CLEARLIFE INTAKE FORM

Date: _____ Marital Status: ❑ Married ❑ Single ❑ Divorced ❑ Widowed ❑ Separated ❑ Other

Name: _____ Telephone: (H) _____ Cell _____ (W) _____

Address: _____ email address: _____

City: _____ State: _____ Zip: _____

Occupation: _____ Date of Birth: _____ Age: _____

Religion while growing up: ❑ None ❑ Jewish ❑ Protestant ❑ Catholic ❑ Other: _____

Education: ❑ Some High School ❑ High School Graduate ❑ Post High School Training ❑ College ❑ Graduate Work

Name of Spouse or Domestic Partner: _____

Children: (first name/age) _____

_____

Please check if you have ever had a: ❑ Child Die ❑ Stillbirth ❑ Pregnancy Terminated ❑ Child Adopted

Are you in counseling now?: ❑ Yes ❑ No If yes, with whom?: _____

Name of Medical Doctor: _____

Address: _____

When was your last medical physical?: _____ Please explain any unusual circumstances/outcome of the exam: _____

_____

Are you currently on medications?: ❑ Yes ❑ No If yes, for what reason?: _____

Medication prescribed by: ❑ Psychiatrist ❑ Other Medical Doctor

Type of medication?: _____ Dosage?: _____

Name of Psychiatrist/Doctor: _____

Address: _____

Please list a person whom we could contact in an emergency:

Name/Relationship to You: _____ Telephone: _____

By whom were you referred?: _____

PROBLEM AREAS

Please check your response:	Not a Problem	Mild Problem	Moderate Problem	Severe Problem
Financial Problems	❑	❑	❑	❑
Physical heath and/or handicap	❑	❑	❑	❑
Misuse of drugs or alcohol	❑	❑	❑	❑
Spiritual concerns	❑	❑	❑	❑
Sexual concerns	❑	❑	❑	❑
Problems between parents/children	❑	❑	❑	❑
Physical abuse/violence	❑	❑	❑	❑
Problems with aging	❑	❑	❑	❑
Communication Problems	❑	❑	❑	❑
Problems with pregnancy	❑	❑	❑	❑
Separation or divorce	❑	❑	❑	❑
Problems between husband/wife	❑	❑	❑	❑
Trouble relating to others	❑	❑	❑	❑
Career problems	❑	❑	❑	❑
Legal difficulties	❑	❑	❑	❑
Lack of self-esteem	❑	❑	❑	❑
Food/body image issues	❑	❑	❑	❑
Other: _____	❑	❑	❑	❑

Rate your overall level of distress:

❑ Mild

❑ Moderate

❑ Severe

How long have you been experiencing these problems?

❑ Under 3 Months

❑ 3-6 Months

❑ 6-12 Months

❑ 1-2 Years

❑ 3-4 Years

❑ 5 or More Years

What symptoms have you been feeling (Please check ALL that apply)?:

- ❑ Numb
- ❑ Depressed
- ❑ Hopeless
- ❑ Confused
- ❑ Disappointed/Let Down
- ❑ Empty
- ❑ Sad
- ❑ Fearful
- ❑ Panic Attacks
- ❑ Anxiety
- ❑ Nervousness
- ❑ Tense
- ❑ Anger
- ❑ Hostile/Violent
- ❑ Resentful
- ❑ "Used"/Put Upon
- ❑ Embarrassed
- ❑ Shameful/Inadequate
- ❑ Lonely
- ❑ Guilty
- ❑ Trapped
- ❑ Fatigue
- ❑ "Wired"/Unable to Slow Down
- ❑ Sleep Problems
- ❑ Too much sleep
- ❑ Not enough sleep/interrupted sleep
- ❑ Nightmares
- ❑ Flashbacks
- ❑ Headaches
- ❑ Worry
- ❑ Racing Thoughts/Obsessive Thoughts
- ❑ Compulsive Behaviors (specify): _____
- ❑ Weight Gain
- ❑ Weight Loss
- ❑ Memory Impairment
- ❑ Trouble Concentrating
- ❑ Hallucinations Voice/Visual
- ❑ Other: _____

How long have you been experiencing these symptoms/feelings?:

- ❑ Under 3 Months
- ❑ 3-6 Months
- ❑ 6-12 Months
- ❑ 1-2 Years
- ❑ 3-4 Years
- ❑ 5 or More Years
- ❑ All My Life

PREVIOUS THERAPY HISTORY

Please list all previous counseling, psychotherapy or treatment. Include outpatient and inpatient hospital stays. Begin with your earliest experience and work forward to present.

