Teresa McIntyre-Harlow, PhD

Licensed Clinical Psychologist
PSY19632
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Placerville, CA 95667
530-677-2213 message/FAX
530.306.9615 cell

laughandlearn@docteresa.com

Name:_____ Date:_____

DOB:_____ Age:_____ Address:_____

_____

Phone:_____ Cell:_____ Messages OK?_____

Employer:_____ Occupation:_____

Physician's Name/Phone/Address:_____

Date of last exam: _____ Previous Psychotherapy?_____

When and with whom?_____

Previous hospitalizations?_____

Reasons for today's
appointment?_____

_____

_____

Children?_____

_____

Person to call in case of
emergency?Phone?_____

_____

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OFFICE POLICIES AND GENERAL INFORMATION

CONFIDENTIALITY:

All information disclosed within sessions and the written records pertaining to those sessions are confidential and may not be revealed to anyone without your written permission, except where discloser is required by law in which information must be released with or without your permission. These situations include: (1) If you appear to be dangerous to yourself or others or are gravely disabled, Dr. McIntyre-Harlow will take measures to attempt to ensure your safety; (2) If you tell Dr. McIntyre-Harlow of a serious intent to physically harm another person, then Dr. McIntyre-Harlow must warn that person and the police; (3) If Dr. McIntyre-Harlow has a reasonable suspicion of child abuse or neglect or sees physical signs of elder abuse of a dependent adult, then a report must be made to the designated protective agency.

Disclosure may also be required pursuant to a legal proceeding. If you place your mental status at issue in litigation initiated by you, the defendant may have the right to obtain the psychotherapy records and/or testimony by Dr. McIntyre-Harlow.

In couple and family therapy, or when different family members are seen individually, confidentiality and privilege do not apply between the couple or among family members. Dr. McIntyre-Harlow will use her clinical judgment when revealing such information. If there is an emergency during our work together, or in the future after termination where Dr. McIntyre-Harlow becomes concerned about you personal safety, the possibility of you injuring someone else, or about you receiving proper psychiatric care, she is obliged to do whatever she can within the limits of the law, to prevent you from injuring yourself or others and to ensure that you receive the proper medical care. For this purpose, she may also contact the person whose name you have provided on the intake/biographical sheet.

Disclosure of confidential information may be required by your health insurance carrier or HMO/PPO/MCO/EAP in order to process the claims. Only the minimum necessary information will be communicated to the carrier. Dr. McIntyre-Harlow has no control or knowledge over what insurance companies do with the information she submits.

Due to the nature of the therapeutic process and the fact that it often involves making a full discloser with regard to many matters which 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,

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injuries, lawsuits, etc.), neither you nor your attorney(s), nor anyone else acting on your behalf will call on Dr. McIntyre-Harlow to testify in court or at any other proceedings, nor will a disclosure of the psychotherapy records be requested.

As a patient, you have the right to receive your records or receive a summary of your records at any time, except in limited legal or emergency circumstances or when Dr. McIntyre-Harlow assesses that releasing such information might be harmful in any way. In such a case, Dr. McIntyre-Harlow may provide the records to an appropriate and legitimate mental health professional of your choice. Considering release of information to any agency/person you specify unless Dr. McIntyre-Harlow assesses that releasing such information might be harmful in any way.

TELEPHONE AND EMERGENCY PROCEDURES:

If you need to contact Dr. McIntyre-Harlow between sessions, please leave a message on the answering system (530.677.2213) and your call will be returned as soon as possible. Dr. McIntyre-Harlow picks up her messages daily. If an emergency situation arises, please indicate it clearly in your message. If you need to speak with someone immediately, please call the El Dorado County Mental Health Crisis Line at 530. 522.3345. If there is a life threatening emergency, please call 911. If your call is not answered in a reasonable time, please call again. No call is deliberately ignored, but errors do sometimes occur when information is relayed through voice mail. You may email her at laughandlearn@docteresa.com.

PAYMENTS AND INSURANCE REIMBURSEMENT:

Clients are expected to pay the fee/copay $_____per 45 minute session at the end of each session unless other arrangements have been made. Telephone conversations, site visits, report writing and reading, consultation with other professionals, release of information, reading records, longer sessions, travel time, etc. will be charged at the same rate, unless indicated and agreed otherwise. Please notify Dr. McIntyre-Harlow if a problem arises during the course of therapy regarding your ability to make timely payments. Clients who carry insurance should remember that professional services are rendered and charged to the patient and not to the insurance company. Unless we agree differently, you will be provided a weekly copy of your receipt which you can submit to your insurance company for reimbursement. Not all conditions which are the focus of psychotherapy are reimbursed by insurance companies. It is your responsibility to verify the specifics of your coverage. If your account is overdue and there is no agreement on a payment plan, Dr. McIntyre-Harlow can use legal means to obtain payment.

