

CONFIDENTIAL CLIENT INFORMATION

Client's Name \_\_\_\_\_ Date \_\_\_\_\_

Address \_\_\_\_\_ Date of Birth \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
Age \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

Cell Phone \_\_\_\_\_

May I call you at home?  Yes  No      Okay to leave a message at home?  Yes  No

May I call your cell?  Yes  No      Okay to leave a message on cell?  Yes  No

May I email you?  Yes  No      Email address: \_\_\_\_\_

Person to notify in the event of an emergency \_\_\_\_\_

Emergency contact's relationship to you \_\_\_\_\_ Contact's phone \_\_\_\_\_

List family members and others in your home

Name	Age	Relationship	Occupation

Medications and supplements taken

Medication	Dosage	Prescribing Physician

Current Treatment Providers

	Name	Phone	Last Seen
Physician			
Psychiatrist			
Therapist			
Other			

Please provide any other information you would like us to know

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## **OFFICE POLICIES & GENERAL INFORMATION** **AGREEMENT FOR PSYCHOTHERAPY SERVICES**

**The following is an outline of my office policies. Please read this information carefully and feel free to ask any questions you may have.**

I am licensed within the State of California as a Clinical Social Worker (LCS #23923).

Although I am in an independent private practice, I work closely, whenever possible and appropriate, with my professional associates. I also utilize professional consultations in order to continually improve my professional skills. I meet regularly with my associates and other professionals for case management and consultation. These professionals must also abide by the ethical rules of confidentiality. I will assume I have your permission to discuss your case (not your name or other identifying information) with any of my colleagues. If this is not acceptable to you, please let me know.

**The Process of Therapy:** A therapy session typically lasts 45-50 minutes, beginning on the hour and ending at 10 minutes before the next. I encourage you to arrive five to ten minutes early to mentally “switch gears” and take advantage of the entire session time.

**Risks and Benefits:** Participation in therapy can result in a number of benefits to you, including improving interpersonal relationships and resolution of the specific concerns that led you to seek therapy. Working toward these benefits, however, requires effort on your part. Psychotherapy requires your very active involvement, honesty and openness in order to change your thoughts, feelings, and/or behavior. I will ask for your feedback and views on your therapy, its progress and other aspects of the therapy, and will encourage you to respond openly and honestly.

During therapy, remembering or talking about unpleasant events, feelings, or thoughts can result in your experiencing considerable discomfort or strong feelings of anger, sadness, worry, fear, etc., or experiencing anxiety, depression, insomnia, etc. As your therapist, I may challenge some of your assumptions or perceptions, or propose different ways of looking at, thinking about, or handling situations that can cause you to feel upset, angry, depressed, challenged, or disappointed. Attempting to resolve issues that brought you to therapy in the first place, such as personal or interpersonal relationships, may result in changes that were not originally intended.

Psychotherapy may result in decisions about changing behaviors, employment, substance use, schooling, housing or relationships. Sometimes a decision that is positive for one family member is viewed quite negatively by another family member. Change will sometimes be easy and swift, but more often it will be slow and even frustrating. Although I certainly expect that psychotherapy will yield positive or intended results, there is no way to guarantee this.

Sometimes more than one approach can be helpful in dealing with a certain situation. During the course of therapy, I will draw on various psychological approaches according, in part, to the problem that is being treated and my assessment of what will best benefit you. These approaches may include but are not limited to behavioral, cognitive, psychodynamic, system/family, developmental, somatic, EMDR (Eye Movement Desensitization and Reprocessing), Pia Melody's **Model of Developmental Immaturity** and/or psycho-educational techniques. I welcome any questions you may have about the therapy process and practices so please feel free to discuss these with me.

**Confidentiality:** All information disclosed during sessions, including that of minors, is confidential, and may not be revealed by me to anyone without prior written consent by you, except where disclosure is either permitted or is required by law. Disclosure is *mandated* under the following circumstances:

- 1) When the client communicates a threat of bodily injury to another person;**
- 2) When the client is imminently suicidal;**
- 3) When there is a reasonable suspicion that child abuse or neglect or abuse to a dependent or elder adult has occurred or is likely to occur;**
- 4) When information is ordered pursuant to a legal proceeding.**

I will, under no circumstances, release such information to appropriate authorities without first sharing my intention to do so with the client.

In order to provide you with the best care, I maintain regular professional consultation, and participate in mandatory continuing education. At no time is a client's name or identifying data revealed to others without prior written consent by you, the client.

