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OFFICE POLICIES / INFORMED CONSENT / NOTICE OF PRIVACY PRACTICES / CLIENT INFORMATION

Welcome to my psychotherapy practice. I look forward to working with you. Please read these polices, *Notice of Privacy Practices*, complete the *Client Information* section, and sign at the end of the document.

Life is about relationships. As a Licensed Clinical Social Worker, I specialize in helping people with relational issues. There are many different types of therapy, and I tend to use an eclectic, transpersonal, and systems-based approach which takes into consideration where a person has been in their life and the many factors which influence where they are right now. I also utilize somatic-based therapies, encourage creative expression and rely on poetic and nature-based healing traditions for inspiration.

Should you choose to proceed, a positive outcome then becomes our mutual responsibility. This begins with your trust in and commitment to the treatment process, and my commitment to address your questions and concerns as they come up during session. It also involves my commitment to you as your therapist, helping you to find healing and wholeness in your thoughts, feelings, behaviors and personal values, while you discover more rewarding ways of relating.

In addition to being a clinical process, therapy involves a professional arrangement, regulated by laws, ethics, your rights as a client, and my standard business practices.

CONFIDENTIALITY

All information that you share with me is kept in complete confidence with the following exceptions: I am legally and ethically required to disclose information without your permission if I suspect that you are a danger to yourself or others, or if I have suspicions of child or elder abuse by you or someone you have told me about.

I may also be required by a court to release your records and would do so only after consultation with you. It may be helpful for me to consult with and exchange information with your other medical and/or psychotherapeutic providers. In order for me to do so, you will need to complete an *Authorization for Release of Information* form.

If you are using insurance coverage to pay for our sessions, I will be required to give them specific information which may include dates of sessions, diagnostic information, and session notes. Please discuss with me if you want further information about this.

If you choose to communicate with me by email, apply for insurance reimbursement, or tell other people about your therapy, I am not responsible for potential outcomes related to those breaches of confidentiality.

PAYMENT OF FEES / CANCELLATION POLICY

My fee for a 55 minute session is $150. I have some low-fee slots available. Please ask about the availability of these slots before we begin treatment. Payment is expected at the time of session. I am open to working with you to make your therapy experience affordable. We can discuss reduced fees and payment plans for extenuating circumstances.

I accept cash, check, credit cards, or PayPal. Returned checks will be assessed a $30 fee. If you need to cancel or reschedule an appointment, please do so at least 48 hours in advance. Late cancellations (less than 48 hours) or no-shows will incur a fee equal to your session fee. Repeated no-shows or cancellations will require prepayment for future appointments. ***Please be advised that if you are using your insurance for our sessions, you will be responsible for any late cancellation or no-show fees as insurance companies do not reimburse for these fees. In these cases, you will be charged my normal hourly rate of $150.***

Written reports, telephone calls or sessions with you and/or authorized telephone consultations with others concerning your therapy — any of which require more than 15 minutes of my time — will be charged proportionally to your hourly fee. These services are generally not covered by insurance. Our sessions end 55 minutes after our scheduled start time. Please be prompt to maximize our time together.

INSURANCE

I am currently a provider for *Medicare, MediCal, Beacon, Triwest, Magellan, CIGNA, ESPYR (EAP Program), Anthem Blue Cross and Blue Shield*. I also see Kaiser patients through Magellan and Beacon. Please check with your insurance carrier prior to commencing treatment to be sure that I am a provider with your particular plan. ***Please be aware that I have limited insurance slots available.*** If you want to use your insurance and I don't have any current openings for insurance clients, I will provide you with a Statement which you can submit to your insurance for reimbursement. As stated above, insurance companies do not reimburse for late cancellation and no-shows, so you are responsible for those fees.

EMERGENCIES / CRISES / CONTACT BETWEEN SESSIONS

I will make every effort to assist you during emergencies or crises. However, there may be times when I am unavailable or unable to do so. If you are in crisis and are unable to reach me, please contact Psychiatric Emergency Services at 576-8181, go to your nearest Emergency Room, or call 911.

I check messages on my voice mail at 707.773.7755 throughout the day Tuesdays through Fridays, and I return calls within 24 hours unless I am out of town, about which I will give you advanced notice. Messages received after 5:00 p.m. and on weekends will be returned the following business day.

