.00**, due before your next appointment will be scheduled. Frequent cancellations or no shows will result in termination of treatment. Your compliance in keeping appointments and active participation in the treatment process are vital.

Appeals and Grievances:
You have the right to request reconsideration in the case that outpatient care (number of visits) is not approved. This is called an appeal. You can request an appeal through your provider. You have the right to submit a Grievance directly to your provider or the medical group to which you belong at any time if you have a compliant about any aspect of your care. If you are not satisfied with the response, you may submit the Grievance to your Health Plan directly.

Emergencies:
If you are in imminent danger, call 911, your nearest police department, or emergency room. Your provider's policy regarding emotional crisis and their availability should be discussed during the first appointment.

Confidentiality:
All information between you and your psychologist is held strictly confidential unless:
1. You authorize the release of information with your signature (or parent/guardian).
2. You present a physical danger to self.
3. You present a danger to others.
4. Child or elder abuse is suspected.

In the latter two cases, we are required by law to inform potential victims and legal authorities so that preventative measure can be taken.

Consent for Treatment:
I authorize Dr. MaryAnn Samuel to carry out psychological examinations and/or treatment, which now, or during the course of my care as a patient are advisable.

Release of Information to health Plan:
I authorize the release of information for claims, certification, case management, quality improvement, and other purposed related to the benefits of my Health Plan.

I have read, understand, and agree to all the terms listed above:

____ ____________
PATIENT SIGNATURE (PARENT OR GUARDIAN) DATE

____
PRINT PATIENT'S NAME

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

HIPAA- Health Insurance Portability and Accountability Act of 1996

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I acknowledge receiving a Notice of Privacy Practices from this office:

PATIENT NAME (PRINTED) PATIENT SIGNATURE

DATE If signed by other than patient, indicate relationship.

NOTE: Parents must have legal custody. Legal guardians and conservator must provide proof of custody.

OFFICE USE ONLY
Patient **did** receive the Notice of Privacy Practices but did not sign this Acknowledgement of Receipt because:

- Patient left office before Acknowledgment could be signed.
- Patient does not wish to sign this form.
- Patient cannot sign this form because:
- ____
- ____

Patient **did not** receive the Notice of Privacy Practices because:
- Patient required emergency treatment.
- Patient declined the Notice and signing of this Acknowledgment.
- Other:
- ____

NAME: ____

SIGNATURE: ____
(Signature of provider)

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PATIENT DEMOGRAPHIC FORM

(This Form is to be updated yearly or with any information changes)

PATIENT INFORMATION

Patient Name:____ Social Security No.: ______ /_______/_______
Date of Birth: _____ /______/______ Age: _____ Sex: ☐ M ☐ F
Marital Status: ☐ Single ☐ Married ☐ Widow/er ☐ Divorced ☐ Partner

Language Preference if not English: ________________________ Other communication issues? ☐ Yes ☐ No What ____________________
Mailing Address: ____
Street Apt. No. City State Zip

Physical Address (if not same as mailing): ____
Street City State Zip
Drivers License No.: _______________ ______ Email Address: ______________________________
Number State
Employer: ______________________________ Occupation: ______________________________
Address: ______________________________ Work Phone: (______) _________ - ________________
Home Phone: (______) _________ - ________________ Cell/Pager No.: (______) _________ - ________________
Spouse Name: ______________________ Date of Birth : _____ /______/______ Social Security No.: _______ /________/________
Address: ______________________________ Work Phone: (______) _________ - ________________
Emergency Contact Name: ______________________ Emergency Contac Phone: (______) _________ - ________________
Address: ______________________________ Relationship: ______________________________

GUARANTOR/PARENT INFORMATION

Responsible
Party Name: ______________________ Date of Birth: _____ /______/______ Social Security No.:______ /_______/_______
Address: ______________________________ Home Phone: (______) _________ - ________________
Employer: ______________________________ Work Phone: (______) _________ - ________________
Relationship to Patient: ______________________ Cell/Pager No .: (______) _________ - ________________

PATIENT'S INSURANCE INFORMATION ** Please provide Insurance Card and Photo ID to Receptionist**

Primary Insurance Company' s Name: ____
Primary Address: ____
Street City State Zip
Name of
Policy Holder: ______________________ Date of Birth: _____ /______/______ Social Security No.:______ /_______/_______
Insurance ID No.: ______________________ Insurance Group No.: ______________________________

Secondary Insurance Company' s Name: ____
Primary Address: ____
Street City State Zip
Name of
Policy Holder: ______________________ Date of Birth: _____ /______/______ Social Security No.:______ /_______/_______
Insurance ID No.: ______________________ Insurance Group No.: ______________________________

PATIENT'S REFERRAL INFORMATION

Referred By (circle or fill in): ☐ Family ☐ Friend ☐ Hospital ☐ Radio ☐ Health Care Provider Name: ______________________
Primary Care Provider: ______________________ Referring Provider: ______________________

I hereby authorize my insurance benefits to be paid directly to the office and I realize I am responsible for paying for non-covered services. I understand and I am responsible for all charges incurred on my behalf, including my added costs incurred due to any effort to collect for services rendered. I hereby authorize the release of patient medical information to insurance carriers.

