

LINDSAY SMITH, LCSW

Licensed Clinical Social Worker, Adolescent, Young Adult and Family Psychotherapy

101 Church St. #24 ▪ Los Gatos ▪ CA 95030

(408) 772-7052 ▪ Lindsay@LosGatosTeenTherapy.com ▪ www.LosGatosTeenTherapy.com

INFORMATION FORM

Client Information

Client Name: _____ Nickname or Preferred Name: _____

Age: _____ Date of Birth: _____ School/Grade: _____

Client Cell Phone: _____ Client E-mail: _____

Home Phone: _____

Home Address: _____

Physician Name and Number: _____

Current Medications & Dosage: _____

Parent Information

Mother's name: _____ **Age:** _____ **Occupation:** _____

Cell phone: _____ E-mail: _____

Address if different from client: _____

Father's name: _____ **Age:** _____ **Occupation:** _____

Cell phone: _____ E-mail: _____

Address if different from client: _____

Parent's marital status: _____

Current custody arrangement (if applicable): _____

Step-parent information (if applicable): _____

Additional Family Members and Other People Living in the Home:

Name: _____ Relationship: _____ Age: _____

Name: _____ Relationship: _____ Age: _____

Name: _____ Relationship: _____ Age: _____

Name: _____ Relationship: _____ Age: _____

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PSYCHOTHERAPY CONTRACT AND CONSENT

This document contains important information about my professional services and business policies. Please read it carefully and ask me any questions that arise. When you sign this document, it represents an agreement between us.

Psychological Services:

Our first 1-3 sessions will involve an assessment of your needs. By the end of the assessment, I will be able to offer you some first impressions of what our work will include and a general treatment plan. After the evaluation, we can both decide if I am the best person to provide the services you need in order to meet your treatment goals. If not, I will refer you to a more appropriate therapist.

We will work together to establish specific, individualized goals for treatment. Throughout therapy, we will continue to assess whether your goals are being met and/or whether they require revision. Most of my clients see me once a week for 3-4 months. After that, we meet less often for several more months before mutually agreeing to terminate treatment.

Risks and Benefits of Therapy:

Participation in therapy can result in a number of benefits, including resolution of the specific concerns that led you to seek therapy. To ensure the best possible results, you are expected to play an active role in your treatment, including collaborating with me to identify treatment goals, completing questionnaires, and designing and completing homework assignments throughout our work together.

While therapy has many benefits, it also has risks. During the assessment or therapy, remembering or talking about unpleasant events, feelings, or thoughts can result in you experiencing considerable discomfort or strong feelings of anger, sadness, worry, fear, frustration, loneliness, helplessness, or other negative emotions. 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 may result in changes that were not originally intended. Sometimes a decision that is positive for one family member is viewed quite negatively by another family member. There is no guarantee that therapy will yield positive or intended results.

Confidentiality:

Your discussions with a licensed clinical social worker are considered confidential, which means that these discussions are protected by law. I may not disclose information about you without your formal written consent, except where disclosure is required by law. These exceptions include:

1. If you present a danger to yourself, to others, to property, or are unable to care for yourself.

2. If there is suspected past or present child, dependent, or elder abuse or neglect.
3. If I am court ordered to release information as part of a legal proceeding, or as otherwise required by the law.

Confidentiality with minors and parents:

Since privacy in psychotherapy is often critical to successful progress, particularly with adolescents, I request an agreement with minors over age 12 and their parents about what information will be shared and how I will share it. This agreement provides that if I see the adolescent client individually, I will ask him/her what he/she does not want me to share with anyone. I will never mention anything to your parents before you and I talk it over together, unless I believe that you or someone else is in immediate danger. Although this agreement is in place, it is important for you to understand that I work as a family psychotherapist, which means that I will often need to speak with everyone involved in order to help you and your family make progress.

Professional Fees:

My current regular fees are as follows and were discussed with you on the phone prior to our first appointment. Standard fees may be raised on an annual basis. You will be notified in writing at least one-month prior to any changes in fees if they occur. At this time, a new contract will be signed.

Regular therapy services: I have agreed to a set fee of \$125 for 45-50 minute individual sessions, \$190 for 70-75 minute individual sessions and 70-75 minute family sessions, and \$225 for the 90 minute initial assessment. Payment options include cash and check. Payment in full is required at the **beginning** of each session.

