Rhonda Scarlata, LCSW
Psychotherapy, Counseling & Coaching

Client Information – Couple

Date_____

(Please Print)

Provide info for each partner – where info is the same, put "same"

Name_____

Age_____ Date of Birth_____ Sex_____

Address_____

_____

_____

Phone #'s (cell)_____

(home/work)_____

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

e-mail address_____

Occupation_____

Name_____

Age_____ Date of Birth_____ Sex_____

Address_____

_____

_____

Phone #'s (cell)_____

(home/work)_____

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

e-mail address_____

Occupation_____

Date of your meeting or beginning dating and date of marriage (if applicable) to one another:

_____

Dates of previous marriages/divorces relationships:

_____

_____

_____

Dates of previous marriages/divorces relationships:

_____

_____

_____

Children and Step Children

Name	Relationship	Age	Occupation/Grade	Residence*

***If not living with you**

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Current Medications:

Person taking med.	Name of medication	Dose	Frequency

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

Referral source (who referred you or how did you hear about my services?)

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

What are the strengths of this relationship?

Reason for seeking help now and what you hope to gain from couple therapy:

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Office Policies and Procedures
& Informed Consent to Care

Welcome to my practice and please call me Rhonda!

(Each individual please read this information.)

The following information is provided to my clients to assist you in understanding policies and procedures at my office.

Fees/Session Length:
Couple Therapy appointments are $170 for a 50-minute session and $255 for 80 minutes. Payment, scheduling further appointments and completing insurance forms or receipts take place before the end of the session.

Individual appointments are $170 for a 50-minute session.

Letters provided (at your request) for school/college or employers are billed to clients, prorated according to the usual hourly fee. (I do not provide letters for emotional support animals.)

Payment:
Payment is due at the time of each session unless some special arrangement is made. Accepted forms of payment are cash, check, credit card or Venmo.

Cancellation Policy
Please give at least twenty-four (24) hours notice if you must cancel your reserved time. Sometimes illnesses and emergencies happen which prevent you from keeping your reserved time, and I do not charge a fee for these infrequent occurrences. In the absence of such circumstances, you will be charged your usual fee for appointments not cancelled twenty-four hours prior to the appointment time. Note: If I have openings and we are able to work out another time for you to make up your missed session *within the same week*, you won't be charged.

We agree to the session fee payment of $170 for a 50-minute session and understand the cancellation policy:

Yes _____ No _____

Phone calls/Texts/E-mails to 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 by e-mail or text but I don't spend time answering e-mails or texts (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.

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Insurance Usage:
I do not participate on any insurance panels. Many clients elect to file third party insurance coverage for the cost of my services. 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 with the necessary information for filing such claims. 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.

Correspondence/Contacting you:

I, _____ give permission for the therapist to correspond with me via text messaging and/or email.
Yes_____ No_____ email only_____ text only_____

I, _____ give permission for the therapist to correspond with me via text messaging and/or email.
Yes_____ No_____ email only_____ text only_____

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 here, 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 your treatment plan with me. After we have met to discuss your concerns, I will construct an individualized treatment plan and share it with you so that you and I have our plan for what problems we are going to solve and how.

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

_____ _____
Signature of Client Date

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Payment Information

Financially responsible party: Self ☐ Both ☐ Other ☐

Please provide the following information about the Financially Responsible Person (s) –
(ONLY IF IT IS NOT ONE OF YOU)

Name:_____

Relationship to client(s):_____ Date of Birth_____

Cell phone: _____ Home/Work phone:_____

Billing address_____
street

_____-
city state zip

E-mail address:_____

(WHOEVER IS PAYING SIGNS BELOW (EVEN IF IT IS YOU)

Payment Agreement & Authorization to Send Reimbursement Information

We accept responsibility for payment of charges for services rendered to the above named person. We understand that full payment is expected at the time services are rendered unless the therapist agrees otherwise. We also understand that any court order I/we may have is an agreement between me/us and the courts NOT the therapist and we are still responsible for payment of all charges. We understand and agree that we may be charged for and required to pay for missed appointments not cancelled at least 24 hours in advance. I/we further understand and agree that a collection agency and/or the courts may be used in the event of delinquent payment, and I/we realize that such action could require that the therapist release to the collection agency, attorneys, and/or the courts, information which identifies the parties involved, gives the client's diagnoses, and describes the dates and nature of the treatment. This consent shall remain in effect until all outstanding balances have been paid in full.

_____ _____
Signature of person who will be financially responsible for fee payment Date

_____ _____
Signature of person who will be financially responsible for fee payment Date

Note: If another party is paying for your treatment, they will need to sign this page

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Notice of Privacy Practices
Receipt and Acknowledgment of Notice

Client Name (Print): _____
***Date of Birth:*_____**

Client Name (Print): _____
***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***

_____
Signature of Client ***Date***

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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 may be used, as needed, in activities related to obtaining payment for your health care services. Examples of payment related activities are: obtaining approval for a hospital stay or residential treatment program, reviewing services provided to you to determine medical necessity, or undertaking utilization review activities

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 at any time.

Others Involved in Your Healthcare. Based on your consent, I may disclose to a member of your family, a relative, a close friend or any other person you identify directly involved in your treatment or as necessary to prevent serious harm.

Emergencies. In an emergency situation, I may use and disclose your protected health information only in order to prevent serious harm. I would try to provide you a copy of this notice as soon as reasonably practical after the delivery of treatment.

Continued

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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 disagreement 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, to 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. I am 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.

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