Responsible Party: ______________________________________ Date: ______________________

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LIMITS OF CONFIDENTIALITY

Contents of all therapy sessions are considered to be confidential. Both verbal information and written records about a client cannot be shared with another party without the written consent of the client or the client's legal guardian. Noted exceptions are as follows:

Duty to Warn and Protect
When a client discloses intentions or a plan to harm another person, the mental health professional is required to warn the intended victim and report this information to legal authorities. In cases in which the client discloses or implies a plan for suicide, the health care professional is required to notify legal authorities and make reasonable attempts to notify the family of the client.

Abuse of Children and Vulnerable Adults
If a client states or suggests that he or she is abusing a child (or vulnerable adult) or has recently abused a child (or vulnerable adult), or a child (or vulnerable adult) is in danger of abuse, the mental health professional is required to report this information to the appropriate social service and/or legal authorities.

Prenatal Exposure to Controlled Substances
Mental Health care professionals are required to report admitted prenatal exposure to controlled substances that are potentially harmful.

Minors/Guardianship
Parents or legal guardians of non-emancipated minor clients have the right to access the clients' records.

Insurance Providers (when applicable)
Insurance companies and other third-party payers are given information that they request regarding services to clients.

Information that may be requested includes, but is not limited to: types of service, dates/times of service, diagnosis, treatment plan, description of impairment, progress of therapy, case notes, and summaries.

I agree to the above limits of confidentiality and understand their meanings and ramifications.

____
Client Signature (Client's Parent/Guardian if under 18)

____
Today's Date

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LATE CANCELLATION AND MISSED APPOINTMENT POLICY

Mental health care requires the collaborative effort of both you and your clinician. When you do not come to your scheduled appointment or cancel your appointment without the required 24 hour notice, not only do you miss an opportunity for treatment but you also deny someone else the opportunity as well. Whenever possible, a courtesy call will be made to remind you of your appointment, however, you are ultimately responsible for keeping your appointments. Consequently, late cancellations and missed appointments will be charged a $100 fee, and payment will be expected on or before your next schedule appointment. Insurance companies do not pay for either late cancellations or missed appointments.

THE RESPONSIBILITY IS YOURS.

I HAVE READ THE ABOVE AND AGREE TO ABIDE WITH THIS POLICY.

Patient's Signature ____

Staff or Clinician Signature _______________________________________

Date ____________________________

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HIPAA Privacy Notice

THIS NOTICE DESCRIBES HOW HEALTH CARE INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW THIS NOTICE CAREFULLY.

Your health record contains personal information about you and your health. This information about you that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services is referred to as Protected Health Information ("PHI"). This Notice of Privacy Practices describes how I may use and disclose your PHI in accordance with applicable law and the Code of Ethics. It also describes your rights regarding how you may gain access to and control your PHI.

I am required by law to maintain the privacy of PHI and to provide you with notice of our legal duties and privacy practices with respect to PHI. I am required to abide by the terms of this Notice of Privacy Practices. I reserve the right to change the terms of our Notice of Privacy Practices at any time. Any new Notice of Privacy Practices will be effective for all PHI that I maintain at that time. I will provide you with a copy of the revised Notice of Privacy Practices by sending a copy to you in the mail upon request or providing one to you at your next appointment.

HOW I MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

For Treatment:
Your PHI may be used and disclosed by those who are involved in your care for the purpose of providing, coordinating, or managing your health care treatment and related services. This includes consultation with clinical supervisors or other treatment team members. I may disclose PHI to any other consultant only with your authorization. I may also contact you to remind you of your appointments or to provide information to you about treatment alternatives or other health-related benefits and services that may be of interest to you.

For Payment:
I may use and disclose PHI so that I can receive payment for the treatment services provided to you. This will only be done with your authorization. Examples of payment-related activities are: making a determination of eligibility or coverage for insurance benefits, processing claims with your insurance company, reviewing services provided to you to determine medical necessity, or undertaking utilization review activities. If it becomes necessary to use collection processes due to lack of payment for services, I will only disclose the minimum amount of PHI necessary for purposes of collection.

For Health Care Operations:
I may use or disclose, as needed, your PHI in order to support our business activities including, but not limited to, quality assessment activities, employee review activities, licensing, and conducting or arranging for other business activities. For example, I may share your PHI with third parties that perform various business activities (e.g., billing or typing services) provided I

have a written contract with the business that requires it to safeguard the privacy of your PHI. For training or teaching purposes PHI will be disclosed only with your authorization.

