CONSENT FOR PSYCHOTHERAPY AND/OR EVALUATION

The following policies and expectations pertain to the psychology services at this office. Please read the following information and if you have any questions, please feel free to ask me.

Services: The psychological services we provide include diagnostic evaluation, individual psychotherapy, family therapy, couples therapy, parenting consultation, and consultation with other professionals (teachers, physicians, etc.) when needed and with your consent.

Psychotherapy is consultation with a psychologist to meet specific emotional or behavioral goals. In order for therapy to be most successful, you will have to be open and honest with your therapist during sessions, and work on the things you and your therapist talk about outside of sessions, at home and in the community. In order to get the most out of a session, please arrive on time, as we cannot extend a session past the scheduled time. Most sessions last 50 minutes.

Psychological evaluation services include administration of scientifically validated instruments and questionnaires. They also include interviews with you, and any individuals you feel should have input on the evaluation. The purpose of psychological evaluation is to provide a diagnosis and detailed information about your psychological functioning. It is not intended to treat or cure any psychological condition. No guarantee of outcome can be made in advance.

Confidentiality: The clinician-client relationship is confidential. Your presence and what you discuss is held in strict confidence and will not be shared with any other individual without your express written consent, except as required by law, as follows:

I. If I have reasonable cause to suspect that a child is being abused or neglected, I must report this to the county's Child Protective Services or police.

II. If I have reasonable cause to suspect that an elder or dependent adult is being abused or neglected, I must report this to the appropriate county agency.

III. If I have reason to believe that you or your child may cause serious harm to yourself/themselves or to another person, I will take protective actions. These may include contacting family members, seeking hospitalization, notifying any potential victims of violence, and/or notifying the police.

Payment: Clients are expected to pay for services, including copays, at the time services are rendered unless other arrangements have been made. Please notify your therapist if any problem arises during the course of treatment regarding your ability to make timely payments. There will be a $30.00 charge for all returned checks due to fines imposed by the bank.

Insurance: Dr. Anvin accepts the following insurance plans: Cigna, Anthem Blue Cross, Claremont & Victim Witness. In the case that your plan denies services, you will be billed directly for services, at the rate negotiated by your plan. If you are not covered under one of the above networks, you will be directly responsible for paying for services at the rate of $140 per hour for therapy, $160 for evaluations. Upon request, your therapist can provide you with a receipt that you may submit to your insurance company for reimbursement.

Cancellation: 24 hours notice is required for rescheduling or canceling an appointment. One-half the hourly fee will be charged for late cancellation. Missed appointments without cancellation will be billed the full hourly fee.

Out-of-Session Services Brief (10 minutes or less) conversations will not be charged. However, time devoted to treatment and assessment other than office visits is charged on a prorated bases according to the regular fee schedule. This includes school visits, lengthy consultations in person and by phone with other professionals, lengthy telephone conversations with the client or parent or guardian of the client, extensive collection and preparation of data, and the preparation and writing of letters and reports. Please note that these services may not be covered by your insurance and you may have additional costs for out of session services.

I understand and agree with the above information wish to engage in
❑ Therapy and/or ❑ Evaluation services with Dr. Susan Anvin.

_____

Name of Client

_____

Signature of Client **Date**

_____ Please initial that you have received a copy of my Privacy Practices

Insurance Information: (required only if using one of the above insurance plans)

Insurance provider: _____ Policy Number: _____
Group Number: _____
Insured's Name: _____ Phone: (_____) _____
Client relationship to insured: ❑ Self ❑ Spouse ❑ Child ❑ Other: _____
Insured's Address:_____
Insured's Date of Birth: _____/_____/_____ Insured's SSN: _____
Insured's Employer: _____ Insured's Gender: ❑ Male ❑ Female

Is there another health benefit plan? (Y/N) If so, please answer below:
Insurance provider: _____ Policy Number: _____
Group Number: _____
Insured's Name: _____ Phone: (_____) _____
Client relationship to insured: ❑ Self ❑ Spouse ❑ Child ❑ Other: _____
Insured's Address:_____
Insured's Date of Birth: _____/_____/_____ Insured's SSN: _____
Insured's Employer: _____ Insured's Gender: ❑ Male ❑ Female

I authorize the release of any medical or other information necessary to process any claims resulting from this agreement with the insurers above. I authorize payment of medical benefits to Dr. Susan Anvin for the services described in this agreement.

