Dr. Nixon Cares
Licensed Clinical Psychologist

1020 East Willow Grove Avenue
Wyndmoor, PA 19038
(215) 402-7335

Client Information Form

Client Name: _____

Address: _____

Home Phone: _____

Mobile Phone: _____

E-mail Address: _____

Date of Birth: _____

Insurance Carrier: _____

PPO or HMO? _____

Insurance ID: _____

Payment Card (optional):

Card Type: _____

Card Number: _____

Emergency Contact: _____

Relationship to Client: _____

Home Phone: _____

Mobile Phone: _____

E-mail Address: _____

Informed Consent for Treatment

Please read this carefully.

This document provides important information about Dr. Shonda R. Nixon's professional services and business policies. It also contains summary information about the Health Insurance Portability and Accountability Act (HIPAA), a federal law that provides increased privacy protections and expanded patient rights with regard to the use and disclosure of your Protected Health Information (PHI). HIPAA requires that I provide you with a Notice of Privacy Practices for use and disclosure of personal health information for treatment, payment, and health care operations. The Notice, which is attached to this document, explains HIPAA and its application to your personal health information in greater detail. The law requires that I obtain your signature acknowledging that I have provided you with this information at the end of this session.

Please read and sign at the bottom to indicate that you have reviewed and understand this information.

PSYCHOLOGICAL SERVICES

Services provided include clinical assessments, psychological evaluations, psychotherapy, consultation/education, and crisis intervention.

Psychotherapy is not easily described in general statements. It varies considerably depending on presenting concerns and individual styles. One of the primary goals of therapy is to help a person achieve a more fulfilling life. The process of psychotherapy involves talking about ongoing concerns with a professionally trained and licensed provider in an attempt to better understand and respond to all that contributes to ongoing difficulties.

Psychotherapy can have benefits and risks. Since therapy often involves discussing unpleasant aspects of your life, you may experience uncomfortable feelings like sadness, guilt, anger, frustration, loneliness, and helplessness. On the other hand, psychotherapy has also been shown to have significant benefits. Therapy often leads to better relationships, solutions to specific problems, and noticeable reductions in feelings of distress. However, there are no guarantees of what you will experience.

The first few sessions will consist of collecting information from you in attempt to

assess various needs and concerns. During this assessment period, we will both decide if I am the best person to provide the services you need in order to meet your treatment goals. If you have any questions about procedures, guidelines, or anything we talk about, we can discuss them at any point.

It is important to emphasize that you may withdraw from treatment at any time.

CONFIDENTIALITY

Psychotherapy necessarily involves the sharing of sensitive, personal, and private information with your therapist. As a result, the information you share is kept strictly confidential, and is not disclosed without your written permission. There are, however, a few carefully agreed-upon exceptions to the protection of confidentiality which you should know about prior to beginning therapy.

Supervision/Consultation:

At times, I find it helpful to consult or receive supervision from other health and mental health professionals about a case. During consultation or supervision, I make every effort to avoid revealing a patient's identity. The other professionals are legally bound to keep the information confidential. I will note all consultations in your Clinical Record (which is called PHI in my Notice of Psychologist's Policies and Practices) to protect the privacy of your health information.

Abuse of a Child or Elderly/Disabled Person:

If I have reason to believe that a child under the age of 18, an elderly person, or disabled person is being abused or neglected, I am obligated by law to report the situation to the appropriate state agency.

Imminent Harm to Self:

If I have reason to believe that you are threatening immediate physical harm to yourself, and if you are unwilling or unable to follow treatment recommendations, I may have to contact a family member or another person who may be able to help to ensure your safety.

Imminent Harm to Others:

If I have reason to believe that you are actually threatening physical violence against another person, or if you are an actual threat to the safety of another person, I am required by law to

take some action to ensure that the other person is protected (such as contacting the police, notifying the other person, seeking hospitalization, or a combination of these alternatives).

Court-Related Proceedings:

In most legal proceedings, you have the right to prevent me from providing any information about your treatment. In some proceedings involving child custody, and those in which your emotional condition is an important issue, a judgment order my testimony if he/she determines that the issues demand it.

Lawsuit:

If a patient files a complaint or lawsuit against me, I may disclose relevant information regarding the case in order to defend myself.

The above situations have rarely occurred in my practice. If an event does occur which may necessitate breaching confidentiality, I will make every effort to fully discuss it with you before taking any action.