Required by Law:
Under the law, I must disclose your PHI to you upon your request. In addition, I must make disclosures to the Secretary of the Department of Health and Human Services for the purpose of investigating or determining our compliance with the requirements of the Privacy Rule.

Without Authorization:
Following is a list of the categories of uses and disclosures permitted by HIPAA without an authorization. Applicable law and ethical standards permit us to disclose information about you without your authorization only in a limited number of situations.

- *Child Abuse or Neglect*: I may disclose your PHI to a state or local agency that is authorized by law to receive reports of child abuse or neglect when I have reasonable grounds to believe that a minor is or has been the victim of neglect or physical and/or sexual abuse.
- *Adult and Domestic Abuse:* If I have the responsibility for the care of an incapacitated or vulnerable adult, I am required to disclose PHI when I have a reasonable basis to believe that abuse or neglect of the adult has occurred oe that exploitation of the adult's property has occurred.
- *Judicial and Administrative Proceedings:* I may disclose your PHI pursuant to a subpoena (with your written consent), court order, administrative order or similar process.
- *Serious Threat to Health or Safety:* I may disclose your PHI if you communicate to me an explicit threat of imminent serious physical harm or death to a clearly identified or identifiable victim(s) and I believe you have the intent and ability to carry out such a threat, I have a duty to take reasonable precautions to prevent the harm from occurring, including disclosing information to the potential victim(s) and the police and in order to initiate hospitalization procedures. If I believe there is an imminent risk that you will inflict serious harm on yourself, I may disclose information in order to protect you.
- *Worker's Compensation:* I may disclose your PHI as authorized by and to the extent necessary to comply with laws relating to worker's compensation or other similar programs, established by law, that provide benefits for work-related injuries or illness without regard to fault.
- *Deceased Patients:* I may disclose PHI regarding deceased patients as mandated by state law. A release of information regarding deceased patients may be limited to an executor or administrator of a deceased person's estate.
- *Medical Emergencies:* I may use or disclose your protected health information in a medical emergency situation to medical personnel only in order to prevent serious harm. Our staff will try to provide you a copy of this notice as soon as reasonably practicable after the resolution of the emergency.

YOUR RIGHTS REGARDING YOUR PHI

You have the following rights regarding PHI I maintain about you. To exercise any of these rights, please submit your request in writing to me.

• *Right of Access to Inspect and Copy:* You have the right, which may be restricted only in exceptional circumstances, to inspect and copy PHI that is maintained in a "designated record set". A designated record set contains mental health/medical and billing records and any other

records that are used to make decisions about your care. Your right to inspect and copy PHI will be restricted only in those situations where there is compelling evidence that access would cause serious harm to you. I may charge a reasonable, cost-based fee for copies. If your records are maintained electronically, you may also request an electronic copy of your PHI.

• *Right to Amend:* If you feel that the PHI I have about you is incorrect or incomplete, you may ask us to amend the information although I are not required to agree to the amendment. If I deny your request for amendment, you have the right to file a statement of disagreement with us. I may prepare a rebuttal to your statement and will provide you with a copy.

• *Right to an Accounting of Disclosures:* You have the right to request an accounting of certain of the disclosures that I make of your PHI. I may charge you a reasonable fee if you request more than one accounting in any 12-month period.

• *Right to Request Restrictions:* You have the right to request a restriction or limitation on the use or disclosure of your PHI for treatment, payment, or health care operations. I am not required to agree to your request unless the request is to restrict disclosure of PHI to a health plan for purposes of carrying out payment or health care operations, and the PHI pertains to a health care item or service that you paid for out of pocket. In that case, I am required to honor your request for a restriction.

• *Right to Request Confidential Communication:* You have the right to request that I communicate with you about medical matters in a certain way or at a certain location.

Psychologist's Duties:

- I am required by law to maintain the privacy of PHI and to provide you with a notice of my legal duties and privacy practices with the respect to PHI.
- I reserve the right to change the privacy policies and practices described in this notice. Unless I notify you of such changes, however, I am required to abide by the terms currently in effect.
- If I revise my policies and procedures, I will inform you and provide you with written documentation during our session at that time.

COMPLAINTS

If you are concerned that I have violated your privacy right, or you disagree with a decision I made about access to your records, you may contact me to discuss your concerns. You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services. I can provide you with the appropriate address upon request.

This Notice goes into effect on December 08, 2011.

I reserve the right to change the terms of this notice and to make the new provisions effective for all PHI that I maintain. I will provide you with a revised written notice during our session.

PATIENT ACKNOWLEDMENT

I,______________________________, have received a copy of the psychologist's Policies and Practices to Protect the Privacy of my Health Information.

___________________________________ ___________________________
Signature of Patient or Legal Guardian Date