CONSENT FORM

Name_____ Birthdate_____ Age_____

Address _____City_____ ZIP_____

Cell Phone_____ Home Phone _____ Okay to leave VM? Y N

Occupation_____Hrs/week_____Employer_____

Marital Status: _____Single _____Dating _____In a relationship _____Married (# years_____)

Primary Physician Name_____ Phone #: _____

Emergency Contact_____Phone #: _____ Relationship_____

CONSENT TO SERVICES: I consent to assessment and psychotherapy treatment from Jennifer Wang-Hall, PhD. I understand that there are no guarantees as to the outcomes of such services. I understand that all communication is privileged except if I am at risk of harming myself or others or is I disclose information regarding neglect or physical, sexual, or emotional abuse.

FINANCIAL AGREEMENTS: Full payment is due at the first visit and at each visit. Credit cards are accepted as payment.

If you agree, please initial the boxes below:
_____I understand that there is a 24-hour cancellation policy and agree to pay $50 for a late cancellation or missed appointment.
_____I authorize payment of benefits to Jennifer Wang-Hall for services provided

Signature_____ Date_____

Printed Name_____

OFFICE POLICIES & GENERAL INFORMATION
AGREEMENT FOR PSYCHOTHERAPY SERVICES

PAYMENTS & INSURANCE REIMBURSEMENT
Clients are expected to pay session fees at the start of each session unless other arrangements have been made. 45-50 minute sessions are $200. Telephone conversations, consultation with other professionals, reading treatment records, etc will be charged at the same rate if such charges are agreed upon in advance by therapist and client. Clients who carry insurance should remember that professional services are rendered and charged to the clients and not to the insurance companies. If you request, your therapist will provide you with a copy of your receipt on a monthly basis, which you can then submit to your insurance company for reimbursement if you so choose. As was indicated in the section, *Health Insurance & Confidentiality of Records,* it is important to be aware that submitting a mental health invoice for reimbursement carries a certain amount of risk. Not all issues which are the focus of psychotherapy, are reimbursed by insurance companies. It is your responsibility to verify the specifics of your coverage.

APPOINTMENT CANCELLATION
Since scheduling of an appointment involves the reservation of time specifically for you, a minimum of 24 hours notice is required for re-scheduling or canceling an appointment. A late cancellation or missed session will result in a $50 charge.

TELEPHONE & EMERGENCY PROCEDURES
If you need to contact me between sessions, call (573) 356-6904. Your call will be returned that day or within the next business day. If you need to speak to a mental health counselor right away and cannot reach me, you may call the San Diego 24-hour crisis line at (800) 479-3339. For emergencies, call 911.

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 disclosure is required by law. Most of the provisions explaining when the law requires disclosure were described to you in the Notice of Privacy Practices that you received with this form.

When Disclosure Is Required By Law: Some of the circumstances where disclosure is required by the law are: where there is a reasonable suspicion of child, dependent or elder, abuse or neglect; and where a client presents a danger to self, to others, to property, or is gravely disabled (for more details see also Notice of Privacy Practices form).

When Disclosure May Be Required: Disclosure may 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 your therapist. 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. Your therapist will use her clinical judgment when revealing such information. Your therapist will not release records to any outside party unless she is authorized to do so by all adult family members who were part of the treatment.

Emergencies: If there is an emergency during the course of therapy treatment, or in the future after termination, in which your therapist becomes concerned about your personal safety, the possibility of you injuring someone else, or about you receiving proper psychiatric care, she will 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 your Emergency Contact person.

Health Insurance & Confidentiality of Records: Disclosure of confidential information may be required by your health insurance carrier in order to process the claims. Only the minimum necessary information will be communicated to the carrier. Unless authorized by you explicitly the Psychotherapy Notes will not be disclosed to your insurance carrier. Your therapist has no control or knowledge over what insurance companies do with the

information she submits or who has access to this information. You must be aware that submitting a mental health invoice for reimbursement carries a certain amount of risk to confidentiality, privacy, or to future eligibility to obtain health or life insurance. The risk stems from the fact that mental health information is entered into insurance companies' computers and soon will also be reported to the congress-approved National Medical Data Bank. Accessibility to companies' computers or to the National Medical Data Bank database is always in question, as computers are inherently vulnerable to break-ins and unauthorized access. Medical data has been reported to have been sold, stolen, or accessed by enforcement agencies; therefore, you are in a vulnerable position.

