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REGISTRATION INFORMATION & INFORMED CONSENT

PATIENT'S NAME_______________________________DATE OF BIRTH__________M____F____

ADDRESS__________________________________CITY___________ZIP CODE_____________

HOME TELEPHONE (______)________________WORK TELEPHONE (___)_________________
CELL NUMBER (_____)_______________

INSURED'S NAME____________________INSURED'S SOCIAL SECURITY NUMBER____________

INSURED'S DATE OF BIRTH_________________________________
RELATIONSHIP TO PATIENT_________________________________

INSURED'S
EMPLOYER_____________________________________OCCUPATION______________________

MARRIED___SINGLE___DIVORCED___OTHER ___ SPOUSE, OR SIGNIFICANT OTHER NAME_____________

PRIMARY INSURANCE COMPANY ____

MEMBERSHIP I.D. NUMER _______________________________

INSURED'S GROUP NUMBER _______________________________
Referred By ____

NAME OF NEAREST RELATIVE__________________________RELATIONSHIP______________________
OR FRIEND (NOT AT YOUR ADDRESS)

ADDRESS ____________________________________PHONE (   ) __________________

PLEASE READ THE FOLLOWING:

ALL THERAPY IS CONSIDERED CONFIDENTIAL EXCEPT IN THE CASE OF: CHILD ABUSE AND/OR MOLESTATION, ABUSE OF THE DISABLED OR ELDERLY, AND THREATENED SUICIDE OR HARM TO OTHERS.

ALL CHARGES/COPAYS FOR SERVICES RENDERED ARE TO BE PAID AT THE TIME OF THERAPY. IF YOU HAVE INSURANCE, I WILL PROVIDE A PAID BILL FOR YOU TO SUBMIT TO YOUR INSURANCE COMPANY. A THERAPY TIME OF 45 MINUTES IS RESERVED FOR YOU. IF YOU ARE UNABLE TO KEEP YOUR APPOINTMENT, NOTIFICATION MUST BE MADE 24 HOURS IN ADVANCE OR A FULL CHARGE WILL BE MADE.

PLEASE READ AND KEEP PAGES TWO, THREE, FOUR, FIVE, SIX, AND SEVEN OF THIS DOCUMENT.

I HAVE READ, OR HAVE HAD READ TO ME, THE ISSUES AND POINTS COVERED IN THE INFORMED CONSENT WHICH CONSISTS OF PAGES 1 - 7, AND THE NOTICE OF PRIVACY PRACTICES CONTAINED IN THE REMAINING PAGES OF THIS DOCUMENT AND AGREE TO ACT ACCORDING TO THOSE POINTS COVERED.

CLIENT SIGNATURE___________________________________DATE______________________
(PARENT SIGNATURE IF CLIENT IS A MINOR)

INFORMED CONSENT – CLIENT COPY

Welcome to Pamela Chambers Counseling Services. I am a Licensed Professional Counselor (LPC). This document contains important information about my professional therapy services and business policies. Please read it carefully and jot down any questions you might have so that we can discuss them at our next meeting. When you sign this document, it will represent an agreement between us.

PSYCHOLOGICAL SERVICES

Psychotherapy is a confidential exploration, discussion and mutually agreed upon plan for change. It varies depending on the personalities of the therapist and client, and the particular problems you bring forward. You and I will define the problem or problems, possible causes, and several treatment approaches. There are many different methods I may use to deal with the problems that you hope to address. These methods include therapies such as cognitive behavioral therapy, EMDR, solution oriented therapy, and a variety of other therapies. Psychotherapy is not like a medical doctor visit. Instead, it calls for a very active effort on your part. In order for the therapy to be most successful, you will have to work on things we talk about both during our sessions and at home.

Psychotherapy can have benefits and risks. Since therapy often involves discussing unpleasant aspects of your life, you may experience uncomfortable feelings like sadness, guilt, anger, frustration, loneliness, and helplessness. On the other hand, psychotherapy has also been shown to have benefits for people who go through it. Therapy often leads to better relationships, solutions to specific problems, and significant reductions in feelings of distress. But there are no guarantees of what you will experience.

Our first few sessions will involve an evaluation of your needs and goals of therapy. By the end of the evaluation, I will be able to offer you some first impressions of what our work will include and a treatment plan if you decide to continue with therapy. You should evaluate this information along with your own opinions of whether you feel comfortable working with me. Therapy involves a large commitment of time, money, and energy, so you should be very careful about the therapist you select. If you have questions about my procedures, we should discuss them whenever they arise. If your doubts persist, I will be happy to help you set up a meeting with another mental health professional for a second opinion.