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THE PROCESS OF THERAPY/ASSESSMENT/EVALUATION:

Participating in therapy can result in a number of benefits to you, including improving interpersonal relationships and resolution of the specific concerns that led you to seek therapy. Working towards these benefits, however, requires effort on your part. Psychotherapy requires your very active involvement, honesty, and openness in order to change your thoughts, feelings, and/or behaviors.

During evaluation, assessment or psychotherapy, remembering or talking about unpleasant events, feelings, or thoughts can result in your experiencing considerable discomfort or strong feelings (for example: anger, sadness, worry, fear, anxiety, depression, insomnia, etc.). Dr. McIntyre-Harlow may redirect some of your assumptions or perceptions or propose different ways of looking at, thinking about, or coping with situations which may result in your feeling upset, angry, depressed, challenged or disappointed. Attempting to resolve issues that brought you to therapy in the first place, such as personal or interpersonal relationships may result in changes that were not originally intended. Psychotherapy may result in decisions about changing behaviors, employment, substance use, schooling, housing, or relationships. Sometimes a decision that is positive for one family member is viewed differently by another family member. Change will sometimes be easy and swift, but more often it will be slow and perhaps even frustrating. There is no guarantee that psychotherapy will yield positive or intended results. During the course of therapy, Dr. McIntyre-Harlow is likely to draw on various psychological approaches according, in part, to the problem that is being treated and her assessment of what will best benefit you. These approaches include EMDR, behavioral, cognitive-behavioral, psychodynamic, existential, system/family, developmental (child, teen, adult, couple, family), spiritual or psycho-educational. If you have any questions about any of the procedures used in the course of your therapy, their risks, Dr. McIntyre-Harlow's expertise in employing them, or about the treatment plan, please ask, and you will be answered fully. You also have the right to ask about other treatments for your condition and their risks and benefits.

If you could benefit from any treatments that Dr. McIntyre-Harlow does not provide, she has an ethical obligation to assist you in obtaining those treatments.

Dr. McIntyre-Harlow consults regularly with other professionals regarding her patents; however, patients' names or other identifying information are never mentioned. Patients' identities remain completely anonymous, and confidentiality is fully maintained.

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After the first few meetings, Dr. McIntyre-Harlow will assess if she can be of benefit to you. Dr. McIntyre-Harlow does not accept clients who, in her opinion, she cannot help. In such a case, she will give you a number of referrals that you can contact. If at any point during the psychotherapy Dr. McIntyre-Harlow assesses that she is not effective in helping you reach the therapeutic goals, she is obligated to discuss it with you and if appropriate, to terminate treatment. In such a case, she would give you a number of referrals which may be of help to you. If you request and authorize in writing, Dr. McIntyre-Harlow will talk to the psychotherapist of your choice in order to help you transition. If at any time you wish another professional's opinion or wish to consult with another therapist, Dr. McIntyre-Harlow will assist you in finding someone qualified, and if she has your written consent, she will provide her or him with the essential information needed.

Please note that therapy NEVER involves sexual or business relationships or any dual relationship that impairs Dr. McIntyre-Harlow's objectivity, clinical judgment, therapeutic effectiveness or can be exploitative in nature.

You have the right to terminate therapy at any time. If you choose to do so, Dr. McIntyre-Harlow will offer to provide you with names of other qualified professionals whose services you might prefer.

CANCELLATION:

Since the scheduling of an appointment involves the reservation of time specifically for you, a minimum of 24 hours (1 day) notice is required for rescheduling or canceling an appointment. Unless we reach a different agreement, the full fee will be charged for sessions missed without such notification. Most insurance companies do not reimburse for missed sessions.

I have read the above office policies and I understand them. I agree to comply with them.

_____

Client Name (Print) Date Signature

_____

Client Name (Print) Date Signature

_____

Teresa McIntyre-Harlow, PhD

Psychologist Date Signature

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HIPPA 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. 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 and on my website. You may also request a copy of this Notice from me, or you can view a copy of it in my office or on my website, which is located at www.DocTeresa.com.

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 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

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psychiatrist is treating you, I may disclose your PHI to her/him in order to coordinate your care.

2. For health care operations. I may disclose you 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 part 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 statues of regulation, such as the Privacy Rule that requires this Notice.

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5. To avoid harm. I may provide PHI to law enforcement personnel or person able to prevent or mitigate a serious threat to the health or safety of a person or the public.
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 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 interest 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.

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17. I am permitted to contact you, without your prior authorization, to provide appointment reminders or information about alternative or other health-related benefits and services that may be of interest to you.
18. If disclosure is required or permitted to a health oversight agency for oversight activities authorized by law. Example: when compelled by US Secretary of Health and Human Services to investigate or assess my compliance with HIPAA regulations.
19. If disclosure is otherwise specifically required by law.

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

1. Disclosures to family, friends, or others. I may provide your PHI to a family member, friend, or other 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.