_____

Signature of Client **Date**

PRIVACY PRACTICES FOR ADVANCING MINDS
Effective November 1, 2006

This notice describes how health information about you may be used and disclosed and how you can get access to this information. Please review it carefully and if you have any questions, please contact us at 408-294-9905

I. INTRODUCTION

This notice of Privacy Practices describes how Psychologists may use and disclose your Protected Health Information (PHI) for purposes permitted or required by law. PHI means health information, including identifying information, we collected from you and/or your health care providers, health plans, or health care clearinghouse. It may include information about your past, present or future physical or mental health condition, the provision of your health care, and payment for your health care services. This notice also describes our obligations to protect your health information and your rights and how you may exercise these rights regarding your health information. We will comply with the terms of this notice, however, we may modify this notice at any time and the new notice will be effective for all PHI in our possession at the time, or received after, the change. Upon request, we will provide you with any revised notice.

II. HOW WE WILL USE AND DISCLOSE YOUR HEALTH INFORMATION

I will use and disclose your health information as described below. These descriptions only generally describe disclosures of your PHI and does not describe all specific uses or disclosures.

A) **Uses and disclosures for treatment, payment, and operations**

1. Treatment

I will use and disclose your health information to provide, coordinate, or manage your health care and any related service. For example, I may use your PHI to contact you, or with you consent share PHI with other professionals.

2. Payment

I may use or disclose your health information to collect payment from a third party for your services. For example, I may disclose your information to your health plan so they can take certain actions before your health plan approves or pays for your services. I may also disclose your health information to another health care provider so they can bill you for services they provided to you. For example, an ambulance service that transported you to the hospital.

B) Uses and disclosures that may be made without your authorization, but for which you will have an opportunity to object

If asked, we will not confirm orally, in writing or through any other medium that you are our current or former client, with the exception of persons involved in your care. In this situation, we may provide health information about you to someone who helps pay for your care or to notify or assist in notifying a family member, personal representative, or any other person that is responsible for your care of your location, general condition, or death. We may also use or disclose your health information to an entity assisting in disaster relief efforts and to coordinate uses and disclosures for this purpose to family or other individuals involved in your health care. We may disclose your health information to a spouse, family member, or a friend so that such person may assist in your care during emergency situations, if we determine that it is in your best interest. We will only disclose information that is directly relevant to participation in your care.

C) Uses and disclosures that may be made without your authorization or opportunity to object

1. Emergencies

I may use and disclose your health information in an emergency treatment situation. A clinician required to treat by law may use or disclose your PHI to treat you, even if they have attempted to obtain your authorization but were unable to do so. For example, I may provide health information to a paramedic who is transporting you in an ambulance.

2. As Required By Law

I will disclose health information about you when required to do so by federal, state, or local law. For example, in response to a court order or to respond to a threat of an imminently dangerous activity by you against yourself or another person.

III. USES AND DISCLOSURES OF YOUR HEALTH INFORMATION WITH YOUR PERMISSION

I will request your written authorization for uses and disclosures of your health information that we did not identify in this notice or for those not otherwise permitted by law. You have the right to revoke an authorization at any time. If you revoke your authorization I will not make any further uses or disclosures of your health information under that authorization, unless I have already taken action relying upon the uses or disclosures you have previously authorized.

IV. YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION

1. Inspect and Copy

You may request access to inspect or copy your health information maintained in our records, including clinical and billing records. You must submit your request in writing and I may charge a fee for the cost of copying, mailing, and supplies associated with your request. In limited circumstances I may deny your request. In some cases, you will have the right to have the denial reviewed in writing if the denial of your request may be reviewed. Once the review is completed, I will honor the decision made by the licensed health care professional reviewer.

2. Amend

You may request that I amend your health information if you believe that it is incorrect or incomplete. To request an amendment, you must submit a written document and explain why you believe the information is incorrect. In some cases, I may deny your request. For example, your request is not in writing or the information is accurate and complete.

