Client Information – Bariatric Surgery Support Group

Therapist: Rhonda Scarlata, LCSW

(Please Print)

Name_____ Date_____
first middle last

Age_____ Date of Birth_____ Sex: Male ☐ Female ☐

Home Address_____
street city state zip

Cell phone_____ Home phone_____ Work phone _____

Which phone number would you prefer me to use to contact you?_____

Is it O.K. to leave a detailed message at that number?_____

E-mail address (optional) _____

Date of Bariatric Surgery_____ Type of Bariatric Procedure_____

Height _____ Pre Surgery Weight _____ Current Weight _____

What is your "goal weight"? _____

What did you weigh at the time you graduated or left High School (if you have an idea) _____

Occupation _____

Marital Status_____# Previous Marriages _____

Children (ages) _____

_____

If you are currently under the care of a psychiatrist, please give your psychiatrist's name and phone number:

_____

Do you currently take any psychotropic medications, if, so please list the med (s) and dose:

_____

_____

Current or previous counseling, treatment, and/or support group experience:

_____

_____

Continued

1901 Acklen Ave., Nashville, TN 37212 • 615.298.2978 • rscarlata@bellsouth.net

Do you have any current medical conditions?

_____

_____

_____

Emergency contact_____Phone # _____

Motivation for joining this support group and what you hope to gain from the experience:

_____

_____

_____

Client Agreement with Policies and Procedures and Informed Consent to Care

Welcome to the Food Rehab Support Group!

The following information is provided to my clients to assist you in understanding the policies and procedures pertaining to your participation in this educational support group.

Fees/Session Length:

The Food Rehab Support Group will meet for Ten Sessions. Each session is 60 minutes in length. The total cost for participation in this group is $400.

Payment:
Half of the total payment ($200) is due before the first group meeting and the remaining payment ($200) will be due at the time of the fifth group meeting. Participants who wish to pay in full prior to the start of the first meeting will receive a 5% discount bringing their total fee to $380. Payment may be made in the form of cash, check (payable to Rhonda Scarlata, LCSW), Visa or MasterCard.

Absences/Attendance
By committing to participation in the group and paying fees up-front, you are making a commitment to yourself to follow through with attendance and active involvement. Attending Group in your best interest and contributes to the experience of your fellow group members.

Continued

Phone calls/E-mails

If there is something you wish to communicate to me outside of group, you may phone me at my office or e-mail me. Phone calls lasting more than 10 minutes will be billed to clients, prorated according to the usual office fee. Generally speaking, I am happy to arrange appointments or answer logistical questions by e-mail but I don't spend time answering e-mails (like phone calls, there would be a charge after ten minutes).

Emergencies:

Should you need to talk to me between appointments and you call during normal office hours, I will return your call as promptly as I can. If your call is an **emergency** and occurs during normal office hours, you should declare your call to be an emergency. Your call will be handled promptly. If your call is an **emergency** and occurs outside of normal office hours, you should phone the Crisis Intervention Center at (615) 244-7444 or go to the nearest Emergency Room.

Insurance Usage:

I do not participate on any insurance panels. You are responsible for filing to receive reimbursement from your insurer. Should you authorize me to do so I will provide a record of your appointments kept after the ten group sessions have taken place. Many plans require an initial precertification of care before you can use your insurance benefits. Additionally, there is often a higher deductible for out of network providers such as myself. If you do elect to use your insurance benefits, it is your responsibility to make sure you meet precertification requirements (i.e., referral from your primary care medical doctor, employee assistance program, other "gate keeping" mechanisms such as calling an 800 number for approval) and deductible requirements.

Confidentiality and Privileged Communications

What you talk about in your established relationship with me is protected by privileged communication laws and confidentiality principles, with the exception of certain specific actions (i.e., clear and imminent danger to self and/or others, or suspected child abuse). With these exceptions, release of Information is controlled by you through written consent.

Your Informed Consent to Care:

I have provided this information to you in the hope of fully informing you about the policies of my office and some of the parameters of care you will receive, such as the importance of confidentiality. Psychiatric and psychological care, like other things in life, offers no absolute guarantee of success and there are limitations to any form of care offered a patient. Since such limitations are always a function of the particular problem in question, I invite you to discuss any concerns you have with the group or with me.

Please feel free to discuss any of these matters with me in more detail. By signing below, you acknowledge having read, understood, and agreeing to these policies and procedures. Your signature acknowledges your informed consent for care.

