

Rhonda Scarlata, LCSW
Psychotherapy, Counseling & Coaching

Client Information - Student

(Please Print)

Date _____

Name _____
First Middle Last

Age _____ Date of Birth _____ Sex _____

Local address _____
Street
City State Zip

Students cell phone _____

E-mail address _____

Mother's Name _____ Date of Birth _____
first middle or maiden last

Mother's address (if different) _____
street city state zip

Mother's cell phone _____ Mother's home or work phone _____

Father's Name _____ Date of Birth _____
first middle last

Father's address (if different) _____
street city state zip

Father's cell phone _____ Father's home/work phone _____

Parents, brothers, sisters (including step and half siblings):

<u>Name</u>	<u>Relationship</u>	<u>Age</u>	<u>Occupation/Grade</u>	<u>Residence*</u>
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

*If not living in the same household as student

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Student's school/college _____ Grade/year _____

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

Current or previous counseling, treatment, and/or support group experience? _____

Current Medications:

<u>Name of medication</u>	<u>Dose</u>	<u>Frequency</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____

Physician's name: _____

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

What do you consider to be your strengths?

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

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**Office Policies and Procedures
& Informed Consent to Care**

(Students and parents please read this information.)

Welcome to my practice! Please call me Rhonda.

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

Fee Policy:

Individual Therapy appointments are \$170 for a clinical hour (50-minutes). Payment, scheduling further appointments and discussing your insurance submission takes place before the end of the session.

Parent Interviews and Family Therapy appointments are \$170 for a clinical hour (50-minutes).

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.

I 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 hourly 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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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 those exceptions, you control release of information through written consent.

Clients often prefer to communicate via text messaging or email. I do accept this form of communication; however it is important to understand that email and text messaging are not secure modes of communication. The correspondence is at risk of being intercepted, can be monitored by email or phone service providers, and human error could result in someone other than the intended recipient receiving the communication. If you choose to correspond with me via email or text messaging, the messages and emails may be printed off and kept in your file.

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 _____

Insurance Usage:

I do not accept insurance or file paperwork with insurance companies. Should you wish to file for insurance reimbursements, it will be important for you to contact your insurance carrier to determine your out-of-network, outpatient mental health benefits. Reimbursement rates vary widely depending on your particular policy as do out of pocket expenses. 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. All insurance companies will require me to provide a clinical diagnosis to justify treatment. This information will become part of your insurance company's digital records.

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 Student

Date

Parent or Guardian (if student is under 18 years)

Date

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Payment Information

Financially responsible party: Self Parent Other

**Please provide the following information about the Financially Responsible Person(s):
(ONLY IF IT IS NOT YOU)**

Name: _____

Relationship to client: _____ Date of Birth _____

Cell phone: _____ Home/Work phone: _____

Billing address _____

Street

City

state

zip

E-mail address: _____

(WHOEVER IS PAYING SIGNS BELOW)

Payment Agreement & Authorization to Send Reimbursement Information

I accept responsibility for payment of charges for services rendered either to me or to the above named person. I understand that full payment is expected at the time services are rendered unless the therapist agrees otherwise. I also understand that any court order I have is an agreement between me and the courts NOT the therapist and I am still responsible for payment of all charges. I understand and agree that I may be charged for and required to pay for missed appointments not cancelled at least 24 hours in advance. I further understand and agree that a collection agency and/or the courts may be used in the event of delinquent payment, and I 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

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: _____

Date of Birth: _____

Please sign below to acknowledge that you have been given an opportunity to read the 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 (if 18 or older) *Date*

Signature or Parent or Guardian *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.