CLIENT INFORMATION SHEET

Name:_____ **Date of Intake:** _____

Sex:_____ **Birthdate:**_____ **Age:**_____ **SS#:**_____

_____

Street Address ***City*** ***State*** ***Zip***

Phone #s (include one emergency contact):

Number	***Contact: self, parent, spouse, etc.***	***Type: home, cell, etc.***
(_____)_____	_____	_____
(_____)_____	_____	_____
(_____)_____	_____	_____

Referred by:_____ **Relation** (PCP, friend, therapist, etc):_____

Primary Insurance:

Company/Plan:_____ **ID#**:_____

Group#:_____ **Name of Primary Insured:**_____

Birthdate of Primary Insured:_____ **Relation to client:** _____

Secondary Insurance (if any):

Company/Plan:_____ **ID#**:_____

Group#:_____ **Name of Primary Insured:**_____

Birthdate of Primary Insured:_____ **Relation to client:** _____

Family Information (list any relations who may be referenced, or included, in therapy):

Name	**Relation:**	**Age:**	**Profession:**	**Living Situation:**

Any special family circumstances (adoption, foster care, divorce):_____

_____

_____

_____

SCHOOL INFORMATION (for school-age clients)

Current School:_____ Grade: _____

_____

Street Address *City* *State* *Zip*

Contact Person: _____ Phone: _____

Any Current Support Services (IEP, 504 plan, Special Education, etc.):

Service: Date/Grade Started: Description:

Significant Educational History (including bullying, struggles with grades/homework)**:**

Michael Parker, LCSW
2526 Monroeville Blvd, Ste 208
Monroeville, PA 15146
412-256-8256

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 THIS NOTICE CAREFULLY.

Your health record contains personal information about you and your health. This information about you that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services is referred to as Protected Health Information ("PHI"). This Notice of Privacy Practices describes how I may use and disclose your PHI in accordance with applicable law, including the Health Insurance Portability and Accountability Act ("HIPAA"), regulations promulgated under HIPAA including the HIPAA Privacy and Security Rules, and the *NASW Code of Ethics*. It also describes your rights regarding how you may gain access to and control your PHI.

I am required by law to maintain the privacy of PHI and to provide you with notice of our legal duties and privacy practices with respect to PHI. I am required to abide by the terms of this Notice of Privacy Practices. I reserve the right to change the terms of our Notice of Privacy Practices at any time. Any new Notice of Privacy Practices will be effective for all PHI that I maintain at that time. I will provide you with a copy of the revised Notice of Privacy Practices by posting a copy on our website, sending a copy to you in the mail upon request or providing one to you at your next appointment.

HOW I MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

For Treatment. Your PHI may be used and disclosed by those who are involved in your care for the purpose of providing, coordinating, or managing your health care treatment and related services. This includes consultation with clinical supervisors or other treatment team members. I may disclose PHI to any other consultant only with your authorization.

For Payment. I may use and disclose PHI so that I can receive payment for the treatment services provided to you. This will only be done with your authorization. Examples of payment-related activities are: making a determination of eligibility or coverage for insurance benefits, processing claims with your insurance company, reviewing services provided to you to determine medical necessity, or undertaking utilization review activities. If it becomes necessary to use collection processes due to lack of payment for services, I will only disclose the minimum amount of PHI necessary for purposes of collection.

For Health Care Operations. I may use or disclose, as needed, your PHI in order to support our business activities including, but not limited to, quality assessment activities, employee review activities, licensing, and conducting or arranging for other business activities. For example, I may share your PHI with third parties that perform various business activities (e.g., billing or typing services) provided I have a written contract with the business that requires it to safeguard the privacy of your PHI. For training or teaching purposes PHI will be disclosed only with your authorization.

Required by Law. Under the law, I must disclose your PHI to you upon your request. In addition, I must make disclosures to the Secretary of the Department of Health and Human Services for the purpose of investigating or determining our compliance with the requirements of the Privacy Rule.

Without Authorization. Following is a list of the categories of uses and disclosures permitted by HIPAA without an authorization. Applicable law and ethical standards permit us to disclose information about you without your authorization only in a limited number of situations. As a social worker licensed in this state and as a member of the National Association of Social Workers, it is our practice to adhere to more stringent privacy requirements for disclosures without an authorization. The following language addresses these categories to the extent consistent with the *NASW Code of Ethics* and HIPAA.

Child Abuse or Neglect. I may disclose your PHI to a state or local agency that is authorized by law to receive reports of child abuse or neglect.

Judicial and Administrative Proceedings. I may disclose your PHI pursuant to a subpoena (with your written consent), court order, administrative order or similar process.

Deceased Patients. I may disclose PHI regarding deceased patients as mandated by state law, or to a family member or friend that was involved in your care or payment for care prior to death, based on your prior consent. A release of information regarding deceased patients may be limited to an executor or administrator of a deceased person's estate or the person identified as next-of-kin. PHI of persons that have been deceased for more than fifty (50) years is not protected under HIPAA.