While this written summary of exceptions to confidentiality should prove helpful in informing you of potential problems, it is important that we discuss any questions or concerns you may have at our next meeting. I will be happy to discuss these issues with you if you need specific advice, but formal legal advice may be needed because the laws governing confidentiality are quite complex, and I am not an attorney.

SESSIONS

Psychotherapy generally involves regular consistent sessions, usually 50 minutes in length scheduled once or twice a week. The duration of treatment and frequency of sessions varies depending on your individual needs. If you need to cancel an appointment, a **24-hour notice is required**; otherwise, you will be expected to pay for the missed session. If possible, I will try to find another time at which to schedule your appointment.

PROFESSIONAL FEES

My hourly rate for individual therapy is $115.00; for couples therapy, it is $140.00. If you have insurance and are required to pay a co-pay, the proper co-pay amount will be required

at the time of service. In addition to weekly appointments, I charge this amount for other professional services you may need, though I will prorate the hourly cost if I work for periods of less than one hour. Other services include report writing, telephone conversations lasting longer than 15 minutes, attendance at meetings with other professionals you have authorized, preparation of records or treatment summaries, and the time spent performing any other service you may request of me. If you become involved in legal proceedings that require my participation, you will be expected to pay for my professional time, even if I am called to testify by another party.

BILLING AND PAYMENTS

You will be expected to pay for each session at the time it is held. Payment schedules for other professional services will be agreed upon when they are requested. In circumstances of unusual financial hardship, I may be willing to negotiate a fee adjustment.

If your account has not been paid for more than 30 days, and arrangements for payment have not been agreed upon, I have the option of using legal means to secure the payment. This may involve hiring a collection agency or going through small claims court. In most collection situations, the only information I release regarding a patient's treatment is his/her name, the nature of services provided, and the amount due.

INSURANCE REIMBURSEMENT

I accept Aetna and HighMark insurance plans only. If you have another insurance company and would like to use your coverage to help pay for your treatment, you will be expected to pay for treatment first and then submit a claim directly to your insurance company for reimbursement. I will be happy to provide you with an insurance form at the end of each month, and well as any necessary receipts, in an attempt to help in this process.

CONTACTING ME

I am often not immediately available by telephone. When I am unavailable, my office mobile phone is answered by either an assistant or voicemail which is monitored frequently. I will make every effort to return your call on the same day that you make it, with the exception of weekends and holidays. If you are difficult to reach, please inform me of your availability. If you are unable to reach me and feel that you cannot wait for me to return your call, contact your family physician or the nearest emergency room and ask for the mental health counsel-

or on call. If I will be unavailable for an extended amount of time, I will provide you with the name of a colleague to contact if necessary.

PROFESSIONAL RECORDS

You should be aware that, pursuant to HIPAA, I kelp Protected Health Information about you in two sets of professional records. One set constitutes for clinical record. It includes:

- information about your reasons for seeking therapy
- a description of the ways in which your problem impacts your life
- your diagnosis
- the goals we set for treatment
- your progress toward these goals
- your medical and social history
- your treatment history
- any past treatment records that I receive from other providers
- reports of any professional consultations or supervision
- your billing records
- any reports that have been sent to anyone, including reports to your insurance carrier

Except in unusual circumstances that involve danger to yourself or others (for which I will provide you with an accurate and representative summary of your record), you may examine and/or receive a copy of your clinical record if you request it in writing. Because these are professional records, they can be misinterpreted and/or upsetting to untrained readers. For this reason, I recommend that you initially review them in my presence, or have them forwarded to another mental health professional so you can discuss the contents.

In addition, I also keep a set of psychotherapy notes. These notes are for my own use and are designed to assist me in providing you with the best treatment. While the contents of psychotherapy notes vary from client to client, they can include the contents of our

conversations, my analysis of those conversations, and how they impact your therapy. They also contain particularly sensitive information that you reveal to me which is not required to be included in your clinical record. These psychotherapy notes are kept separate from your clinical record. While insurance companies can request and revive a copy of your clinical record, they cannot receive a copy of your psychotherapy notes without your signed, written authorization. Insurance companies cannot require your authorization as a condition of coverage, nor can they penalize you in any way for your refusal. You may examine and/or receive a copy of your psychotherapy notes, unless I determine that such disclosure would be injurious to you.