Other services: Telephone conversations (5 minutes or longer), site visits, report writing and reading, consultation with other professionals on your child's behalf, release of information, reading records, longer sessions, travel time, etc. will be charged at my regular rate, unless indicated and agreed otherwise. I will provide you with a bill for these services at the end of each month, unless you request it sooner.

Insurance Reimbursement: I am an out-of-network provider and am not on any insurance panels. I will provide you with a statement at the end of each month that you can choose to submit to your insurance carrier for reimbursement. Some insurance companies will not cover outpatient psychotherapy. Therefore, it is your responsibility to contact your insurance company prior to our initial appointment to inquire about reimbursement.

Litigation Limitation:

Due to the nature of the therapeutic process and the fact that it often involves making a full disclosure with regard to many matters that may be of a confidential nature, it is agreed that should there be legal proceedings (such as, but not limited to, divorce and custody disputes, injuries, lawsuits, etc.), neither parent/guardian nor your attorney, nor anyone else acting on your behalf will call on me to testify in court or at any other proceeding, nor will a disclosure of the psychotherapy records be requested. If I am called to testify by another party, you will be expected to pay for all of my professional time, including preparation and transportation costs. I charge \$250 per hour for preparation and attendance at any legal proceedings.

Consultation:

I consult regularly with other professionals regarding my clients; however, no identifying information is ever mentioned. Your identity remains completely anonymous and confidentiality is fully maintained. If you do not 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.

Medications:

Medications need to be prescribed by a psychiatrist or physician. A referral to a psychiatrist for an evaluation can be made if needed.

Professional Relationship:

In your best interest, and following the Board of Behavioral Science's standards, I can only be your therapist. I cannot have any other role in your life. I cannot, now or ever, be a close friend or socialize with any of my clients and/or their parents. I can never have a sexual or romantic relationship with any client and/or their parents, during or after the course of therapy. I cannot have a business relationship with any of my clients and/or their parents, other than the therapy relationship. To respect your privacy, if I see you in the community, I will not acknowledge you unless you have first acknowledged me.

Contacting Me:

If you need to contact me between sessions, please leave a message on my voicemail at (408) 772-7052 and your call will be returned as soon as possible. I check my messages a few times a day. If an emergency situation arises, please indicate it clearly in your message. If you need to talk to someone right away, you can call the Police (911) or 24-hour Suicide and Crisis Service at (408) 279-3312.

Cancellations, Missed Sessions, and Tardiness:

You will be charged the usual fee for sessions that you miss or cancel with less than **48 hours notice**, regardless of the reason.

Please initial here to acknowledge this policy: _____

Generally, I will start sessions on time. Sessions will end at the set time, even if you are late. If (on rare occasion) I begin a session late, I will make up the missed time in some mutually agreeable fashion (eg. by extending the session, if convenient for you.)

Ending Therapy:

You may end therapy at any time. A final session is strongly recommended for closure of our work together. If at any point during treatment I feel that I am not effective in helping you reach your therapeutic goals or if I believe that you could benefit from a treatment I cannot provide, I will discuss this with you and give you the names of other qualified professionals who may be better able to help you at this time.

If I must discontinue our relationship because of illness, disability, or other presently unforeseen circumstances, I ask you to agree to my transferring your records to another therapist who will assure their confidentiality, preservation, and appropriate access.

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HIPAA NOTICE OF PRIVACY PRACTICES

I. 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.

II. It is my legal duty to safeguard your protected health information (PHI).

By law I am required to insure that your PHI is kept private. The PHI constitutes information created or noted by me that can be used to identify you. It contains data about your past, present, or future health or condition, the provision of health care services to you, or the payment for such health care. I am required to provide you with this notice about my privacy procedures. This notice must explain when, why, and how I would use and/or disclose your PHI. Use of PHI means when I share, apply, utilize, examine, or analyze information within my practice; PHI is disclosed when I release, transfer, give, or otherwise reveal it to a third party outside my practice. With some exceptions, I may not use or disclose more of your PHI than is necessary to accomplish the purpose for which the use or disclosure is made; however, I am always legally required to follow the privacy practices described in this notice.

Please note that I reserve the right to change the terms of this notice and my privacy policies at any time as permitted by law. Any changes will apply to PHI already on file with me. Before I make any important changes to my policies, I will immediately change this notice and post a new copy of it in my office. You may also request a copy of this notice from me, or you can view a copy of it in my office.