Medical Emergencies. I may use or disclose your PHI in a medical emergency situation to medical personnel only in order to prevent serious harm. Our staff will try to provide you a copy of this notice as soon as reasonably practicable after the resolution of the emergency.

Family Involvement in Care. I may disclose information to close family members or friends directly involved in your treatment based on your consent or as necessary to prevent serious harm.

Health Oversight. If required, I may disclose PHI to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies and organizations that provide financial assistance to the program (such as third-party payors based on your prior consent) and peer review organizations performing utilization and quality control.

Law Enforcement. I may disclose PHI to a law enforcement official as required by law, in compliance with a subpoena (with your written consent), court order, administrative order or similar document, for the purpose of identifying a suspect, material witness or missing person, in connection with the victim of a crime, in connection with a deceased person, in connection with the reporting of a crime in an emergency, or in connection with a crime on the premises.

Specialized Government Functions. I may review requests from U.S. military command authorities if you have served as a member of the armed forces, authorized officials for national security and intelligence reasons and to the Department of State for medical suitability determinations, and disclose your PHI based on your written consent, mandatory disclosure laws and the need to prevent serious harm.

Public Health. If required, I may use or disclose your PHI for mandatory public health activities to a public health authority authorized by law to collect or receive such information for the purpose of preventing or controlling disease, injury, or disability, or if directed by a public health authority, to a government agency that is collaborating with that public health authority.

Public Safety. I may disclose your PHI if 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.

Research. PHI may only be disclosed after a special approval process or with your authorization.

Fundraising. I may send you fundraising communications at one time or another. You have the right to opt out of such fundraising communications with each solicitation you receive.

Verbal Permission. I may also use or disclose your information to family members that are directly involved in your treatment with your verbal permission.

With 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, except to the extent that I have already made a use or disclosure based upon your authorization. The following uses and disclosures will be made only with your written authorization: (i) most uses and disclosures of psychotherapy notes which are separated from the rest of your medical record; (ii) most uses

and disclosures of PHI for marketing purposes, including subsidized treatment communications; (iii) disclosures that constitute a sale of PHI; and (iv) other uses and disclosures not described in this Notice of Privacy Practices.

YOUR RIGHTS REGARDING YOUR PHI

You have the following rights regarding PHI I maintain about you. To exercise any of these rights, please submit your request to me in writing:

- **Right of Access to Inspect and Copy.** You have the right, which may be restricted only in exceptional circumstances, to inspect and copy PHI that is maintained in a "designated record set". A designated record set contains mental health/medical and billing records and any other records that are used to make decisions about your care. Your right to inspect and copy PHI will be restricted only in those situations where there is compelling evidence that access would cause serious harm to you or if the information is contained in separately maintained psychotherapy notes. I may charge a reasonable, cost-based fee for copies. If your records are maintained electronically, you may also request an electronic copy of your PHI. You may also request that a copy of your PHI be provided to another person.
- **Right to Amend.** If you feel that the PHI I have about you is incorrect or incomplete, you may ask us to amend the information although I am not required to agree to the amendment. If I deny your request for amendment, you have the right to file a statement of disagreement with us. I may prepare a rebuttal to your statement and will provide you with a copy. Please contact the Privacy Officer if you have any questions.
- **Right to an Accounting of Disclosures.** You have the right to request an accounting of certain of the disclosures that I make of your PHI. I may charge you a reasonable fee if you request more than one accounting in any 12-month period.
- **Right to Request Restrictions.** You have the right to request a restriction or limitation on the use or disclosure of your PHI for treatment, payment, or health care operations. I am not required to agree to your request unless the request is to restrict disclosure of PHI to a health plan for purposes of carrying out payment or health care operations, and the PHI pertains to a health care item or service that you paid for out of pocket. In that case, I am required to honor your request for a restriction.
- **Right to Request Confidential Communication.** You have the right to request that I communicate with you about health matters in a certain way or at a certain location. I will accommodate reasonable requests. I may require information regarding how payment will be handled or specification of an alternative address or other method of contact as a condition for accommodating your request. I will not ask you for an explanation of why you are making the request.
- **Breach Notification.** If there is a breach of unsecured PHI concerning you, I may be required to notify you of this breach, including what happened and what you can do to protect yourself.
- **Right to a Copy of this Notice.** You have the right to a copy of this notice.

COMPLAINTS

If you believe I have violated your privacy rights, you have the right to file a complaint in writing to 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. **I will not retaliate against you for filing a complaint.**

The effective date of this Notice is September 2013.