1. WHEN (year)_____ from _____ to_____ Weekly or_____ ❑ Individual ❑ Couple ❑ Family ❑ Group

WHERE (Name of therapist/clinic/hospital):

Name:_____ City:_____ State:_____

Reason for seeking therapy:_____

What did you learn about yourself?:_____

Was medication prescribed during this time?: ❑ Yes ❑ No

If yes, what medication _____ Dosage:_____ Prescribed for what:_____

Are you still taking the prescribed medication ❑ Yes ❑ No If not, for how long did you use?_____

2. WHEN (year)_____ from _____ to_____ Weekly or_____ ❑ Individual ❑ Couple ❑ Family ❑ Group

WHERE (Name of therapist/clinic/hospital):

Name:_____ City:_____ State:_____

Reason for seeking therapy:_____

What did you learn about yourself?:_____

Was medication prescribed during this time?: ❑ Yes ❑ No

If yes, what medication _____ Dosage:_____ Prescribed for what:_____

Are you still taking the prescribed medication ❑ Yes ❑ No If not, for how long did you use?_____

3. WHEN (year)_____ from _____ to_____ Weekly or_____ ❑ Individual ❑ Couple ❑ Family ❑ Group

WHERE (Name of therapist/clinic/hospital):

Name:_____ City:_____ State:_____

Reason for seeking therapy:_____

What did you learn about yourself?:_____

Was medication prescribed during this time?: ❑ Yes ❑ No

If yes, what medication _____ Dosage:_____ Prescribed for what:_____

Are you still taking the prescribed medication ❑ Yes ❑ No If not, for how long did you use?_____

NOTE: Please use a separate sheet of paper for additional space if needed.

BACKGROUND

IDENTIFY AREAS OF CONCERN THAT APPLY TO YOU OR A FAMILY MEMBER
Write in self, mother, father, brother, sister, spouse, lover in the space provided.

❑ Smoker_____
❑ Alcohol Abuse_____
❑ Dependent_____
❑ Other Drug Abuse_____
❑ Drug Dependent_____
❑ Too Religious_____
❑ Helpless/Victim_____
❑ Pleaser_____
❑ "Picture Perfect"_____
❑ Too Positive_____
❑ Too Negative_____
❑ Rageaholic_____
❑ Compulsive Cleaner_____
❑ All Rational/Non-Feeling_____
❑ Compulsive Gambler_____
❑ Other_____

Food/Eating Disorders
❑ Compulsive Eater_____
❑ Bulemic_____
❑ Anorexic_____
❑ Exercise Addict_____
❑ Sexual Addict_____
❑ Numerous Affairs_____
❑ Sexually Abusive_____
❑ Emotionally Abusive_____
❑ Physically Abusive_____
❑ Panic/Anxiety Attacks_____
❑ Too Dependent_____
❑ Too Independent_____
❑ Depression_____
❑ Workaholic_____
❑ Chronic Mental Illness/Diagnosis_____
❑ Chronic Physical Illness/Disease_____

How would you describe yourself as a child?:_____

Who raised you as a child?:_____

Were your parents separated, divorced, or did one parent die when you were growing up? Please explain:_____

How many brothers and sisters do you have?:_____

What number child are you? ❑ Only ❑ First ❑ 2nd ❑ 3rd ❑ _____

How were you disciplined as a child?:_____

Which parent were you closer to as a child?: ❑ Mother ❑ Father ❑ Both the Same

Were you sexually abused by anyone as a child or adolescent? ❑ Yes ❑ No ❑ Not Sure, Please explain:_____

Were you emotionally abused by anyone as a child or adolescent? ❑ Yes ❑ No ❑ Not Sure, Please explain:_____

Were you physically abused by anyone as a child or adolescent? ❑ Yes ❑ No ❑ Not Sure, Please explain:_____

Have you been physically beaten, emotionally battered or sexually abused/raped by a spouse or anyone else as an adult?