**Payment and Insurance:** My fee is \$140.00 for a 50-minute session. Payment is due at the end of each session. You may pay by check, cash or credit card. If you pay by check, it is preferred that you bring a completed check with you to each session so that check-writing will not interfere with your full amount of time.

Some insurance companies will cover your mental health session. Please check with your insurance provider as to your coverage, your current deductible. I will be happy to supply you with a Statement to submit for reimbursement to your provider.

At times, if EMDR (Eye Movement Desensitization and Reprocessing) is utilized as a treatment modality, we may decide on longer sessions. This will be fully discussed with you and charges will be pro-rated according to our fee arrangement.

**Discussion of Treatment Plan:** Within a reasonable period of time after the initiation of treatment, I will discuss with you my working understanding of the problem, treatment plan, therapeutic objectives and my view of the possible outcomes of treatment. If you have any unanswered questions about any of the procedures used in the course of your therapy, the possible risks, or about the treatment plan, please ask and you will be answered fully. You also have the right to ask about other treatments for your condition and their risks and benefits. If you could benefit from any treatment that I do not provide, I have an ethical obligation to assist you in obtaining these treatments and will gladly do so.

**Cancellation: Since the scheduling of an appointment involves reservation of a time set especially for you, a minimum of 24-hour notice is required for rescheduling an appointment. This time will allow me to adjust my schedule. Thank you for honoring my policy.**

To avoid being charged for the canceled session, please make sure to call in your cancellation a **full 24 hours** in advance of the scheduled appointment. If feasible, I will reschedule a missed session or a late cancellation if the new appointment can be made during the same week. If, for any reason, rescheduling the same week is not possible, and **if a full 24 hours advance cancellation is not received, full payment for the missed session is due.**

**Emergency Consultation:** If you need to contact me for an emergency between sessions, please leave a message on my office voice mail at 310.897.0410, leaving your name and your phone number. I will call you back as soon as I possibly can. If you need to talk to someone right away, or if there is a life-threatening emergency, please hang up and dial 911 or go to the nearest Emergency Room at a local hospital. When I am out of town, or otherwise not available, I will leave information as to whom if anyone will be available during my absence.

Between sessions, if you feel a need to talk to me, I am available for brief conversations without charge. If the particular problem or situation requires **more than 10 minutes**, we can schedule time to meet prior to your next regular session or set an emergency session by phone. **The phone session will be subject to our pre-set fee.**

**Continuing Education:** Please be advised that I am out of the office approximately 2-3 weeks per year. I take my continuing education seriously; at times I will be away at conferences and at other times, it will be for vacation.

If you have any questions, please feel free to ask me any time. If there is an unexpected change in your circumstances, financial or otherwise, please discuss it with me. I want our therapeutic relationship to be open, free of miscommunication and misunderstanding. The trust and confidence you expressed in selecting me as your therapist is greatly appreciated.

***Emails, Cell Phones, Computers and Faxes:*** It is very important to be aware that computers, emails and cell phone communications can be relatively easy to access by unauthorized individuals, and hence can compromise the privacy and confidentiality of such communication. Emails, in particular, are vulnerable to such unauthorized access. If you should decide to communicate confidential or private information via email, I will assume that you have made an informed decision that you are agreeing to take that risk that this communication may be intercepted. However, to protect your confidentiality, I will respond to emails regarding appointments and will not respond to other emails.

***Terminating Treatment:*** Termination from therapy is an important process, which can be of benefit to clients and therapist. This is an important opportunity to reflect on progress, or lack of, and the process of where you are now and where you hope to be going. I encourage client to participate with me in this process of finding out what was helpful, as well as what could have been more helpful. It is your right to terminate therapy at any time. If you choose to terminate, I will be glad to provide referrals to qualified professionals. I do request that you do come in to discuss leaving and any feelings that may be associated with the process. As your therapist, I have the right and duty to terminate therapy under the following circumstances: when I assess that treatment is no longer helpful or beneficial to you, if I determine that another professional would better serve your needs, if you have not paid for the last two sessions without the required 24-hour notice of cancellation. In all cases I will be happy to provide you with resources and referrals as necessary.