Confidentiality of Cell Phone and Faxes: It is very important to be aware that cell phone communication and faxes can be relatively easily accessed by unauthorized people and hence, the privacy and confidentiality of such communication can be compromised.

OTHER THERAPEUTIC CONSIDERATIONS

Termination of Therapy: If at any time during treatment your therapist assesses that she cannot be effective in helping you reach your therapeutic goals, she will provide multiple referrals to resources that may be of help to you. If at any time you want another professional's opinion or wish to consult with another therapist, your therapist will assist you in finding someone qualified. You have the right to terminate therapy at any time. At the close of therapy, your therapist will offer to provide you referrals for additional resources for continuing personal development.

Dual Relationships: Not all dual relationships are unethical or avoidable. Therapy never involves sexual or any other dual relationship that impairs your therapist's objectivity, clinical judgment, or therapeutic effectiveness or can be exploitative in nature. Your therapist will assess carefully before entering into non-sexual and non-exploitative dual relationships with clients. Your therapist will discontinue the dual relationship if she finds it interfering with the effectiveness of the therapeutic process or the welfare of the client and, of course, you can do the same at any time.

Consultation with Colleagues: Your therapist may consult with other professionals to ensure she is providing the best treatment for her clients. However, the client's name or other identifying information is never mentioned, and confidentiality is fully maintained.

Chance Encounters: San Diego is a relatively small community and many clients know each other or your therapist from the community. Your therapist will never acknowledge working with you therapeutically to anyone without your written permission. If you see your therapist in a public place, she will acknowledge you only if you initiate the interaction, so as to maintain your confidentiality. Likewise, please respect the privacy of other clients you may recognize in the waiting room or outside the office by not sharing your knowledge of their therapy participation.

Please initial each of the following statements to indicate your agreement and print/sign your name below.

_____ I understand that there is a $50 fee for a missed session that is not cancelled with at least 24 hours notice.

_____ I have read the above Agreement and Office Policies and General Information carefully; I understand them and agree to comply with them.

_____ I have received the Health Insurance Portability and Accountability Act (HIPAA) notice and I consent to the use or disclosure of my Protected Health Information as specified.

_____

Client name #1 (print) **Date** **Signature**

_____

HIPAA NOTICE OF PRIVACY PRACTICES

Health Insurance Portability and Accountability Act (HIPAA)

I. **THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN ACCESS 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 ensure that your PHI is kept private. Your PHI 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.

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. 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 MAY USE AND DISCLOSE YOUR PHI.

The following sections detail federal regulations regarding the conditions under which I am *allowed* to use or disclose your medical information. However, out of regard for your confidentiality, I *will not* disclose any identifying information about you without your prior consent (written, whenever possible), unless I am mandated to do so by law (e.g, to protect the safety of you or others). Federal regulations indicate the following:

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 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 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 of 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.
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 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. **I am permitted to contact you, without your prior authorization, to provide appointment reminders or information about alternative or other heath-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 U.S. 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.

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 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 $.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 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 accounting 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 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 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. 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 Email You have the right to get this notice by email. You have the right to request a paper copy of it, as well.

Consent to Use or Disclose Information for

Treatment, Payment, and Health Care Operations (TPO)

This form provides you the option of explicitly consenting to the use or disclosure of your Protected Health Information as described below.

Federal regulations (HIPAA) allow me (your therapist) to use or disclose Protected Health Information (PHI) from your record in order to provide treatment to you, to obtain payment for the services we provide, and for other professional activities (known as "health care operations."). Nevertheless, I ask your consent in order to make this permission explicit. The Notice of Privacy Practices describes these disclosures in more detail. You have the right to review the Notice of Privacy Practices before signing this consent. I reserve the right to revise the Notice of Privacy Practices at any time. If I do so, the revised Notice will be posted in my office. You may ask for a printed copy of the Notice at any time.

You may ask me to restrict the use and disclosure of certain information in your record that otherwise would be disclosed for treatment, payment, or health care operations; however, I do not have to agree to these restrictions. If I do agree to a restriction, that agreement is binding.