MEETINGS

I normally conduct an evaluation that will last from 1 to 2 sessions. During this time, we can both decide if I am the best person to provide the services you need in order to meet your treatment goals. If psychotherapy is begun, I will usually schedule one 45 minute session (one appointment hour of 45 minutes duration) every 2 weeks, although some sessions may be longer, or more, or less frequent. Once an appointment hour is scheduled, you will be expected to pay for it unless you provide 24 hours advance notice of cancellation, unless we both agree that you were unable to attend due to circumstances beyond your control.

PROFESSIONAL FEES

My hourly fee is $150.00. In addition to psychotherapy sessions, I charge this amount for other professional services you may need, though I will break down the hourly cost if I work for periods of less than one hour. Other services include completion of assessments, report writing, telephone conversations lasting longer than 10 minutes, attendance at meetings with other professionals you have authorized, and the time spent performing any other service you may request of me. If I am asked to go to court, my professional fee is $200.00 from the time I leave my office until the time I return back to the office. Any preparation time for the court date will be billed at my hourly fee of $150.00

BILLING & PAYMENTS

You will be expected to pay for each session at the time it is held, unless we agree otherwise, or unless you have insurance coverage that requires another arrangement. Payment schedules for other professional services will be agreed to when they are requested.

If your account has not been paid for more than 60 days and arrangements for payment have not been agreed upon, I have the option of using legal means to secure the payment. This may involve hiring a collection agency or going through small claims court. If such legal action is necessary, its costs will be included in the claim. In most collection situations, the only information I release regarding a patient's treatment is his/her name, the nature of services provided, and the amount due.

INSURANCE REIMBURSEMENT

In order for us to set realistic treatment goals and priorities, it is important to evaluate what resources you have available to pay for your treatment. If you have a health insurance policy, it will usually provide some coverage for mental health treatment. I will fill out forms and provide you with whatever assistance I can in helping you receive the benefits to which you are entitled; however, you (not your insurance company) are responsible for full payment of my fees. It is very important that you find out exactly what mental health services your insurance policy covers.

You should carefully read the section in your insurance coverage booklet that describes mental health services. If you have questions about the coverage, call your plan administrator. Of course I will provide you with whatever information I can based on my experience and will be happy to help you in understanding the information you receive from your insurance company.

You should also be aware that most insurance companies require you to authorize me to provide them with a clinical diagnosis. Sometimes, I have to provide additional clinical information such as treatment plans or summaries, or copies of the entire record (in rare cases). This information will become part of the insurance company files and will probably be stored in a computer. Though all insurance companies claim to keep such information confidential, I have no control over what they do with it once it is in their hands. In some cases, they may share the information with a national medical information databank.

Once we have all of the information about your insurance coverage, we will discuss what we can expect to accomplish with the benefits that are available and

what will happen if they run out before you feel ready to end our sessions. It is important to remember that you always have the right to pay for my services yourself to avoid the problems described above.

CONTACTING ME

I am typically not immediately available by telephone. When I am unavailable, my telephone is answered by voicemail that I monitor frequently. I will make every effort to return your call on the same day you make it, with the exception of weekends and holidays. If you are difficult to reach, please inform me of some times when you will be available. If you are unable to reach me and feel that you can't wait for me to return your call, contact your family physician or the nearest emergency room and ask for the psychologist [psychiatrist] on call. You also have the option of calling the valley wide 24 hour crisis line at 602-222-9444. If I will be unavailable for an extended time, I will provide you with the name of a colleague to contact, if necessary.

CONFIDENTIALITY

In general, the law protects the privacy of all communications between a client and his/her therapist, and I can only release information about our work to others with your written permission. There are some situations in which I am legally obligated to take action to protect others from harm, even if I have to reveal some information about a patient's treatment. These exceptions to confidentiality include:

- When a child, elderly person, or disabled person is being abused, I am required to file a report with the appropriate state agency.
- If I believe that a patient is threatening serious bodily harm to another, I am required to take protective actions. These actions may include notifying the potential victim, contacting the police, or seeking hospitalization for the patient.
- If the client threatens to harm himself/herself, I am obligated to seek hospitalization for him/her, or to contact family members or others who can help provide protection.

These situations have rarely occurred in my practice. If a similar situation occurs, I will make every effort to fully discuss it with you before taking any action.

I may occasionally find it helpful to consult other professionals about a case. During a consultation, I make every effort to avoid revealing the identity of my patient. The consultant is also legally bound to keep the information confidential. If you don't object, I will not tell you about these consultations unless I feel that it is important to our work together.

