Sutherland Psychotherapy Associates

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# INDIVIDUAL INFORMATION FORM

Patient Name: _____Today's Date: _____

Address: _____

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Social Security Number: _____

Telephone: home: _____work: _____cell: _____

Age: _____ Date of Birth: _____ Marital Status: _____

Employer and Occupation: _____

Education: _____

Religious Preference: _____

Who is your regular physician? _____

Describe any major health problems you have had: _____

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List medications you regularly use: _____

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Weekly consumption of Alcohol: _____

Describe your reason for seeking help: _____

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What efforts have you made to handle the problem? _____

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Have you ever received psychiatric or psychological help or counseling of any kind before: _____

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Who suggested you contact us? _____

Please circle any of the following problems that pertain to you:

| | | | | |
|---|---|---|---|---|
| Nervousness | Depression | Alcohol Use | Temper | Shyness |
| Friends | Suicide | Children | Separation | Divorce |
| Self-Control | Appetite | Drug Use | Nightmares | Marriage |
| Sexual Problems | Anger | Being a Parent | Finances | Fear |
| Stomach Trouble | Stress | Career choices | Unhappiness | Sleep |
| Relaxation | Headaches | Bowel Trouble | Legal | Work |
| Concentration | Inferiority | Energy | Insomnia | Memory |
| Decisions | Loneliness | Unusual Sounds | Thoughts | Ambition |
| Education | Unusual Visuals | Health Problems | Tiredness | Moodiness |

Please list any other problems not on the list: _____

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_____

List members of your family or others in the home:

| Name | Age | Relationship | Occupation |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

Insurance Coverage or EAP Co: _____

Policy & ID #: _____Group # _____

# AGREEMENT FOR THERAPY

1. Therapy sessions are scheduled, as much as possible, for your convenience. Therefore, cancellations should be made at least 24 hours in advance or you will be charged a cancellation fee of $25. If you fail to come or call you will be billed for the entire session.

2. This is an agreement between the patient and their therapist, the insurance company is not involved in this agreement.

3. Therapy sessions will be 50 minutes in length unless otherwise agreed upon by you and your therapist.

4. If we are unable to collect payment from you (or your insurance company), the bill will be forwarded to a collection agency, and you will be billed a 25% fee to cover the expense of the collection agency fee.

By signing the form, I acknowledge that I have read, understand, and agree to the above.

_____ _____

signature date

# NOTICE OF PRIVACY PRACTICES
**Confidentiality & Patient/Client Rights**

**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, and future health condition (HIV, AIDS, etc.), 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. Use of PHI means that I share, apply, utilize, examine, and analyze information within my practice; PHI is disclosed when I release, transfer, give, or otherwise reveal 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 of disclosure is made; however, I am always legally required to follow the privacy practices described within 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.

**III. How I will use or disclose your PHI.**
I will use and disclose your PHI for many different reasons. Some of the uses of disclosures will require prior written authorization; others, however, will not. Below you will find the different categories on 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, or 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 him/her 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 you PHI to attorneys, accountants, consultants, and others to make sure I am in compliance with applicable laws.
3. **To obtain payment for treatment**: I may use or disclose you PHI to bill and collect payment for treatment and services provided to 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 attempt to obtain you consent but you are unable to communicate with me (i.e., 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 and 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 make a disclosure to the appropriate officials when a law requires me to report information to government agencies, law enforcement personnel, and/or 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 government law enforcement agency.
4. If disclosure is compelled by the patient or patient's representative pursuant to Georgia 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 Georgia Child Abuse and Neglect Reporting law. For example, if I have a reasonable suspicion of child or elder abuse or neglect.
8. If disclosure is mandated by the Georgia 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 protesting the President of the United States or assisting with intelligence operations.
13. For research and publication purposes. In certain circumstances, I may provide PHI in order to conduct medical research and/or for the purpose of improving healthcare outcomes. Your anonymity will be safeguarded to the highest extent while maintaining the integrity of the research and professional publication.
14. For Worker's Compensation purposes. I may provide PHI in order to comply with Worker's 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 an arbitration is lawfully requested by either party, pursuant to subpoena *duces tectum* (e.g., a subpoena for mental health records) or any other provision of 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 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. HIPAA regulations.
19. If disclosure is otherwise specifically required by law.

**C. Certain Uses and Disclosures Require You to Have the Opportunity to Object.** (i.e., 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 know who does, I will advise you regarding how to get it. You will receive a response from me within 30 days from receipt of your written request. Under certain circumstances, I may deny your request. If I do deny your request, I will provide you written reason(s) 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 $0.50 per page in addition to an hourly rate for my time. Also, it may be appropriate to provide you with a summary or explanation of the PHI, but only if you agree to it, as well as to the cost of my time and preparation, 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 postal mail) if such may be provided without undue inconvenience to me.
D. The Right to Obtain a list of the Disclosures I have Made.

By signing this notice, you agree that you have received a copy.

_____ _____

Client signature & Date Signature & Date of Minor's Legal Guardian (if applicable)