**California's AB1775 New Child Pornography Law**

**California's AB1775 New Child Pornography Law in Effect January 1, 2015, requires psychotherapists, counselors and other mental health professionals to report if a client has knowingly downloaded, streamed, or accessed (that is, viewed) an electronic or digital image in which anyone under 18 is engaged in an act of obscene sexual conduct.**

I authorize and request my therapist to carry out psychological evaluations, treatment and/or diagnostic procedures that now, or during the course of my treatment become advisable. I understand the purpose of these procedures will be explained to me upon my request, and are outlined above in this document, and that they are subject to my agreement.

***Client signature*** \_\_\_\_\_ ***Date:*** \_\_\_\_\_

***Client signature:*** \_\_\_\_\_ ***Date:*** \_\_\_\_\_

# 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 IT CAREFULLY.**

## **I. I HAVE A LEGAL DUTY TO SAFEGUARD YOUR PROTECTED HEALTH INFORMATION (PHI)**

I am legally required to protect the privacy of your PHI, which includes information that can be used to identify you that I've created or received about your past, present, or future health or condition, the provision of health care to you, or the payment of this health care. I must provide you with this Notice about my privacy practices, and such Notice must explain how, when, and why I will "use" and "disclose" your PHI. A "use" of PHI occurs when I share, examine, utilize, apply, or analyze such information within my practice; PHI is "disclosed" when it is released, transferred, has been given to, or is otherwise divulged to a third party outside of my practice. With some exceptions, I may not use or disclose any more of your PHI than is necessary to accomplish the purpose for which the use or disclosure is made. And, I am legally required to follow the privacy practices described in this Notice.

However, I reserve the right to change the terms of this Notice and my privacy policies at any time. Any changes will apply to PHI on file with me already. Before I make any important changes to my policies, I will promptly change this Notice and post a new copy of it in my office and on my website. You can also request a copy of this Notice from me, or you can view a copy of it in my office or at my website, which is located at [www.karencoreylcsw.com](http://www.karencoreylcsw.com).

## **II. HOW I MAY USE AND DISCLOSE YOUR PHI.**

I will use and disclose your PHI for many different reasons. For some of these uses or disclosures, I will need your prior 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.

### **A. Uses and Disclosures Relating to Treatment, Payment, or Health Care Operations Do Not Require Your Prior Written Consent.** I can use and disclose your PHI without your consent for the following reasons:

**1. For treatment.** 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 you're being treated by a psychiatrist, I can disclose your PHI to your psychiatrist in order to coordinate your care.

**2. To obtain payment for treatment.** I can use and disclose 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.

**3. For health care operations.** I can 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 our accountants, attorneys, consultants, and others to make sure I'm complying with applicable laws.

**4. Other disclosures.** I may also disclose your PHI to others with-out your consent in certain situations. 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.

**B. Certain Uses and Disclosures Do Not Require Your Consent.** I can use and disclose your PHI without your consent or authorization for the following reasons:

- 1. When disclosure is required by federal, state or local law; judicial or administrative proceedings; or, law enforcement.** For example, I may make a disclosure to applicable officials when a law requires me to report information to government agencies and law enforcement personnel about victims of abuse or neglect; or when ordered in a judicial or administrative proceeding.
- 2. For public health activities.** For example, I may have to report information about you to the county coroner.
- 3. For health oversight activities.** For example, I may have to provide information to assist the government when it conducts an investigation or inspection of a health care provider or organization.
- 4. For research purposes.** In certain circumstances, I may provide PHI in order to conduct medical research.
- 5. To avoid harm.** In order to avoid a serious threat to the PHI to law enforcement personnel or persons able to prevent or lessen such harm.
- 6. For specific government functions.** I may disclose PHI of military personnel and veterans in certain situations. And I may disclose PHI for national security purposes, such as protecting the President of the United States or conducting intelligence operations.
- 7. For workers' compensation purposes.** I may provide PHI in order to comply with workers' compensation laws.

**Appointment reminders and health related benefits or services.** I may use PHI to provide appointment reminders or give you information about treatment alternatives, or other health care services or benefits I offer.

**C. Certain Uses and Disclosures Require You to Have the Opportunity to Object.**

1. Disclosures to family, friends, or others. I may provide your PHI to a family member, friend, or other person that you indicate is involved in your care or the payment for your health care, unless you object in whole or in part. The opportunity to consent may be obtained retroactively in emergency situations.

**D. Other Uses and Disclosures Require Your Prior Written Authorization.** In any other situation not described in sections III A, B, and C above, I will ask for your written authorization before using or disclosing any of your PHI. If you choose to sign an authorization to disclose your PHI, you can later revoke such authorization in writing to stop any future uses and disclosures (to the extent that I haven't taken any action in reliance on such authorization) of your PHI by me.