❑ Yes ❑ No ❑ Not Sure, Please explain:_____

Are you currently being physically beaten or emotionally battered?: ❑ Yes ❑ No ❑ Not Sure, Please explain:_____

Have you sexually abused a child, adolescent or an adult? ❑ Yes ❑ No ❑ Not Sure, Please explain:_____

Have you emotionally abused a child, adolescent or an adult? ❑ Yes ❑ No ❑ Not Sure, Please explain:_____

Have you physically abused a child, adolescent or an adult? ❑ Yes ❑ No ❑ Not Sure, Please explain:_____

CURRENT HISTORY

Are you feeling suicidal?: ❑ Yes ❑ No

Have you ever had suicidal thoughts?: ❑ Yes ❑ No If yes, how recently?: _____

Have you ever made a plan to commit suicide?: ❑ Yes ❑ No If yes, please explain:_____

_____

Have you ever attempted suicide?: ❑ Yes ❑ No If yes, state when and what happened:_____

_____

Why are you seeking therapy?:_____

_____

What symptoms are you experiencing?:_____

_____

What do you hope to gain from therapy?:_____

_____

Do you know what some of the defenses are that keep you "stuck"? Please explain:_____

_____

_____

How might you sabotage yourself/your therapy work? Please explain:_____

_____

_____

How satisfied are you with:

Your work/career?:_____

Your social life/friendships?:_____

Your intimate life? (spouse/lover):_____

Your sexuality?:_____

Please include any other information that you think would be helpful for us to know about you:_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

I certify the information on this Intake Form is correct and complete:

Signature:_____ Date:_____

Mail all Forms to Friel Associates PO Box 270250 St. Paul, MN 55127 or by Electronic Fax to 651.628.0220

or if agreed upon beforehand, bring them to your first session, or to your next session

rev 2/2015

Friel Associates/ClearLife®Reno PO Box 270250 St. Paul, MN 55127

Signature Page For *Agreeing With* Nevada HIPAA Notice Form And Psychotherapist-Patient Services Agreement

NOTE!! CANCELLATION POLICY: PLEASE READ THIS SECTION CAREFULLY: YOU WILL BE CHARGED FOR SESSIONS THAT YOU DO NOT CANCEL IN TIME, AND THE TIME INCREASES WITH THE LENGTH OF THE APPOINTMENT—24 hours for a 50-minute appointment, 48 hours for a 100-minute appointment, etc. Confirmation of your cancellation

YOUR SIGNATURE BELOW INDICATES THAT YOU HAVE RECEIVED, *READ*, AND *AGREE* TO THE TERMS OF THE 7-PAGE "NEVADA PSYCHOTHERAPIST-PATIENT AGREEMENT" AND THE NEVADA HIPAA NOTICE FORM.

by US must come via either text, email or voicemail...without that from us, you are still legally responsible

_____	_____	_____
Signature of Client #1	Date of Birth	Date
_____	_____	_____
Signature of Client #2	Date of Birth	Date
_____		_____
Signature of Parent Or Guardian		Date

ClearLife®

Friel Asociates

Reno: 5421 Kietzke L
Mpls: 1409 Willow St.

Mpls Tel: 651.628.0220
Electronic Fax: 651.628.0220
Reno Tel: 775.337.0299

John C. Friel, Ph.D.
MN Lic Psychologist LP0504
NV Lic Psychologist PY0370
Linda D. Friel, M.A.
MN Lic Psychologist LP0724

All Mail Goes To:
PO Box 270250
St. Paul, MN 55127

AUTHORIZATION FOR EXCHANGE OF CONFIDENTIAL INFORMATION

CLIENT NAME_____ DATE OF BIRTH_____

ADDRESS_____
street city state zip

TELEPHONE__H_____w_____CELL_____

E-MAIL_____

I/WE_____AUTHORIZE THE EXCHANGE OF THE FOLLOWING LISTED INFORMATION **BETWEEN** MY DOCTOR/THERAPIST/ETC
(NAME)_____

ADDRESS_____
street city state zip

TELEPHONE_____FAX_____

___**AND**____ (YES NO) JOHN C. FRIEL, PH.D (YES NO) LINDA D. FRIEL, M.A.

INFORMATION WHICH MAY BE EXCHANGED...

T**HE LIMITATIONS TO THIS AUTHORIZATION ARE...**

WITH THE EXCEEPTION OF THE ABOVE LIMITATIONS, THE ABOVE-NAMED PROFESSIONALS ARE AUTHORIZED TO EXCHANGE INFORMATION REGARDING AND AND ALL ACADEMIC, SOCIAL, MEDICAL, AND PSYCHOLOGICAL RECORDS IN THEIR POSSESSION, WHICH MAY INCLUDE TREATMENT FOR SUBSTANCE ABUSE AND/OR HIV/AIDS TEST RESULTS OR DIAGNOSES

THE PURPOSE OF THIS AUTHORIZATION IS....