Michael Parker, LCSW
2526 Monroeville Blvd, Ste 208
Monroeville, PA 15146
412-256-8256

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NOTICE OF PRIVACY PRACTICES
RECEIPT AND ACKNOWLEDGMENT OF NOTICE

Client Name: _____

DOB: _____ SSN: _____

I hereby acknowledge that I have received and have been given an opportunity to read a copy of Michael Parker, LCSW's Notice of Privacy Practices. I understand that if I have any questions regarding the Notice of Privacy Practices, I can contact Michael Parker, LCSW at 412-256-8256.

_____

Signature of Patient/Client **Date**

_____

Signature or Parent, Guardian or Personal Representative * **Date**

_____

*If you are signing as a personal representative of an individual, please describe your legal authority to act for this individual (power of attorney, healthcare surrogate, etc.).

❑ **Patient/Client Refuses to Acknowledge Receipt**:

_____

Signature of Staff Member **Date**

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Informed Consent

Welcome to my practice. Here are some things that are important to know as you begin therapy:

- I utilize cognitive behavioral therapy (CBT). This is a practical approach to therapy rooted in the "here and now." A majority of our time will be spent talking about your current habits, thoughts, and feelings, and looking for any current thinking patterns and behavior that are making your symptoms worse. This is not to say we will never talk about the past. It is often necessary to discuss and work through old, painful experiences in session. But we will still focus most of our time challenging any unhelpful thoughts and behaviors that may have developed as a result of these past experiences.
- Be aware that therapy can be a difficult as well as rewarding experience. Sharing thoughts and feelings that you've been trying to avoid can be painful. Trying to change your current habits and beliefs can be difficult. But change often involves feeling a little bit worse before you can begin to feel better. When working on anxiety issues specifically, treatment involves feeling small doses of anxiety and discomfort on purpose so that you can feel less anxious and uncomfortable in the future. To make this process more manageable, we will identify the resources you have at your disposal, including available coping skills and social supports. You can always let me know if anything you decide to work on ever turns out to be too difficult or too big a step.
- Working hard between our sessions by making small behavioral changes and completing any "homework" assignments will be key ingredients to your success. Generally speaking, the harder you work, the more quickly change will occur.
- You have the right to ask questions about anything that happens in therapy. I welcome questions and give feedback about your therapy at any time.
- Although the psychotherapeutic techniques that I utilize are evidenced-based (there are proven positive outcomes), this does not guarantee that therapy works for all people.
- I currently accept Highmark and UPMC commercial insurance plans. Please let me know immediately if there are any changes to your insurance, to avoid any billing errors and/or unexpected charges. If you will be paying out-of-pocket, my standard rate is $120 per 60 minutes.
- When you must cancel, I require at least 24 hours notice. I am rarely able to fill a cancelled session otherwise. If you cancel without providing at least 24 hours advance, you will be charged a half session fee ($60).
- If you are not on psychiatric medication when you begin therapy, I may at some point discuss this as an option for you and will provide an appropriate referral if this is a direction you wish to pursue.
- You can contact me by phone at 412-256-8256 or by email at threeriverstherapist@gmail.com. I respond to all communications requiring a response within 24 hours on weekdays. If you need to contact me about a clinical matter between sessions, phone is the most secure method. I can't guarantee the security of any emails you send, as they can be intercepted by third parties while passing through internet servers. You can still choose to email me protected health information, or request that I email you your protected health information, but you do so accepting the security risks involved.

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- Crisis Procedure: If you are ever in a mental health crisis, you can gain immediate help by calling the Re:Solve Crisis Network at 1-888-796-8226. This 24-hour crisis line will connect you with a skilled and knowledgeable clinician who can dispatch a team to speak with you in person if needed. If you attempt to contact me directly during a crisis, I can't guarantee that I will be immediately reachable, as I may be seeing clients during work hours or otherwise inaccessible during off-work hours. I will reach out to you as quickly as I am able.
- Confidentiality: Written authorization is required for me to disclose any information about your treatment. That authorization can be withdrawn by you at any time. There are a few exceptions to the confidentiality rule which are listed below. For further detail please review the HIPPA Notice of privacy Practices which I have made available to you.
  1. If I have good reason to believe that a patient will harm another person, I must attempt to inform that person and warn them of the patient's intentions. I must also contact the police and ask them to protect the intended victim.
  2. If I have good reason to believe that someone is abusing or neglecting a child or vulnerable adult, I must inform Child Protective Services or Adult Protective Services immediately.
  3. If I believe that a patient is in imminent danger of harming him or herself, I may legally break confidentiality and call the police or the county crisis team. I would explore all other options first before taking that step.

I have read this statement, and have understood it. I have also had sufficient time to consider its contents and ask any questions that I have. I understand the limits of confidentiality required by law. I agree to undertake therapy with Michael Parker, LCSW. I know I can end therapy at any time I wish and that I can refuse any request or suggestions made by Michael Parker, LCSW. I am over the age of eighteen.

Signature: _____ Date:_____

Print Name: _____

Witness: _____ Date: _____