III. How I will use and disclose your PHI.

I will use and disclose your PHI for many different reasons. Some of the uses or disclosures will require your prior written authorization; others, however, will not. Below you will find the different categories of my uses and disclosures, with some examples.

A. Uses and Disclosures Related to Treatment, Payment, or Health Care Operations Do Not Require Your Prior Written Consent

I may use and disclose your PHI without your consent for the following reasons:

1. For treatment: I can use your PHI within my practice to provide you with mental health treatment. I may disclose your PHI to physicians, psychiatrists, psychologists, and other licensed health care providers who provide you with health care services or are otherwise involved in your care. Example: If a psychiatrist is treating you, I may disclose your PHI in order to coordinate your care.

2. For health care operations: I may disclose your PHI to facilitate the efficient and correct operation of my practice. Examples: Quality control—I might use your PHI in the evaluation of the quality of health care services that you have received or to evaluate the performance

of the health care professionals who provided you with these services. I may also provide your PHI to my attorneys, accountants, consultants, and others to make sure that I am in compliance with applicable laws.

3. **To obtain payment for treatment:** I may use and disclose your PHI to bill and collect payment for the treatment and services I provided you. Example: I might send your PHI to your insurance company or health plan in order to get payment for the health care services that I have provided to you. I could also provide your PHI to business associates, such as billing companies, claims processing companies, and others that process health care claims for my office.
4. **Other disclosures:** Examples: Your consent isn't required if you need emergency treatment provided that I attempt to get your consent after treatment is rendered. In the event that I try to get your consent but you are unable to communicate with me (for example, if you are unconscious or in severe pain) but I think that you would consent to such treatment if you could, I may disclose your PHI.

B. Certain Other Uses and Disclosures Do Not Require Your Consent

I may use and/or disclose your PHI without your consent or authorization for the following reasons:

1. **When disclosure is required by federal, state, or local law; judicial, board, or administrative proceedings; or law enforcement** Example: I may make a disclosure to the appropriate officials when a law requires me to report information to government agencies, law enforcement personnel, and/or in an administrative proceeding.
2. **If disclosure is compelled by a party to a proceeding before a court of an administrative agency pursuant to its lawful authority.**
3. **If disclosure is required by a search warrant lawfully issued to a governmental law enforcement agency.**
4. **If disclosure is compelled by the patient or the patient's representative pursuant to California health and safety codes or to corresponding federal statutes or regulations, such as the privacy rule that requires this notice.**
5. **To avoid harm.** I may provide PHI to law enforcement personnel or persons able to prevent or mitigate a serious threat to the health or safety of a person or the public (i.e., adverse reaction to meds).
6. **If disclosure is compelled or permitted by the fact that you are in such mental or emotional condition as to be dangerous to yourself or the person or property of others, and if I determine that disclosure is necessary to prevent the threatened danger.**
7. **If disclosure is mandated by the California Child Abuse and Neglect Reporting law.** For example, if I have a reasonable suspicion of past or present child abuse or neglect.
8. **If disclosure is mandated by the California Elder/Dependent Adult Abuse Reporting law.** For example, if I have a reasonable suspicion of elder abuse or dependent adult abuse.

9. If disclosure is compelled or permitted by the fact that you tell me of a serious/imminent threat of physical violence by you against a reasonably identifiable victim or victims.

10. For public health activities. Example: In the event of your death, if a disclosure is permitted or compelled, I may need to give the county coroner information about you.

11. For health oversight activities. Example: I may be required to provide information to assist the government in the course of an investigation or inspection of a health care organization or provider.

12. For specific government functions. Examples: I may disclose PHI of military personnel and veterans under certain circumstances. Also, I may disclose PHI in the interests of national security, such as protecting the president of the United States or assisting with intelligence operations.

13. For research purposes. In certain circumstances, I may provide PHI in order to conduct medical research.

14. For Workers' Compensation purposes. I may provide PHI in order to comply with Workers' Compensation laws.

15. Appointment reminders and health-related benefits or services. Examples: I may use PHI to provide appointment reminders. I may use PHI to give you information about alternative treatment options or other health care services or benefits I offer.

16. If an arbitrator or arbitration panel compels disclosure, when arbitration is lawfully requested by either party, pursuant to subpoena *duces tectum* (e.g., a subpoena for mental health records) or any other provision authorizing disclosure in a proceeding before an arbitrator or arbitration panel.