I UNDERSTAND THAT ANY ELECTRONIC TRANSMISSION OF THIS INFORMATION, WHETHER BY CELL PONE, E-MAIL,OR FAX MACHINE POSES A POTENTIAL RISK TO MY PRIVACY, AS THESE DEVIDES ARE NOT SECURE AND THERE IS NO CONTROL OVER INFORMATION ELEASED INTO CYBERSPACE.

I FURTHER UNDERSTAND THAT THIS AUTHORIZATION MAY BE REVOKED BY MYSELF, IN WRITING, AT ANY TIME, EXCEPT TO THE EXTENT THAT ACTION HAS ALREADY BEEN TAKEN IN RELIANCE THEREUPON.

THE TERMINATION DATE OF THIS AUTHORIZATION IS... (specify date) _____

_____ _____
signature of client, parent, or guardian/s date

_____ _____
witness date

ClearLife®

John C. Friel, Ph.D.
MN Psychology Lic LP0504
NV Psychology Lic PY0370
Linda D. Friel, M.A.
MN Psychology Lic LP0724

Friel Associates
PO Box 270250
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http://www.clearlife.com

5421 Kietzke Ln
Reno, NV 89511
775.337.0299

Tel: 651.628.0220
Electronnic Fax: 651.628.0220

2015 Men's Group Rules/Contract

These ground rules are offered out of respect for all group participants. Ground rules model clean, structured boundaries and provide a clear understanding between therapists and group members that if left unclear lead to avoidable misunderstandings.

If a group member will not be able to attend a given session, he is expected to call and leave a voice message at 775.337.0299 prior to the beginning of that day's group. An uninformed absence causes all of us to wonder and/or worry about your well-being, and can be a distraction from the group work that day.

Each client agrees to be respectful of self and others, and to give clear notice to us of the decision to terminate membership in the group. After notice has been given, it is expected that you will attend one last time to say "goodbye" and get closure with the group. This can be one of the more important aspects of a group process, especially given that people growing up in dysfunctional families often have a hard time giving or getting that kind of respectful closure.

The fee for each 2-hour group is $70. Each group member is financially responsible for each regularly scheduled group session, whether or not the session is attended. In other words, you are buying a "season ticket" or "season pass" for group. There are two (2) excused absences per calendar year for which you will not be billed, and all the rest are your responsibility. The charge for group is payable at each session. By signing below, you are agreeing to pay for each group except for the two mentioned above, and you give us permission to bill your credit card for the full amount due, or to send your bill to a collection agency or court to attempt to get payment.

The schedule for men's group sessions is posted on our web site at http://www.clearlife.com. Go to the bottom of the main page and click on the link there. Should there be extreme extenuating circumstances (8 feet of snow, a 7.5 earthquake, etc.), I will leave a notice on my voicemail at 775.337.0299 to cancel group.

A request for a leave of absence will be treated the same as a termination in most cases. A person may re-enter the group as an opening comes up. Former group members who would like to return to work on additional issues in the future are welcome to come back as openings come up. We look forward to working with you.

_____ _____

Signature Date

rev 2/2015

ClearLife® **Reno**

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Licensed Psychologists

5421 Kietzke Ln Reno, NV 89511
775/337-0299

NEVADA PSYCHOTHERAPIST-PATIENT SERVICES AGREEMENT

Welcome to Friel Associates/ClearLife®Reno. This document (the Agreement) contains important information about my professional services and business policies. It also contains summary information about the Health Insurance Portability and Accountability Act (HIPAA), a new federal law that provides new privacy protections and new patient rights with regard to the use and disclosure of your Protected Health Information (PHI) used for the purpose of treatment, payment, and health care operations. HIPAA requires that I provide you with a Notice of Privacy Practices (the Notice) for use and disclosure of PHI for treatment, payment and health care operations. The Notice, which is attached to this Agreement, explains HIPAA and its application to your personal health information in greater detail.

The law requires that I obtain your signature acknowledging that I have provided you with this information. Although these documents are long and sometimes complex, it is very important that you read them carefully before our next session. We can discuss any questions you have about the procedures at that time. When you sign this document, it will also represent an agreement between us. You may revoke this Agreement in writing at any time, except for the portions of it pertaining to appointment cancellation notification times, billing and payments, and insurance reimbursement. That revocation will be binding on me unless I have taken action in reliance on it; if there are obligations imposed on me by your health insurer in order to process or substantiate claims made under your policy; or if you have not satisfied any financial obligations you have incurred. **You should be aware that, except for the exceptions noted above, this Agreement will be in effect for one year from the date of signing unless you specifically request that it remain in effect for a shorter time. This contract, or any provision of this contract, can be revoked by you at any time, except to the extent that we have relied on it.**