You may revoke this consent at any time by giving written notification. Such revocation will not affect any action taken in reliance on the consent prior to the revocation.

This consent is voluntary; you may refuse to sign it. However, I am permitted to refuse to provide health care services if this consent is not granted, or if the consent is later revoked.

I hereby consent to the use or disclosure of my Protected Health Information as specified above.

Client Name: _____

Client Signature: _____ *Date:* _____

ACKNOWLEDGMENT OF NOTICE OF PRIVACY PRACTICES

Provider Copy

The Notice of Privacy Practices (NPP) provides information about how I may use and disclose protected health information about you.

I acknowledge that I have received the Notice of Privacy Practices.

_____ _____
Signature of Client or Client's Representative *Date*

_____
Print Name

WRITTEN ACKNOWLEDGMENT NOT OBTAINED
Please document your efforts to obtain acknowledgment and reason it was not obtained.

- ☐ Notice of Privacy Practices Given – Client Unable to Sign
- ☐ Notice of Privacy Practices Given – Client Declined to Sign
- ☐ Notice of Privacy Practices and Acknowledgment Mailed to Client
- ☐ Other Reason Client Did Not Sign

_____ _____
Therapist Signature *Date*

ACKNOWLEDGMENT OF NOTICE OF PRIVACY PRACTICES

Patient Copy

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I acknowledge that I have received the Notice of Privacy Practices.

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Print Name

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- ☐ Notice of Privacy Practices and Acknowledgment Mailed to Client
- ☐ Other Reason Client Did Not Sign

_____ _____

Therapist Signature *Date*

Areas of Concern

For any item below that is a concern for you, indicate the severity by placing check marks on the line next to it: ✓ = low; ✓✓ = medium, ✓✓✓ = high.
(blank = not a concern)

____ Depression/Sadness
____ Low self-esteem
____ Mood swings
____ Suicidal thoughts
____ Racing thoughts
____ Anxiety/Worrying/Fearfulness
____ Panic attacks
____ Stress
____ Irritability
____ Obsessive thinking
____ Anger
____ Paranoia
____ Lack of energy
____ Poor concentration
____ Poor memory
____ Traumatic experiences
____ Easily startled
____ Nightmares
____ Upsetting memories
____ Sleep difficulties
____ Physical pain or discomfort
____ Health issues
____ Headaches
____ Back aches
____ Digestive problems
____ Weight
____ Food, eating habits, nutrition
____ Body image or appearance

____ Sexual concerns
____ Family
____ Children
____ Relationships
____ Dating
____ Grief/loss
____ Loneliness or isolation
____ Shyness
____ Trusting others
____ Cultural identity
____ Career
____ School
____ Spiritual/religious
____ Money/finances
____ Legal
____ Drug use
____ Alcohol use
____ Caffeine use
____ Cigarette/nicotine use
____ Addictive behavior
____ Impulsiveness
____ Dishonesty
____ Perfectionism
____ Guilt
____ Indecisiveness
____ Poor judgment
____ Other: _____
____ Other: _____

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: _____ Date of Birth: _____

I request and authorize Dr. Jennifer Wang-Hall
to release healthcare information of the patient named above to and from:

Name: _____ Position: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____ Fax: _____

- I understand that This Release is Voluntary.
- I may revoke this authorization at any time, provided that I do so in writing and submit to the clinic's address.
- I am entitled to receive a copy of this Authorization.
- By signing below, I acknowledge that I have read and understand the information on this form.

This request and authorization applies to:

☐ Mental Health Treatment Records ☐ Medical Records

☐ Alcohol/Drug Treatment ☐ Other: _____

☐ Yes ☐ No I authorize the release of my lab results and medical records to the person(s) listed above. I understand that the person(s) listed above will be notified that I must give specific written permission before disclosure of these test results to anyone.

☐ Yes ☐ No I authorize the release of any records regarding drug, alcohol, or mental health treatment to the person(s) listed above.

Patient Signature: _____ Date Signed: _____

Parent Signature: If under 18 _____ Date Signed: _____

Witness Signature _____ Date Signed: _____

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: _____ Date of Birth: _____

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to release healthcare information of the patient named above to and from:

Name: _____ Position: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____ Fax: _____

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Name: _____ Position: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____ Fax: _____

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Witness Signature _____ Date Signed: _____