**III. WHAT RIGHTS YOU HAVE REGARDING YOUR PHI**

**You have the following rights with respect to your PHI:**

**A. The Right to Request Limits on Uses and Disclosures of Your PHI.** You have the right to ask that I limit how I use and disclose your PHI. I will consider your request, but I am not legally required to accept it. If I accept your request, I will put any limits in writing and abide by them except in emergency situations. You may not limit the uses and disclosures that I am legally required or allowed to make.

**B. The Right to Choose How I Send PHI to You.** You have the right to ask that I send information to you to at an alternate address (for example, sending information to your work address rather than your home address) or by alternate means (for example, e-mail instead of regular mail) I must agree to your request so long as I can easily provide the PHI to you in the format you requested.

**C. The Right to See and Get Copies of Your PHI.** In most cases, you have the right to look at or get copies of your PHI that I have, but you must make the request in writing. If I don't have your PHI but I know who does, I will tell you how to get it. I will respond to you within 30 days of receiving your written request. In certain situations, I may deny your request. If I do, I will tell you, in writing, my reasons for the denial and explain your right to have my denial reviewed. If you request copies of your PHI, I will charge you not more than \$.25 for each page. Instead of providing the PHI you requested, I may provide you with a summary or explanation of the PHI as long as you agree to that and to the cost in advance.

**D. The Right to Get a List of the Disclosures I Have Made.**

You have the right to get a list of instances in which I have disclosed your PHI. The list will not include uses or disclosures that you have already consented to, such as those made for treatment, payment, or health care operations, directly to you, or to your family. The list also won't include uses and disclosures made for national security purposes, to corrections or law enforcement personnel, or disclosures made before April 15, 2003.

I will respond to your request for an accounting of disclosures within 60 days of receiving your request. The list I will give you will include disclosures made in the last six years unless you request a shorter time. The list will include the date of the disclosure, to whom PHI was disclosed (including their address, if known), a description of the information disclosed, and the reason for the disclosure. I will provide the list to you at no charge, but if you make more than one request in the same year, I will charge you a reasonable cost based fee for each additional request.

**E. The Right to Correct or Update Your PHI.** If you believe that there is a mistake in your PHI or that a piece of important information is missing, you have the right to request that I correct the existing information or add the missing information. You must provide the request and your reason for the request in writing. I will respond within 60 days of receiving your request to correct or update your PHI. I may deny your request in writing if the PHI is (i) correct and complete, (ii) not created by me, (iii) not allowed to be disclosed, or (iv) not part of my records. My written denial will state the reasons for the denial and explain your right to file a written statement of disagreement with the denial. If you don't file one, you have the right to request that your request and my denial be attached to all future disclosures of your PHI. If I approve your request, I will make the change to your PHI, tell you that I have done it, and tell others that need to know about the change to your PHI.

**F. The Right to Get This Notice by E-Mail.** You have the right to get a copy of this notice by e-mail. Even if you have agreed to receive notice via e-mail, you also have the right to request a paper copy of it.

**IV. HOW TO COMPLAIN ABOUT MY PRIVACY PRACTICES**

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 complaint with the person listed in Section VI below. You also may send a written complaint to the Secretary of the Department of Health and Human Services at 200 Independence Avenue S.W., Washington, D.C. 20201. I will take no retaliatory action against you if you file a complaint about my privacy practices.

**V. PERSON TO CONTACT FOR INFORMATION ABOUT THIS NOTICE OR TO COMPLAIN ABOUT MY PRIVACY PRACTICES**

If you have any questions about this notice or any complaints about my privacy practices, or would like to know how to file a complaint with the Secretary of the Department of Health and Human Services, please contact: Karen R. Corey, 310.897.0410. If Karen R. Corey is not available, you may make an appointment for a personal conference in person or by telephone within 2 working days.

**VI. EFFECTIVE DATE OF THIS NOTICE**

This notice went into effect on April 14, 2003.

*Karen R. Corey, LCSW*  
*License LCS 23923*  
*326 South Pacific Coast Highway, Suite 205,*  
*Redondo Beach, CA 90277*  
*310.897.0410*

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I have received a copy of the latest guidelines related to disclosure and privacy of my PROTECTED HEALTH INFORMATION (PHI).

These guidelines went into effect on April 14, 2003.

Signature \_\_\_\_\_ Date \_\_\_\_\_

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(This documented activity will be kept on file)