PSYCHOLOGICAL SERVICES

Psychotherapy is not easily described in general statements. It varies depending on the personalities of the psychologist and patient, and the particular problems you are experiencing. There are many different methods we may use to deal with the problems that you hope to address. 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 many benefits. 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. By the end of the evaluation, we will be able to offer you some first impressions of what our work will include and a treatment plan to follow, if you decide to continue with therapy. You should evaluate this information along with your own opinions of whether you feel comfortable working with us. 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 our procedures, we should discuss them whenever they arise. If your doubts persist, we will be happy to help you set up a meeting with another mental health professional for a second opinion.

INTAKE PROCEDURES ** SESSIONS ** POLICY REGARDING MISSED APPOINTMENTS

During the first 1-4 hours of therapy, we can both decide if we are the best people to provide the services you need in order to meet your treatment goals.

As part of the initial evaluation, you will be asked to complete and sign an Intake Form.

When psychotherapy starts, we will usually schedule one or two 50-minute segments (one or two appointment segments of 50 minutes duration each) to begin with, although in the case of our couple intensives, this session length may be up to 12 segments in length (12 x 50 minutes = 600 minutes). Individual, group, and couple sessions may vary in length depending on the therapist and the situation.

Once an appointment is scheduled, you will be expected to pay for it unless you provide 24 hours advance notice of cancellation, by calling our office at 775/337-0299. We will keep a recording of your telephone message with its date and time stamp if we deem it necessary. In the case of sessions longer than a 50-minute segment, this notice time will increase as follows: 48 hours for a 2-segment session, 72 hours for a 3-segment session, 96 hours for a 4-segment session, and 10 days for a weekend couple intensive of 8-12 segments. A non-refundable deposit may also be required in the case of these longer intensives. There are very few reasons for missing an appointment that will not fall under this rule, and we must <u>both</u> agree that you were unable to attend due to circumstances beyond your control. "Forgetting" does not meet this criterion. It is important to note that insurance companies do not provide reimbursement for cancelled sessions. Please also note that if you miss your scheduled appointment, it may take up to 2-3 weeks to get in to see us again.

PROFESSIONAL FEES

Our hourly fee for **individual, couple, or family therapy** is **$175,** our fee for men's **group therapy is $70, and for women's group $85** and the fee for the MMPI-2 or Millon-III is **$100**. There is a **$25** charged for any checks returned N.S.F. In addition to weekly appointments, we charge **$175** per hour for other professional services you may need, though we will break down the hourly cost if we work for periods of less than one hour. Other services include report writing, **telephone conversations lasting longer than 5 minutes**, con other professionals with your permission, preparation of records or treatment summaries, and the time spent performing any other

service you may request of us. If you become involved in legal proceedings that require our participation, you will be expected to pay for all of our professional time, including preparation and transportation costs, even if we are called to testify by another party. Because of the difficulty of legal involvement, we charge **$750 per hour** for preparation and attendance at any legal proceeding. **We do psychotherapy. If you believe that you will need a psychologist to do legal work for you, please let us know in the beginning, and we will try to find another professional with whom you can work.**

BILLING AND PAYMENTS

You will be expected to pay for each session at the time it is held. 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, which will require me to disclose otherwise confidential information. 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. If such legal action is necessary, its costs will be included in the claim.

Assignment of Benefits/Overpayments: Should there be an unpaid balance due on my account, you hereby authorize your insurance carrier to assign benefits to the provider, Friel Associates—that is, to pay them directly rather than paying you. Should there be an overpayment on your account, a refund will be promptly sent to you.

INSURANCE REIMBURSEMENT

I am not on any insurance panels, I do not file insurance forms, and I do not guarantee insurance coverage. I will not code your claim for couple therapy as individual therapy, which would be considered insurance fraud. If I am seeing you as an individual client and ask you to bring in your significant other for a session or two, as an adjunct to your individual therapy, then it will still be coded as individual therapy. **I** will send you a statement at the end of each month with the appropriate procedure code and diagnosis code, which you can then submit to your insurance carrier if you would like. As noted elsewhere, I expect payment at the time of service, which can be made by check, cash, VISA, or MasterCard. Individual insurance policies, even within companies, vary widely. It is very important that you find out exactly what mental health services your insurance policy covers. I am a Licensed Psychologist, and the work you do with me is either outpatient individual or group psychotherapy.