If you choose to communicate with me via email, please be aware that this method of communication is not confidential. I will return emails at the same schedule of voice mail messages listed above. Please be aware that I do not communicate with clients via Facebook, Twitter or other social media platforms. Texting is possible for scheduling or other logistical issues only, and only if we agree to do so beforehand.

DRUG / ALCOHOL USE

I ask that you not attend sessions under the influence of drugs or alcohol. If you appear to be under the influence, I will ask you to reschedule the appointment. You will be responsible for payment for the session.

RISKS ASSOCIATED WITH PSYCHOTHERAPY

Like many things in life, psychotherapy has inherent risks. Some of these risks to you are:

- disruptions in your daily life that can occur because of therapeutic changes;
- emotional pain due to exploring personal issues and family history;
- experiencing emotional pain within your current relationships;
- although we hold the intention, there is no guarantee that your life and relationship(s) will improve.

TREATMENT TERMINATION

Ideally, therapy ends when we agree your treatment goals have been achieved. However, you have the right to stop treatment at any time. If you make this choice, I can give you referrals to other therapists. I will also ask you to attend at least one final 'termination' session. Legal, ethical or other circumstances may arise that require that I terminate treatment with you. If this occurs, I will explain this to you and offer referrals to other local therapists. Also, please be advised that I cannot diagnose or treat problems outside the recognized boundaries of my competencies.

NOTICE OF PRIVACY PRACTICES

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

Your health record contains personal information about you and your health. This information, which may identify you and relates to your past, present or future physical or mental health or condition and related health care services, is referred to as Protected Health Information ("PHI"). This Notice of Privacy Practices describes how I may use and disclose your PHI in accordance with applicable law. It also describes your rights regarding how you may gain access to and control your PHI.

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

HOW I MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU:

For Treatment. Your PHI may be used and disclosed by those who are involved in your care for the purpose of providing, coordinating, or managing your health care treatment and related services. This includes consultation with clinical supervisors or other treatment team members. I may disclose PHI to any other consultant only with your authorization.
For Payment. I may use or disclose PHI so that I can receive payment for the treatment services provided to you. This will only be done with your authorization. Examples of payment-related activities are: making a determination of eligibility or coverage for insurance benefits, processing claims with your insurance company, reviewing services provided to you to determine medical necessity, or undertaking utilization review activities. If it becomes necessary to use collection processes due to lack of payment for services, I will only disclose the minimum amount of PHI necessary for purposes of collection.
For Health Care Operations. I may use or disclose, as needed, your PHI in order to support my business activities including, but not limited to, quality assessment activities, reminding you of appointments, to provide information about treatment alternatives or other health related benefits and services, licensing, and conducting or arranging for other business activities. For example, I may share your PHI with third parties that perform various business activities (e.g., billing or typing services) provided we have a written contract with the business that requires it to safeguard the privacy of your PHI. For training or teaching purposes PHI will be disclosed only with your authorization.
Required by Law. Under the law, I must make disclosures of your PHI to you upon your request. In addition, I must make disclosures to the Secretary of the Department of Health and Human Services for the purpose of investigating or determining my compliance with the requirements of the Privacy Rule.

Following is a list of the categories of uses/disclosures permitted by HIPAA without an authorization:

Abuse and Neglect	**Emergencies**
Judicial and Administrative Proceedings	**National Security**
Law Enforcement	
Public Safety (Duty to Warn)	

Without Authorization. Applicable law and ethical standards permit me to disclose information about you without your authorization only in a limited number of other situations. The types of uses and disclosures that may be made without your authorization are those that are:

- Required by law, such as the mandatory reporting of child abuse or neglect or mandatory government agency audits or investigations (such as the social work licensing board or health department)
- Required by Court Order
- Necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. If information is disclosed to prevent or lessen a serious threat, it will be disclosed to a person or persons reasonably able to prevent or lessen the threat, including the target of the threat.

Verbal and/or Written Permission. I may use or disclose your information to family members that are directly involved in your treatment with your written permission. IN CASE OF EMERGENCY, I may use or disclose your information to family members that are directly involved in your treatment with or without your written or verbal permission.
With Authorization. Uses and disclosures not specifically permitted by applicable law will be made only with your written authorization, which may be revoked.