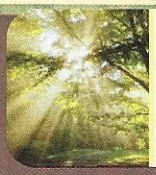
D. Other Uses and disclosures Require Your Prior Written Authorization. In any other situation not described in Sections IIIA, IIIB, and IIIC above, I will request your written authorization before using or disclosing any of your PHI. Even if you have signed an authorization to disclose your PHI, you 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. WHAT RIGHTS YOU HAVE REGARDING YOUR PHI

These are your rights with respect to your PHI:

A. The right to see and get copies of you PHI. In general, you have the right to see you 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 you PHI, I will charge you not more than $.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 disclosers 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



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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 you 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 email 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.

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, i.e., 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, to corrections or law enforcement personnel, or disclosures made before April 15, 2003. After April 15, 2003, disclosure records will be held for six years. I will respond to your request for an account of disclosures within 60 days of receiving your request. The list I give you will include disclosures made in the previous six years (the first six year period being _____) 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 one 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. our 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

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been made, and I will advise all others who need to know about the change(s) to you PHI.
F. The right to get this notice by email. You have the right to get this notice by email. You have the right to request a paper copy of it, as well.

V. HOW TO COMPLAIN ABOUT MY PRIVACY PRACTICES
If, in your opinion, I may have violated our 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 complain to the Secretary of the Department of Health and Human Services at 200 Independence Avenue S.W., Washington, DC 20201. I 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 Department of Health and Human Services, please contact me at Teresa McIntyre-Harlow, PhD, 493 Main Street, Suite D, Diamond Springs, CA 95619, 530-677-2213 message and fax, or www.DocTeresa.com.

VII. EFFECTIVE DATE OF THIS NOTICE
This notice went into effect on April 14, 2003

I acknowledge receipt of this notice

Patient Name (Please print):_____

Date: _____

Signature: _____

Patient Name (Please print):_____

Date: _____

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Signature: _____

Patient Name (Please print): _____

Date: _____

Signature: _____

Patient Name (Please print): _____

Date: _____

Signature: _____

Patient Name (Please print): _____

Date: _____

Signature: _____

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TELEPHONE CONTACT PREFERENCES/DIRECTIONS

I hereby give permission:

YES NO

____ ____ Leave a message for me on my telephone answering system at my home telephone number: _____.

____ ____ Leave a message for me with a family member at my home telephone number: _____.

____ ____ Leave a message for me on my cell phone. Telephone number: _____.

____ ____ Leave a message for me on my telephone answering system at my work. Telephone number: _____.

____ ____ Leave a message for me at my work with a colleague indicating only that _____.

____ ____ Text or email me with messages at the following phone number(s) or email: _____.

Patient Name:_____ Date:_____

Signature:_____

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AUTHORIZATION CONSENTING TO RELEASE OF INFORMATION

I, _____ and/or _____

Name of Client Name of Parent/Guardian

authorize Teresa McIntyre-Harlow, PhD, Licensed Clinical Psychologist, PSY19632 to discuss verbally or in writing any materials that have been brought up during psychotherapy with the person(s) or staff of clinic, office, agency, or institution(s) named below and to receive any relevant information from the person(s) named below. Please Initial _____

1. _____

Name / Address / Telephone Number

2. _____

Name / Address / Telephone Number

3. _____

Name / Address / Telephone Number

This consent may be revoked by me at any time. This consent is in effect only for three years from the date of the last session, unless revoked earlier or renewed.

Client: _____ Date: _____

Parent/Guardian: _____ Date: _____

Witness: _____ Date: _____

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CONSENT FOR EYE MOVEMENT DESENSITIZATION AND REPROCESSING TREATMENT

Teresa McIntyre-Harlow, PhD: Certified EMDR Practitioner, Levels I and II

I have been advised and understand that Eye Movement Desensitization and Reprocessing Treatment (EMDR) is a treatment approach that has been widely validated by research only with civilian PTSD. Research on other applications of EMDR is now in progress.

I have also been specifically advised of the following:

1. Distressing, unresolved memories may surface through the use of the EMDR procedure.

2. Some clients have experienced reactions during the treatment sessions that neither they nor the administering clinician may have anticipated, including a high level of emotion or physical sensations.

3. Subsequent to the treatment session, the processing of incidents/material may continue, and other dreams, memories, flashbacks, feelings, etc. may surface.

Before commencing EMDR treatment, I have thoroughly considered all of the above. In addition, I acknowledge that I do not now nor ever have had a known medical condition that would prohibit my participation in EMDR treatment. I have obtained whatever additional input and/or professional advice I deemed necessary or appropriate to having EMDR treatment, and by my signature below I hereby consent to receiving EMDR treatment.

My signature on this acknowledgement and consent is free from pressure or influence from any person or entity.

CLIENT SIGNATURE: _____

DATE: _____