In most legal proceedings, you have the right to prevent me from providing any information about your treatment. In some proceedings involving child custody and those in which your emotional condition is an important issue, a judge may order my testimony if he/she determines that the issues demand it.

While this written summary of exceptions to confidentiality should prove helpful in informing you about potential problems, it is important that we discuss any questions or concerns that you may have at our next meeting. I will be happy to discuss these issues with you if you need specific advice, but formal legal advice

may be needed because the laws governing confidentiality are quite complex. Your signature on the face sheet of this document indicates that you have read the information in this document and agree to abide by its terms during our professional relationship.

Due to the nature of the therapeutic process and the fact that it often involves making a full disclosure with regard to many matters which may be of a confidential nature, it is agreed that should there be legal proceedings (such as, but not limited to divorce and custody disputes, injuries, lawsuits, etc.) neither you, your attorneys, or anyone else acting on your behalf will call on Pamela Chambers to testify in court or at any other proceedings, nor will a disclosure of the psychotherapy records be requested without a release of information. My customary fee of $150 per hour applies for consultation with child custody evaluators. If you bring your child to therapy and are divorced, a copy of your divorce PAPERS THAT OUTLINES THE TYPE OF CUSTODY AND THE LANGUAGE PERTAINING TO TREATMENT OF THE MINOR CHILD **is also required.**

TERMINATION

It is my policy to support all termination, for whatever reason. I ask that you give me advance notice when you are ready to terminate your therapy and, if possible, allow for one final session. When leaving is handled in this way, it often turns out to be the most productive time in therapy for the client. Even if you are not able to give me advance notice, I will still do my best to help you leave well.

If you have any further questions regarding your bill, insurance, or treatment, please check with me. I am here to help you in every way possible.

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW CAREFULLY:

THE HEALTH INSURANCE PORTABILITY & ACCOUNTABILITY ACT OF 1996 (“HIPAA”) IS A FEDERAL PROGRAM THAT REQUIRES THAT ALL MEDICAL RECORDS AND OTHER INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION USED OR DISCLOSED BY US IN ANY FORM, WHETHER ELECTRONICALLY, ON PAPER, OR ORALLY ARE KEPT PROPERLY CONFIDENTIAL. THIS ACT GIVES YOU, THE PATIENT, SIGNIFICANT NEW RIGHTS TO UNDERSTAND AND CONTROL HOW YOUR HEALTH INFORMATION IS USED. “HIPAA” PROVIDES PENALTIES FOR COVERED ENTITIES THAT MISUSE PERSONAL HEALTH INFORMATION.

AS REQUIRED BY “HIPAA,” I HAVE PREPARED THIS EXPLANATION OF HOW I AM REQUIRED TO MAINTAIN THE PRIVACY OF YOUR HEALTH INFORMATION AND HOW I MAY USE AND DISCLOSE YOUR HEALTH INFORMATION.

I WILL USE AND DISCLOSE YOUR PRIVATE HEALTH INFORMATION (PHI) FOR MANY DIFFERENT REASONS. FOR SOME OF THESE USES OR DISCLOSURES, I WILL NEED YOUR PRIOR WRITTEN AUTHORIZATION; FOR OTHERS, HOWEVER, I DO NOT. LISTED BELOW ARE THE DIFFERENT CATEGORIES OF MY USES AND DISCLOSURES, ALONG WITH SOME EXAMPLES OF EACH CATEGORY.

TREATMENT: I CAN USE YOUR PHI WITHIN MY PRACTICE TO PROVIDE YOU WITH MENTAL HEALTH TREATMENT, INCLUDING DISCUSSING OR SHARING YOUR PHI WITH MY TRAINEES OR INTERNS. I CAN DISCLOSE YOUR PHI TO PHYSICIANS, PSYCHIATRISTS, PSYCHOLOGISTS, AND OTHER LICENSED HEALTH

CARE PROVIDERS WHO PROVIDE YOU WITH HEALTH CARE SERVICES OR ARE INVOLVED IN YOUR CARE. FOR EXAMPLE, IF A PSYCHIATRIST IS TREATING YOU, I CAN DISCLOSE YOUR PHI TO YOUR PSYCHIATRIST TO COORDINATE YOUR CARE.

PAYMENT: I CAN USE YOUR PHI TO BILL AND COLLECT PAYMENT FOR THE TREATMENT AND SERVICES PROVIDED BY ME TO YOU. FOR EXAMPLE, I MIGHT SEND YOUR PHI TO YOUR INSURANCE COMPANY OR HEALTH PLAN TO GET PAID FOR THE HEALTH CARE SERVICES THAT I HAVE PROVIDED TO YOU. I MAY ALSO PROVIDE YOUR PHI TO MY BUSINESS ASSOCIATES, SUCH AS BILLING COMPANIES, CLAIMS PROCESSING COMPANIES, AND OTHERS THAT PROCESS MY HEALTH CARE CLAIMS.