You should also be aware that your contract with your health insurance company requires that I provide it with information relevant to the services that I provide to you. I am required to provide a clinical diagnosis. Sometimes I am required to provide additional clinical information such as treatment plans or summaries, or copies of your entire Clinical Record. In such situations, I will make every effort to release only the minimum information about you that is necessary for the purpose requested. 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. I will provide you with a copy of any report we submit, if you request it. By signing this Agreement, you agree that I can provide requested information to your carrier.

CONTACTING ME

I am often not immediately available by telephone. My telephone is answered by voice mail that I monitor frequently. I will make every effort to return your call within 24 hours, but please remember that unless you are in a life-threatening crisis, it is part of therapy to learn to handle personal difficulties until your next scheduled appointment. 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 hospital emergency room and ask for the psychologist or psychiatrist on call, or dial 911. If I will be unavailable for an extended time, I will provide you with the name of a colleague to contact, if necessary.

LIMITS ON CONFIDENTIALITY

The law protects the privacy of all communications between a patient and a psychologist. In most situations, I can only release information about your treatment to others if you sign a written **Authorization Form** that meets certain legal requirements imposed by HIPAA. There are other situations that require only that you provide written, advance consent. Your signature on this Agreement provides consent for those activities, as follows:

- I may occasionally find it helpful to consult other health and mental health professionals about a case. During a consultation, I make every effort to avoid revealing the identity of my patient. The other professionals are 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. I will note all consultations in your Clinical Record (which is called "PHI" in my Notice of Psychologist's Policies and Practices to Protect the Privacy of Your Health Information).

- You should be aware that I employ a part-time administrative staff. In most cases, I need to share protected information with these individuals for both clinical and administrative purposes, such as scheduling, billing and quality assurance. All of the mental health professionals are bound by the same rules of confidentiality. All staff members have been given training about protecting your privacy and have agreed not to release any information outside of the practice without the permission of a professional staff member.

- Disclosures required by health insurers or to collect overdue fees are discussed elsewhere in this Agreement.

There are some situations where I am permitted or required to disclose information without either your consent or Authorization:

- If you are involved in a court proceeding and a request is made for information concerning your diagnosis and treatment, such information is protected by the psychologist-patient privilege law. I cannot provide any information without your (or your legal representative's) written authorization, or a **court order. If you are involved in or contemplating litigation,**

you should consult with your attorney to determine whether a court would be likely to order me to disclose information.

- If a government agency is requesting the information for health oversight activities, I may be required to provide it.

- If a patient files a complaint or lawsuit against me, I may disclose relevant information regarding that patient in order to defend myself.

- If a patient files a worker's compensation claim, I must, upon appropriate request, disclose relevant information to the insurer or a third party administrator.

There are some situations in which I am legally obligated to take actions, which I believe are necessary to attempt to protect others from harm and I may have to reveal some information about a patient's treatment. These situations are unusual in my practice.

- If I know or have reasonable cause to believe that a child has been abused or neglected, the law requires that I file a report with the appropriate governmental agency, usually the nearest child welfare agency. Once such a report is filed, I may be required to provide additional information.

- If I know or have reasonable cause to believe that an older person has been abused, neglected, exploited or isolated the law requires that I make a report to the appropriate governmental agency, usually the local office of the Department of Human Resources Division of Aging Services. Once such a report is filed, I may be required to provide additional information.

- If I believe that a patient presents a risk of imminent serious harm to another person, I may be required to take protective actions. These actions may include notifying the potential victim, contacting the police, and/or seeking hospitalization for the patient.

- If a patient presents an imminent risk of harm to himself/herself, I may be obligated to seek hospitalization for him/her, or to contact family members or others who can help provide protection.

If such a situation arises, I will make every effort to fully discuss it with you before taking any action and I will limit my disclosure to what is necessary.

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 now or in the future. The laws governing confidentiality can be quite complex, and I am not an attorney. In situations where specific advice is required, formal legal advice may be needed.