3. Accounting of Disclosures

You have the right to receive a list of instances in which I disclosed your health information for purposes, other than treatment, payment, and certain other activities, for the last 6 years. I may charge you a reasonable, cost-based fee if the accounting is more than once in a year.

4. Request Restrictions

You may request restrictions on certain uses of your health information regarding treatment, payment or health care operations. You must make your request in writing and it must specify the information you wish restricted and how you want it restricted. I am not required to honor your request. If I do agree to a restriction, I will honor your request until I receive notice that you no longer want the restriction or unless I need the information to provide you with emergency treatment.

5. Request Confidential Communications

You may request that we communicate with you about your healthcare only in a certain method. For example, you may want wish to be contacted only at work. Please specify how and where you wish to be contacted and I will accommodate all reasonable requests.

V. COMPLAINTS

You may file a complaint with us or with the Secretary of the U.S. Department of Health and Human Services if you believe your rights have been violated. Please submit all complaints in writing. We will not retaliate against you for filing a complaint.

INTAKE QUESTIONNAIRE – ADULT HISTORY FORM

Please fill out all the information to the best of your ability and if you have any questions, please feel free to ask us.

Identifying Information:

Name: _____ Date of Birth: _____

Address: _____

Phone – Home: _____ Work: _____ Cell: _____

Occupation: _____Employer:_____

Ethnicity: _____ Marital status: _____

Living Situation: Living Alone / With Friends / With Spouse or Partner / With Parents / _____

Emergency contact: _____

Reason for Evaluation/Treatment:

Please describe briefly why you are seeking treatment/evaluation at this time: _____

_____

_____

_____

How long have you noticed these concerns?_____

What have you tried so far to manage these concerns? _____

_____

_____

_____

Please mark the difficulties you have now, or have had in the past:

Behavior	Now	Past	Behavior	Now	Past	Behavior	Now	Past
Trouble paying attention			Feeling anxious, tense, or worried			Trouble falling asleep		
Hyperactive			Panic attacks			Waking early and cannot sleep		
Disorganized			Phobias or unusual fears			Cannot wake up in morning		
Problems with work/school			Feeling tired or fatigued			Fall asleep during day		
Making careless errors			Feeling sad or upset			Frequent headaches		
Loses things / Forgetful			Indecisive			Frequent stomach aches/nausea		
Accident prone			Have frequent mood swings			Frequent body aches/pains		
Losing temper			Withdrawn / avoid friends			Lost/Gained weight unintentionally		
Irritable / Easily annoyed			Low self-esteem			Hearing voices / Seeing things		
Sensitive / Feelings easily hurt			Tearfulness/crying spells			Drinking excessively		
Feeling dangerous or out-of-control			Thoughts of death/suicide			Use of illegal drugs		

Medical History:

Does you have any current illnesses? _____

Any chronic health problems? (asthma, heart conditions, diabetes)_____

Are you taking any medications? Yes / No. If yes, please list medication and dosage:

_____

_____

Are you allergic to any medications (Y/N), food (Y/N) or other (Y/N)? If so please list:_____

_____

_____

Have you ever been in the hospital? When and why? _____

Have you ever had a head injury or seizure? When? _____

How often each week do you use alcohol?_____When did you last drink? _____

How often each week do you use cigarettes?_____When did you last smoke?_____

How often each week do you use marijuana?_____When did you last smoke? _____

How often each week do you use other drugs?_____When did you last use?_____

Mental Health History:

Have you seen a therapist or psychologist before? Yes / No. If yes:

When and where? _____

For what concerns? _____

Was treatment helpful? _____

Have you been evaluated for learning difficulties before? Yes / No. If yes, state date and results:

_____

Have you ever been hospitalized for psychological reasons? _____

Have you been physically, emotionally or sexually abused? _____

Does anyone in your extended family (parents, siblings, aunts, uncles, cousins, grandparents) suffer (now or in the past) from the following difficulties? If so state whom.

Depression: _____ Bipolar Disorder: _____

Anxiety: _____ Schizophrenia: _____

Learning Disabilities: _____ ADHD/ADD: _____

Alcohol abuse/addiction: _____ Drug abuse/addiction: _____

Has any relative been hospitalized for psychological reasons? _____

_____