HEALTH CARE OPERATIONS: I CAN USE AND DISCLOSE YOUR PHI TO OPERATE MY PRACTICE. FOR EXAMPLE, I MIGHT USE YOUR PHI TO EVALUATE THE QUALITY OF HEALTH CARE SERVICES THAT YOU RECEIVED OR TO EVALUATE THE PERFORMANCE OF THE HEALTH CARE PROFESSIONALS WHO PROVIDED SUCH SERVICES TO YOU. I MAY ALSO PROVIDE YOUR PHI TO MY ACCOUNTANT, ATTORNEY, CONSULTANTS, OR OTHERS TO FURTHER MY HEALTH CARE OPERATIONS.

PATIENT INCAPACITATION OR EMERGENCY: I MAY ALSO DISCLOSE YOUR PHI TO OTHERS WITHOUT YOUR CONSENT IF YOU ARE INCAPACITATED OR IF AN EMERGENCY EXISTS. FOR EXAMPLE, YOUR CONSENT ISN'T REQUIRED IF YOU NEED EMERGENCY TREATMENT, AS LONG AS I TRY TO GET YOUR CONSENT AFTER TREATMENT IS RENDERED. OR IF I TRY TO GET YOUR CONSENT, BUT YOU ARE UNABLE TO COMMUNICATE WITH ME (FOR EXAMPLE, IF YOU ARE UNCONSCIOUS OR IN SEVERE PAIN), AND I THINK THAT YOU WOULD CONSENT TO SUCH TREATMENT IF YOU WERE ABLE TO DO SO.

CERTAIN OTHER USES AND DISCLOSURES ALSO DO NOT REQUIRE YOUR CONSENT OR AUTHORIZATION. I CAN USE AND DISCLOSE YOUR PHI WITHOUT YOUR CONSENT OR AUTHORIZATION FOR THE FOLLOWING REASONS:

1. WHEN FEDERAL, STATE, OR LOCAL LAWS REQUIRE DISCLOSURE. FOR EXAMPLE, I MAY HAVE TO DISCLOSE TO APPLICABLE GOVERNMENT OFFICIALS WHEN A LAW REQUIRES THAT I REPORT INFORMATION TO GOVERNMENT AGENCIES AND LAW ENFORCEMENT PERSONNEL ABOUT VICTIMS OF ABUSE OR NEGLECT.
2. WHEN JUDICIAL OR ADMINISTRATIVE PROCEEDINGS REQUIRE DISCLOSURE. FOR EXAMPLE, IF YOU ARE INVOLVED IN A LAWSUIT OR A CLAIM FOR WORKERS' COMPENSATION BENEFITS.
3. I MAY HAVE TO DISCLOSE YOUR PHI IN RESPONSE TO A COURT OR ADMINISTRATIVE ORDER. I MAY ALSO HAVE TO USE OR DISCLOSE YOUR PHI IN RESPONSE TO A SUBPOENA.
4. WHEN LAW ENFORCEMENT REQUIRES DISCLOSURE. FOR EXAMPLE, I MAY HAVE TO USE OR DISCLOSE YOUR PHI IN RESPONSE TO A SEARCH WARRANT.
5. WHEN PUBLIC HEALTH ACTIVITIES REQUIRE DISCLOSURE. FOR EXAMPLE I MAY HAVE TO USE OR DISCLOSE YOUR PHI TO REPORT TO A GOVERNMENT OFFICIAL AN ADVERSE REACTION THAT YOU HAVE TO A MEDICATION.
6. WHEN HEALTH OVERSIGHT ACTIVITIES REQUIRE DISCLOSURE. FOR EXAMPLE, I MAY HAVE TO PROVIDE INFORMATION TO ASSIST THE GOVERNMENT IN CONDUCTING AN INVESTIGATION OR INSPECTION OF A HEALTH CARE PROVIDER OR ORGANIZATION.
7. TO AVERT A SERIOUS THREAT TO HEALTH OR SAFETY. FOR EXAMPLE, I MAY HAVE TO USE OR DISCLOSE YOUR PHI TO AVERT A SERIOUS THREAT TO THE HEALTH OR SAFETY OF OTHERS. HOWEVER, ANY SUCH DISCLOSURES WILL ONLY BE MADE TO SOMEONE ABLE TO PREVENT THE THREATENED HARM FROM OCCURRING.
8. FOR SPECIALIZED GOVERNMENT FUNCTIONS. FOR EXAMPLE, IF YOU ARE IN THE MILITARY, I MAY HAVE TO USE OR DISCLOSE YOUR PHI FOR NATIONAL SECURITY PURPOSES, INCLUDING PROTECTING THE PRESIDENT OF THE UNITED STATES OR CONDUCTING INTELLIGENCE OPERATIONS.
9. TO REMIND YOU ABOUT APPOINTMENTS AND TO INFORM YOU OF HEALTH RELATED BENEFITS OR SERVICES. FOR EXAMPLE, I MAY HAVE TO USE OR DISCLOSE YOUR PHI TO REMIND YOU ABOUT YOUR APPOINTMENTS, OR TO GIVE YOU INFORMATION ABOUT TREATMENT ALTERNATIVES, OTHER HEALTH CARE SERVICES, OR OTHER HEALTH CARE BENEFITS THAT I OFFER THAT MAY BE OF INTEREST TO YOU.

