Holistic Psychotherapy
30 Old Kings Highway South
Darien, Connecticut 06820
203-655-4854

Client Information

Client Last Name	First Name	Middle Initial	Date of Birth

Address	City	State	Zip Code

Home Phone	Work Phone	Cell Phone	Email

Referred by

Emergency Contact Name and Phone Numbers

Welcome to Holistic Psychotherapy. I am truly honored and excited to be on this journey of self-discovery with you. I look forward to helping you through your struggles so that you can experience and enjoy life to the fullest.

Please take a moment to familiarize yourself with our office policies and procedures. If there are any items that are unclear to you, please do not hesitate to ask for clarification.

Appointments, Fees, and Cancellation Policy

Healing and change occur by taking the time to explore your experiences and how they have influenced your thoughts and feelings and behaviors. Personal growth is a learning process. Each session builds on the next; therefore, it is important to be consistent with your appointments in order to get the most out of therapy.

Payment is due at the time of your appointment. If for any reason you cancel an appointment with less than 24-hours notice you are responsible for payment. Phone sessions at the time of your scheduled appointment are offered as a substitute in the event of unexpected circumstances. If you cannot make it into the office, please let me know if you would like a phone session, and call the office at the appointed time.

There is a fee for any written or verbal communication in regards to you that would require a substantial amount of my time. These charges are prorated based on my hourly fee.

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The preferred form of payment is a check, credit cards are accepted also. Payment is due at the time of service. If payment is not received within 2 weeksof the appointment, the credit card on file will be charged. The discounted rate for payment with a check will not be applied.

Credit Card and #:_____

Expiration Date:_____ Security Code:_____ Zip Code: _____

Use of the Internet for Communication

The internet is not an entirely secure means of communicating information. This includes email, text, and telecommunication. Communication can be intercepted or misdirected.
Use of email, text, and telecommunication indicates that you acknowledge and accept the possible risks associated with such communication(s).

Contacting me

Unfortunately, because I am often in session, I am usually not immediately available by telephone. I will make every effort to return your call as soon as possible. I will always try and notify you in person when I will be out of the office and not returning calls; otherwise, you will be informed through my voice mail. If you have an emergency, and I cannot be reached, please contact Info-Line at 1-800-203-1234. This crisis line is available 24-hours a day.

Insurance

We participate with out-of-network insurance companies only. I will provide you with a statement at the time of your appointment which will include: the date of service, your name, and diagnosis, type of service, the fee, my license number, and social security number. It is your decision if you would like to submit it to your insurance company for reimbursement.

Confidentiality and the Release of Information

Your participation in therapy and all information about you is confidential and will not be disclosed to anyone without your written consent. The only expectations are: 1) cases of suspected abuse or neglect of a child or elder, 2) cases where I believe the client presents a clear and imminent danger to him/herself or to another person, 3) judicial proceedings if ordered by a judge and 4) workers compensation.

I have read and understood the above policies and procedures.

_____ _____
Signature Date

_____ _____
Signature of Parent (s) / Legal Guardian (s) if client is a minor Date

_____ _____
Printed Name (s) Relationship to client

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CONNECTICUT NOTICE FORM

Notice of Psychotherapist's 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.
  – *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 such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.
- "*Disclosure*" applies to activities outside of my office 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, or 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, or health care operations, I will obtain authorization from you before releasing this information. I will also need to obtain 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, 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, in the ordinary course of my profession, have reasonable cause to suspect or believe that any child under the age of eighteen years (1) has been abused or neglected, (2) has had a nonaccidental physical

injury, or injury which is at variance with the history given of such injury, inflicted upon such child, or (3) is placed at imminent risk of serious harm, then I must report this suspicion or belief to the appropriate authority.

- *Adult and Domestic Abuse* – If I know or in good faith suspect that an elderly individual or an individual, who is disabled or incompetent, has been abused, I may disclose the appropriate information as permitted by law.

- *Judicial and 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 information without the written authorization of you or your legally appointed representative or court order. The privilege does not apply when you are being evaluated by 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* – If I believe in good faith that there is a risk of imminent personal injury to you or to other individuals or risk of imminent injury to the property of other individuals, I may disclose the appropriate information as permitted by law.

- *Worker's Compensation* – I may disclose protected health information regarding you as authorized by and to the extent necessary to comply with laws relating to worker's compensation or other similar programs, established by law, that provide benefits for work-related injuries or illness without regard to fault.

IV. Patient's Rights and Psychotherapist'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. 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. On 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. 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.

Psychotherapist'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 provide you with a revised form in person or by mail.

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 State of Connecticut, Dept. of Public Health (860-509-7603). 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 the first date of service.

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 hand or by U.S. mail.

After you review this form, I will ask you to sign that you have read and understood these privacy policies on a form that will be maintained in your client file.

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ACKNOWLEDGEMENT OF RECEIPT OF HIPAA PRIVACY NOTICE

YOUR SIGNATURE BELOW INDICATES THAT YOU HAVE RECEIVED THE HIPAA PRIVACY NOTICE FOR HOLISTIC PSYCHOTHERAPY. IF YOU HAVE ANY QUESTIONS ABOUT ITS CONTENT, YOU ARE ENCOURAGED TO ASK FOR FURTHER CLARIFICATION.

_____
(Print Name)

_____
(Your Signature)

_____
(Date)