17. If disclosure is required or permitted to a health oversight agency for oversight activities authorized by law. Example: When compelled by U.S. Secretary of HHS to investigate or assess my compliance with HIPAA regulations.

18. If disclosure is otherwise specifically required by law.

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

I may provide your PHI to a family member, friend, or other individual who you indicate is involved in your care or responsible for the payment for your health care, unless you object in whole or in part. Retroactive consent may be obtained in emergency situations.

D. Other Uses and Disclosures Require Your Prior Written Authorization

In any other situation not described in Sections IIIA, IIIB, and IIIC above, I will request your written authorization before using or disclosing any of your PHI. Even if you have signed an authorization to disclose your PHI, you may later revoke that authorization, in writing, to stop any future uses and disclosures (assuming that I haven't taken any action subsequent to the original authorization) of your PHI by me.

IV. The rights you have regarding your PHI

A. The Right to See and Get Copies of Your PHI.

In general, you have the right to see your PHI that is in my possession, or to get copies of it; however, you must request it in writing. If I do not have your PHI, but I know who does, I will advise you how you can get it. You will receive a response from me within 30 days of my receiving your written request. Under certain circumstances, I may feel I must deny your request, but if I do, I will give you, in writing, the reasons for the denial. I will also explain your right to have my denial reviewed.

If you ask for copies of your PHI, I will charge you not more than \$0.25 per page. I may see fit to provide you with a summary or explanation of the PHI, but only if you agree to it, as well as to the cost, in advance.

B. 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. While I will consider your request, I am not legally bound to agree. If I do agree to your request, I will put those limits in writing and abide by them except in emergency situations. You do not have the right to limit the uses and disclosures that I am legally required or permitted to make.

C. The Right to Choose How I Send Your PHI to You

It is your right to ask that your PHI be sent to you at an alternate address (for example, sending information to your work address rather than your home address) or by an alternate method (for example, via e-mail instead of by regular mail). I am obliged to agree to your request providing that I can give you the PHI, in the format you requested, without undue inconvenience. I may not require an explanation from you as to the basis of your request as a condition of providing communications on a confidential basis.

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

You are entitled to a list of disclosures of your PHI that I have made. The list will not include uses or disclosures to which you have already consented, that is, those for treatment, payment, or health care operations, sent directly to you, or to your family; neither will the list include disclosures made for national security purposes, disclosures to corrections or law enforcement personnel, or disclosures made before April 15, 2003. After April 15, 2003, disclosure records will be held for 6 years.

I will respond to your request for an accounting of disclosures within 60 days of receiving your request. The list I give you will include disclosures made in the previous 6 years (the first 6-year period being 2003–2009) unless you indicate a shorter period. 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 cost, unless you make more than 1 request in the same year, in which case I will charge you a reasonable sum based on a set fee for each additional request.

E. The Right to Amend Your PHI

If you believe that there is some error in your PHI or that important information has been omitted, it is your right to request that I correct the existing information or add the missing information. Your request and the reason for the request must be made in writing. You will receive a response within 60 days of my receipt of your request. I may deny your request, in writing, if I find that: the PHI is (a) correct and complete, (b) forbidden to be disclosed, (c) not part of my records, or (d) written by someone other than me. My denial must be in writing and must state the reasons for the denial. It must also explain your right to file a written statement

objecting to the denial. If you do not file a written objection, you still have the right to ask that your request and my denial be attached to any future disclosures of your PHI. If I approve your request, I will make the change(s) to your PHI. Additionally, I will tell you that the changes have been made, and I will advise all others who need to know about the change(s) to your PHI.

F. The Right to Get This Notice by E-mail

You have the right to get this notice by e-mail. You also have the right to request a paper copy of it.

V. How to complain about my privacy practices

If, in your opinion, I may have violated your privacy rights, or if you object to a decision I made about access to your PHI, you are entitled to file a complaint with the person listed in Section VI below. You may also 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 or by calling (202) 619-0257. If you file a complaint about my privacy practices, I will take no retaliatory action against you.

VI. 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 DHHS, please contact me at: 315 University Avenue, Los Gatos, CA 95030.

VII. Effective date of this notice

This notice is in effect as of April 15, 2003.

ADDENDUM: Please note that Lindsay Smith, LCSW provides privacy protection beyond these Federal requirements. However, your notification of the above is required by Federal law.