ANY OTHER USES AND DISCLOSURES WILL BE MADE ONLY WITH YOUR WRITTEN AUTHORIZATION. YOU MAY REVOKE SUCH AUTHORIZATION IN WRITING, AND WE ARE REQUIRED TO HONOR AND ABIDE BY THAT WRITTEN REQUEST, EXCEPT TO THE EXTENT THAT WE HAVE ALREADY TAKEN ACTIONS RELYING ON YOUR AUTHORIZATION.

YOU HAVE THE FOLLOWING RIGHTS WITH RESPECT TO YOUR PROTECTED HEALTH INFORMATION WHICH YOU CAN EXERCISE BY PRESENTING A WRITTEN REQUEST TO THE PRIVACY OFFICER:

- THE RIGHT TO REQUEST RESTRICTIONS ON CERTAIN USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION; INCLUDING THOSE RELATED TO DISCLOSURES TO FAMILY MEMBERS, OTHER RELATIVES, CLOSE PERSONAL FRIENDS, OR ANY OTHER PERSON IDENTIFIED BY YOU.
- WE ARE HOWEVER, NOT REQUIRED TO AGREE TO A REQUESTED RESTRICTION. IF WE DO AGREE TO A RESTRICTION, WE MUST ABIDE BY IT UNLESS YOU AGREE IN WRITING AND REMOVE IT. HOWEVER, BE ADVISED, THAT YOU MAY NOT LIMIT THE USES AND DISCLOSURES THAT I AM LEGALLY REQUIRED TO MAKE.
- THE RIGHT TO REASONABLE REQUESTS TO RECEIVE CONFIDENTIAL COMMUNICATIONS OF PROTECTED HEALTH INFORMATION FROM ME BY ALTERNATIVE MEANS OR AT ALTERNATIVE LOCATIONS.
- THE RIGHT TO INSPECT AND COPY YOUR PROTECTED HEALTH INFORMATION., BUT YOU MUST MAKE YOUR REQUEST IN WRITING.
- THE RIGHT TO AMEND YOUR PROTECTED HEALTH INFORMATION.
- THE RIGHT TO RECEIVE AN ACCOUNTING OF DISCLOSURES OF PROTECTED HEALTH INFORMATION.
- THE RIGHT TO OBTAIN A PAPER COPY OF THIS NOTICE FROM ME UPON REQUEST.

THIS NOTICE IS EFFECTIVE AS OF TODAY'S DATE, AND I AM REQUIRED TO ABIDE BY THE TERMS OF THE NOTICE OF PRIVACY PRACTICE CURRENTLY IN EFFECT. I RESERVE THE RIGHT TO CHANGE THE TERMS OF OUR NOTICE OF PRIVACY PRACTICES AND TO MAKE THE NEW NOTICE PROVISIONS EFFECTIVE FOR ALL PROTECTED HEALTH INFORMATION THAT I MAINTAIN. I WILL PROVIDE YOU WITH A WRITTEN COPY OF A REVISED NOTICE OF PRIVACY PRACTICES FROM ME.

IF YOU THINK THAT I MAY HAVE VIOLATED YOUR PRIVACY RIGHTS, OR YOU DISAGREE WITH A DECISION I MADE ABOUT ACCESS TO YOUR PHI, YOU MAY FILE A WRITTEN COMPLAINT TO THE SECRETARY OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES AT 200 INDEPENDENT AVENUE S.W. , WASHINGTON D.C. 20201. I WILL TAKE NO RETALIATORY ACTION AGAINST YOU IF YOU FILE A COMPLAINT ABOUT MY PRIVACY PRACTICES.