PROFESSIONAL RECORDS

You should be aware that, pursuant to HIPAA, I keep Protected Health Information about you in two sets of professional records. One set constitutes your **Clinical Record**. It includes information about your reasons for seeking therapy, a description of the ways in which your problem impacts on your life, your diagnosis, the goals that we set for treatment, your progress towards those goals, your medical and social history, your treatment history, any past treatment records that I receive from other providers, reports of any professional consultations, your billing records, and any reports that have been sent to anyone, including reports to your insurance carrier. Except in unusual circumstances that involve danger to yourself and others, you may examine and/or receive a copy of your Clinical Record, if you request it in writing. Because these are professional records, they can be misinterpreted and/or upsetting to untrained readers. For this reason, I recommend that you initially review them in my presence, or have them forwarded to another mental health professional so you can discuss the contents. [I am sometimes willing to conduct this review meeting without charge.] I am allowed to charge you a copying fee of 60 cents per page (and for certain other expenses). The exceptions to this policy are contained in the attached Notice Form. If I refuse your request for access to your Clinical Record, you have a right of review, which I will discuss with you upon request.

In addition, I also keep a set of **Psychotherapy Notes**. These Notes are for my own use and are designed to assist me in providing you with the best treatment. While the contents of Psychotherapy Notes vary from client to client, they can include the contents of our conversations, my analysis of those conversations, and how they impact on your therapy. They also contain particularly sensitive information that you may reveal to me that is not required to be included in your Clinical Record. These Psychotherapy Notes are kept separate from your Clinical Record. While insurance companies can request and receive a copy of your Clinical Record, they cannot receive a copy of your Psychotherapy Notes without your signed, written Authorization**. Insurance companies cannot require your Authorization as a condition of coverage nor penalize you in any way for your refusal to authorize release of your Psychotherapy Notes**. You may examine and/or receive a copy of your Psychotherapy Notes unless I believe it will cause you mental or emotional harm.

PATIENT RIGHTS

HIPAA provides you with several new or expanded rights with regard to your Clinical Records and disclosures of protected health information. These rights include requesting that I amend your record; requesting restrictions on what information from your Clinical Records is disclosed to others; requesting an accounting of most disclosures of protected health information that you have neither consented to nor authorized; determining the location to which protected information disclosures are sent; having any complaints you make about my policies and procedures recorded in your records; and the right to a paper copy of this Agreement, the attached Notice form, and my privacy policies and procedures. I am happy to discuss any of these rights with you.

MINORS & PARENTS

Patients under 18 years of age who are not emancipated and their parents should be aware that the law usually allows parents to examine their child’s treatment records unless I decide that such access is likely to injure the child. The only exception is when the psychologist believes disclosure would jeopardize treatment necessary to the minor's life or necessary to avoid a serious and

immediate threat to the minor's health, or unless we agree otherwise. Because privacy in psychotherapy is often crucial to successful progress, particularly with teenagers, it is sometimes my policy to request an agreement from parents that they consent to give up their access to their child’s records. If they agree, during treatment, I will provide them only with general information about the progress of the child’s treatment, and his/her attendance at scheduled sessions. I will also provide parents with a summary of their child’s treatment when it is complete. Any other communication will require the child’s Authorization, unless I feel that the child is in danger or is a danger to someone else, in which case, I will notify the parents of my concern. Before giving parents any information, I will discuss the matter with the child, if possible, and do my best to handle any objections he/she may have.

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ClearLife®

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NEVADA NOTICE FORM

Notice of Psychologists' Policies and Practices to Protect the Privacy of Your Health Information

THIS NOTICE DESCRIBES HOW PSYCHOLOGICAL AND MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

I. Uses and Disclosures for Treatment, Payment, and Health Care Operations

I may *use* or *disclose* your *protected health information* (*PHI*), for *treatment, payment, and health care operations* purposes with your *consent*. To help clarify these terms, here are some definitions:

- "*PHI"* refers to information in your health record that could identify you.
- *"Treatment, Payment and Health Care Operations"*
  – *Treatment* is when I provide, coordinate or manage your health care and other services related to your health care. An example of treatment would be when I consult with another health care provider, such as your family physician or another psychologist.
  - *Payment* is when I obtain reimbursement for your healthcare. Examples of payment are when I disclose your PHI to your health insurer to obtain reimbursement for your health care or to determine eligibility or coverage.
  - *Health Care Operations* are activities that relate to the performance and operation of my practice. Examples of health care operations are quality assessment and improvement activities, business-related matters such as audits and administrative services, and case management and care coordination.
- "*Use*" applies only to activities within my [office, clinic, practice group, etc.] such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.
- "*Disclosure*" applies to activities outside of my [office, clinic, practice group, etc.], such as releasing, transferring, or providing access to information about you to other parties.