YOUR RIGHTS REGARDING YOUR PHI

You have the following rights regarding your personal PHI maintained by my office. To exercise any of these rights, please submit your request in writing to me at 115 Liberty Street, Suite 9, Petaluma, CA 94952:

- **Right of Access to Inspect and Copy.** You have the right, which may be restricted only in exceptional circumstances, to inspect and copy PHI that may be used to make decisions about your care. Your right to inspect and copy PHI will be restricted only in those situations where there is compelling evidence that access would cause serious harm to you. I may charge a reasonable, cost- based fee for copies.
- **Right to Amend.** If you feel that the PHI I have about you is incorrect or incomplete, you may ask me to amend the information, although I am not required to agree to the amendment.
- **Right to an Accounting of Disclosures.** You have the right to request an accounting of certain of the disclosures that I make of your PHI. I may charge you a reasonable fee if you request more than one accounting in any 12-month period.
- **Right to Request Restrictions.** You have the right to request a restriction or limitation on the use or disclosure of your PHI for treatment, payment, or health care operations. I am not required to agree to your request unless the request is to restrict disclosure of PHI to a health plan for purposes of carrying out payment or health care operations, and the PHI pertains to a health care item or service that you paid for out of pocket. In that case, I am required to honor your request for a restriction.
- **Right to Request Confidential Communication.** You have the right to request that we communicate with you about medical matters in a certain way or at a certain location.
- **Breach Notification.** If there is a breach of unsecured protected health information concerning you, I may be required to notify you of this breach, including what happened and what you can do to protect yourself.
- **Right to a Copy of this Notice.** You have the right to a copy of this notice.

COMPLAINTS

If you believe I have violated your privacy rights, you have the right to file a complaint in writing with the Secretary of Health and Human Services at 200 Independence Avenue, S.W., Washington, D.C. 20201, or by calling 202.619.0257. **I will not retaliate against you for filing a complaint. The effective date of this Notice is November 1, 2016.**

Authorization to Commence Psychotherapy

My signature below verifies that I have read and understood the information in these policies and Privacy Practices. My signature also acknowledges my willingness to participate in psychotherapy with Christina Ingenito, LCSW, and I understand I can address any future questions to her at the above address.

I also agree to enter into a professional business arrangement according to all business practices outlined in this agreement. I accept financial responsibility for payment of fees and services as described, regardless of insurance coverage or any other 'third-party' payers. I also release Christina Ingenito of liability that directly or indirectly results from disclosure or exchange of information covered in this agreement.

_____ _____

Client Signature **Today's Date**

_____ **Client Refuses to Acknowledge Receipt**

_____ _____

Therapist Signature **Today's Date**

Client Personal Information

Name _____ **Date of Birth** _____

Address _____

City/State _____ **Zip** _____

Email _____

Cell Phone _____ **Home Phone** _____ **Work Phone** _____

Which phone number would you prefer me to use to contact you? _____

Is it okay to leave a detailed and confidential message at that number? _____

Is it okay to text scheduling information only to your cell phone? _____

Emergency Contact Person _____

Phone number(s): _____ **Relationship:** _____

Primary Care Physician _____ **Phone number:** _____

If you are currently under the care of a psychiatrist, please give psychiatrist's name and phone number:

_____

How were you referred to me? _____

Who do you live with? _____

Your relationship status? _____

Occupation _____ **Employer**_____

Have you been in therapy before? _____ **If so, please state the purpose, provider(s) & approximate dates:**

_____

FOR WHAT REASONS ARE YOU CURRENTLY SEEKING THERAPY?

Please circle all that apply.

Grief/Loss	Relationship issues	Cancer or other medical diagnosis
Anxiety/Depression	Family counseling	Gender identity issues
Self-esteem/Self-image	Work/employment issues	Substance abuse/addictions of any kind
Sexuality	Childhood issues	Stress Management
Trauma	Communication issues	Finding meaning and purpose

Other (please explain) _____

Are you having any suicidal thoughts right now or have you in the past? _____

_____

Any significant medical conditions I should know about? _____

_____

Current Medications & Purpose

_____

_____

Any family history of mental illness, alcoholism, substance abuse, suicidal thoughts, attempts or completed suicides? _____

_____

Anything else you want me to know before we begin treatment? _____

_____