_____ _____

Signature of Client Date

Continued

Rhonda Scarlata
Licensed Clinical Social Worker

The passage of the federal "medical records privacy law" known as **HIPAA** (Health Insurance Portability and Accountability Act) requires that I give you a copy of this document and to secure your signature indicating you have received a copy of it. Laws such as these are important, but also complex and in my **Notification of Patient Rights** document I have tried to inform you about your rights in plain, simple language. Please read the contract and do not hesitate to ask me about any questions you might have about its content.

Notice of Privacy Practices

This Notice of Privacy Practices describes how I may use and disclose your protected health information in accordance with applicable law. It also describes your rights regarding how you may gain access to and control your protected health information. Please Review it carefully.

1. HOW YOUR PROTECTED HEALTH INFORMATION MAY BE USED AND DISCLOSED

Treatment. With your written consent only, I will use and disclose your protected health information to provide, coordinate, or manage your health care treatment and related services. For example, your protected health information may be provided to a doctor or treatment team member to whom you have been referred to ensure that the doctor or treatment team member has the necessary information to diagnose or treat you.

Payment. Your protected health information will be used, as needed, in activities related to obtaining payment for your health care services. For example, obtaining approval for a hospital stay or residential treatment program may require that your relevant be disclosed to your health insurance company to obtain approval for the admission.

Business Associates. I may use or disclose your protected health information with third party "business associates" that perform various activities (e.g. billing services). If ever an arrangement between a business associate and me involves the use or disclosure of your protected health information, I will have a written contract from them that contains terms that will protect the privacy of your protected health information.

Written Authorization. Uses and disclosures not specifically permitted by applicable law will be made only with your written authorization, which may be revoked.

Opportunity to Object. I may use and disclose your protected health information in the following instances. You have the opportunity to object. If you are not present or able to object, then your provider may, using professional judgment, determine whether the disclosure is in your best interest.

Others Involved in Your Healthcare. Unless you object, I may disclose to a member of your family, a relative, a close friend or any other person you identify, your protected health information the relates to that person's involvement in your health care.

Emergencies. In an emergency situation, your provider shall try to provide you a Notice of Privacy as soon as reasonably practical after the delivery of treatment.

Continued

Rhonda Scarlata
Licensed Clinical Social Worker

Without Authorization. Applicable law and ethical standards permit me to disclose information about you without your authorization only in a limited number of other situations. The types of uses and disclosures that may be made without your authorization are those that are:

- Required by Law, such as the mandatory reporting of child abuse or neglect or mandatory government agency audits or investigations (such as the health department)
- Required by Court Order
- Necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. If information is disclosed to prevent or lessen a serious threat it will be disclosed to a person or persons reasonably able to prevent or lessen the threat, including the target of the threat.

YOUR RIGHTS REGARDING YOUR PROTECTED HEALTH INFORMATION

- **Right To Inspect and Copy your protected health information**. However, I may refuse to provide access to certain psychotherapy notes or information for a civil or criminal proceeding.
- **Right to Amend.** You may request an amendment of protected health information about you. If I deny your request for amendment, you have the right to file a statement of disagree with me and your medical record will note the disputed information.
- **Right to an Accounting of Disclosures.** You have the right to request an accounting of the disclosures that I may have made for purposes other than treatment, payment or healthcare operation. It excludes disclosures I may have made to you, for a facility director, to family members or friends involved in your care, or for notification purposes
- **Right to Request Restrictions.** You have the right to request a restriction or limitation on the use or disclosure of your protected health information for treatment, payment, or health care operations. We are not required to agree to your request.
- **Right to Request Confidential Communication.** You have the right to request that I communicate with you about your health information in a certain way or at a certain location. I may also condition this accommodation by asking you for information as to how payment will be handled or specification of an alternative address of other method of contact.
- **Right to a Copy of this Notice.** You have the right to a copy of this notice.

COMPLAINTS

If you believe that I have violated your privacy rights, you have the right to file a complaint in writing with me or with the Secretary of Health and Human Services at 200 Independence Avenue, S.W., Washington D.C. 20201 or by calling (202) 619-0257. You may file a complaint without fear of retaliation.

(Receipt and Acknowledgement Page Follows)

Rhonda Scarlata
Licensed Clinical Social Worker

Notice of Privacy Practices
Receipt and Acknowledgment of Notice

Client Name:_____
***Date of Birth:*_____**

Please sign below to acknowledge that you have been given an opportunity to read this Notice of Privacy Practices. This page will be placed in your client file to indicate you have been provided with a copy of the Notice of Privacy Practices under HIPPA as required by law.

_____

Signature of Client ***Date***

1901 Acklen Ave., Nashville, TN 37212 • 615.298.2978 • rscarlata@bellsouth.net