II. Uses and Disclosures Requiring Authorization

I may use or disclose PHI for purposes outside of treatment, payment, and health care operations when your appropriate authorization is obtained. An "*authorization"* is written permission above and beyond the general consent that permits only specific disclosures. In those instances when I am asked for information

for purposes outside of treatment, payment and health care operations, I will obtain an authorization from you before releasing this information. I will also need to obtain an authorization before releasing your psychotherapy notes. *"Psychotherapy notes"* are notes I have made about our conversation during a private, group, joint, or family counseling session, which I have kept separate from the rest of your medical record. These notes are given a greater degree of protection than PHI.

You may revoke all such authorizations (of PHI or psychotherapy notes) at any time, provided each revocation is in writing. You may not revoke an authorization to the extent that (1) I have relied on that authorization; or (2) if the authorization was obtained as a condition of obtaining insurance coverage, and the law provides the insurer the right to contest the claim under the policy.

III. Uses and Disclosures with Neither Consent nor Authorization

I may use or disclose PHI without your consent or authorization in the following circumstances:

- **Child Abuse:** If I have reasonable cause to believe that a child has been abused or neglected, I must report this and relevant information, within 24 hours, to the Division of Child and Family Services, the county agency which provides child welfare services or a law enforcement agency.

- **Adult and Domestic Abuse:** If I have reasonable cause to believe that an older person has been abused, neglected, exploited or isolated, I must make a report to the local office of the Nevada Department of Human Resources Division of Aging Services, the police department or sheriff's office, or other appropriate agency within 24 hours after becoming aware of this information.

- **Health Oversight:** If I receive a request from the Nevada Board of Psychological Examiners with respect to an inquiry or complaint about my professional conduct, I must make available any record relevant to such inquiry.

- **Judicial or Administrative Proceedings:** If you are involved in a court proceeding and a request is made for information about your diagnosis and treatment and the records thereof, such information is privileged under state law, and I will not release this information without written authorization from you or your legally-appointed representative, or a court order. The privilege does not apply when you are being evaluated for a third party or where the evaluation is court-ordered. You will be informed in advance if this is the case.

- **Serious Threat to Health or Safety:** I may disclose confidential information from your records if I believe such disclosure is necessary to protect you or another person from a clear and substantial risk of imminent, serious harm. I may only disclose such information and to such persons as are consistent with the standards of my profession in addressing such problems.

- **Worker's Compensation:** If you file a worker's compensation claim, and if I provide treatment to you relevant to that claim, then I must submit to your employer's insurer or a third party administrator, a report on services rendered.

IV. Patient's Rights and Psychologist's Duties

Patient's Rights:

- *Right to Request Restrictions* –You have the right to request restrictions on certain uses and disclosures of protected health information about you. However, I am not required to agree to a restriction you request.

- *Right to Receive Confidential Communications by Alternative Means and at Alternative Locations* – You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations. (For example, you may not want a family member to know that you are seeing me. Upon your request, I will send your bills to another address.)

- *Right to Inspect and Copy* – You have the right to inspect or obtain a copy (or both) of PHI in my mental health and billing records used to make decisions about you for as long as the PHI is maintained in the record. I may deny your access to PHI under certain circumstances, but in some cases, you may have this decision reviewed. On your request, I will discuss with you the details of the request and denial process.

- *Right to Amend* – You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. I may deny your request. On your request, I will discuss with you the details of the amendment process.

- *Right to an Accounting* – You generally have the right to receive an accounting of disclosures of PHI for which you have neither provided consent nor authorization (as described in Section III of this Notice). On your request, I will discuss with you the details of the accounting process.

- *Right to a Paper Copy* – You have the right to obtain a paper copy of the notice from me upon request, even if you have agreed to receive the notice electronically.

Psychologist's Duties:

- I am required by law to maintain the privacy of PHI and to provide you with a notice of my legal duties and privacy practices with respect to PHI.
- I reserve the right to change the privacy policies and practices described in this notice. Unless I notify you of such changes, however, I am required to abide by the terms currently in effect.
- If I revise my policies and procedures, I will notify you in writing by U.S. Mail, by e-mail, or by giving you the revision in person.
-

V. Complaints

If you are concerned that I have violated your privacy rights, or you disagree with a decision I made about access to your records, you may contact the Nevada Board of Psychological Examiners, PO Box 2286, Reno, NV 89505-2286, (775) 688-1268.

You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services. The person listed above can provide you with the appropriate address upon request.

VI. Effective Date, Restrictions and Changes to Privacy Policy

This notice will go into effect on April 14, 2003.

- I reserve the right to change the terms of this notice and to make the new notice provisions effective for all PHI that I maintain. I will provide you with a revised notice by U.S. Mail, by e-mail, or by giving you the revision in person.