Patient Rights

HIPAA provides you with several new or expanded rights with regard to your clinical record and disclosures of protected health information. These rights include:

- requesting that I amend your record
- requesting restrictions on what information from your clinical record is disclosed to others
- requesting an accounting of most disclosures of protected health information that you have neither consented to nor authorized
- determining the location to which protected information disclosures are sent
- having any complaints you make about my policies and procedures recorded in your records
- the right to a paper copy of this agreement, the attached notice form, and my privacy policies and procedures

I am happy to discuss any of these rights with you.

MINORS

If you are under 18 years of age, please be aware that the law may provide your parents with the right to examine your treatment records. It is my policy to request and agreement from parents giving up access to your records. If they agree, I will provide them only with general information about our work together, unless I feel there is a high risk that you will

seriously harm yourself or someone else. In this case, I will notify them of my concern. I will also provide them with a summary of your treatment when it is comets. Before giving them any information, I will discuss the matter with you, if possible, and do my best to handle any objections you may have with what I am prepared to discuss.

Your signature below indicates that you have read the information in this document and agree to abide by its terms during our professional relationship.

Client Name: _____ Date:_____

Client Signature: _____ Date:_____

Witness Signature: _____ Date:_____

Your signature below serves as an acknowledgment that you have received the HIPAA notice form described above.

Client Name: _____ Date:_____

Client Signature: _____ Date:_____

Witness Signature: _____ Date:_____

Notice of Privacy Policy

(HIPAA)

The information you share with me is very personal. I make every reasonable effort to preserve your privacy. This notice described the measures that I take to protect your privacy and defines your role in that process.

CLINICAL AND FINANCIAL RECORDS

All records, clinical and financial, are maintained within secured systems. All clinical information that you share with me is confidential to the extent allowed by law. You will have the opportunity, if you come to therapy, to review and sign the Consent to Treatment that defines the scope and limitations of confidentiality. If you wish for me to release information to another care provider, I will do so only with your explicit written consent. In addition, I will not respond to any inquiries about your care that you have not authorized.

I recognize that the risk exists for information to be disclosed inadvertently through financial transactions between client and therapist. When billing information is communicated to third parties (e.g. insurance companies), there is a de facto disclosure of personal information. To minimize the risk of violating privacy, the following procedures have been developed:

- I will not engage in any direct transactions with third party payers (e.g. insurance companies). You must submit any requests for reimbursement directly to your insurance provider.
- If your insurance company subsequently requests additional information, I will not reply until I have written consent from you to do so. Should your insurance company's inquiry be received with a Consent to Release Information form, I will make an effort to confirm your awareness of the information that will be released. In the event that this occurs, I will not use any electronic means to share information (fax or e-mail).

COMMUNICATIONS

It is your responsibility to notify me if the address or phone numbers that you provided at the time of your initial contact with me change, or if you wish to change your preferred method of contact.

Please check all appropriate methods of contact:

_____ mail to home address

_____ home phone

_____ mobile phone

_____ work phone

_____ e-mail

In addition, please know that should a medical or clinical emergency occur, I may need to be in touch with the person you designated as your emergency contact.

CLIENT RIGHTS

You have to right to:

- request restriction on uses and disclosures of your personal information for treatment, payment, and healthcare options as delineated in this notice
- ask me to communicate with you by preferred methods
- ask questions, requested additional information about privacy, or report a concern about privacy
- receive and keep a copy of this notice of privacy upon request
- be informed of any charges should revisions be made to these privacy practices

By signing this notice, you acknowledge that:

- you have reviewed this policy and have had the opportunity to ask questions about it.
- it is your responsibility to keep your contact information current (address, phone number, etc.).
- you may make changes in your authorization of contact mode by providing a directive in writing.

Client Name: _____

Client Signature: _____

Date: _____

Fee Agreement

I understand that Dr. Nixon's fee per 50-minute session is $125.00. We have agreed that a fee of $_____ will be paid at the completion of each meeting by cash, check, or credit card.

I agree that if my check is returned, I will assume all bank charges in addition to session fees.

I understand and agree that I will give 24 hours' for a session cancellation, and two weeks' notice if I will be on vacation during a scheduled appointment time. If I miss a scheduled session or fail to give 24 hours' notice for a session cancellation, I will be charged and agree to pay the full session fee.

If I would like to submit my bills to my insurance company, I understand that I will receive a receipt following each session that I may submit on my own. Dr. Nixon will not be responsible for filing claims on my behalf.

My signature indicated that the terms of this agreement set forth by Dr. Nixon have been explained to me, and that I fully understand.

Client Name: _____

Client Signature: _____

Date: _____