Allan Weisbard, LCSW
Licensed Clinical Social Worker
Ashland, Oregon 97520
(541) 821-1083

NEW SOLUTIONS FOR OLD PROBLEMS

Patient Intake Form

Please Save a copy of your completed document, then email a copy to allan@healthyoptimism.com

Today's Date:

Name:

Date of Birth:

Mailing Address:

Phone No(s) where we may leave messages for you:

Employer:

Occupation:

Referred by:

May I thank them for the referral? ☐ Yes or ☐ No

Whom can we call if we cannot reach you in an emergency?

Name:

Their Phone No.:

Relationship:

I, the undersigned, authorize payment directly to this provider of services for all medical/mental health benefits otherwise payable to the insured for services rendered. I understand that ultimately the fees for services provided are my financial responsibility, whether or not paid by insurance. I authorize the release of any medical or other information necessary to secure these benefits and for the use of this signature on all my insurance submissions.

Patient Signature:

Date:

Please fill out the following as fully as possible.

1. Marital Status:

2. Others living in your home.

Name	Age	Relationship

3. For what problems are you seeking counseling?

4. What significant life changes or stressful events have you experienced recently?

5. Have you previously received any type of mental health services (counseling/medication)? ☐Yes or ☐No

If yes, when, with whom, and for what issues?

6. Are you currently taking prescription medication? ☐Yes or ☐No

If yes, please list:

7. Have you ever been prescribed psychiatric medication? ☐Yes or ☐No

If yes, please provide medication name and dates:

8. Have you seen a physician within the past year? ☐Yes or ☐No

If yes, for what reason(s)?

9. What is the name and address of your physician?

10. May we contact your physician? ☐Yes or ☐No

11. Please list any specific health problems you have experienced:

12. Please list any specific sleep problems you have experienced:

13. Please list any difficulties you experience with your appetite or eating patterns:

14. Please list any difficulties you have had with depression:

15. Have you ever had suicidal thoughts? ☐Yes or ☐No

Details:

16. Have you ever had any suicide attempts? ☐Yes or ☐No

Details:

17. Have you ever experienced overwhelming sadness, grief, or depression? ☐Yes or ☐No

If yes, describe:

18. Have you ever experienced anxiety, panic attacks, or phobias? ☐Yes or ☐No

If yes, describe:

19. Do you use tobacco? ☐Yes or ☐No

Details:

20. Do you drink caffeine? ☐Yes or ☐No

Details:

21. Do you drink alcohol or use recreational drugs? ☐Yes or ☐No

Details:

22. Estimate how many hours a day you spend online:

Do you feel your technology use is balanced and healthy or could it be improved? Please explain:

23. Do you have ways of managing your stress? ☐Yes or ☐No

Details:

24. Family Mental Health History
In the section below, identify a family history of any of the following.

	List Family Member(s)
Alcohol/Substance Abuse	
Anxiety	
Depression	
Excessive Anger/Rage	
Eating Disorders	
Obsessive Compulsive Behaviors	
Suicide Attempts	
Other:	

25. What do you consider your major strengths?

26. What do you consider your major challenges?

27. What would you like to see change and/or accomplish while you are in therapy?

28. Anything else you would like me to know about you.

PLEASE READ AND SIGN EACH OF THE NEXT THREE DISCLOSURE NOTICES ON PAGES 6, 10 & 13

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TELEHEALTH INFORMED CONSENT

I , hereby consent to participate in telemental health with Allan Weisbard LCSW, LLC as part of my psychotherapy.

I understand the following with respect to telemental health:

1) I understand that I have the right to terminate therapy at any time.

2) I understand that there are risks, benefits, and consequences associated with telemental health, including but not limited to, disruption of transmission by technology failures, interruption and/or breaches of confidentiality by unauthorized persons, and/or limited ability to respond to emergencies.

3) I understand that there will be no recording of any of the online sessions by either party. All information disclosed within sessions and written records pertaining to those sessions are confidential and may not be disclosed to anyone without written authorization, except where the disclosure is permitted and/or required by law.

4)I understand that if I am having suicidal or homicidal thoughts, actively experiencing psychotic symptoms or experiencing a mental health crisis that cannot be resolved remotely, it may be determined that telemental health services are not appropriate and a higher level of care is required.

5)I understand that during a telemental health session, we could encounter technical difficulties resulting in service interruptions. If this occurs, and we are unable to reconnect, **please call me at 541-821-1083** to continue our session by phone.

I have read the information above and understand the information provided.

Patient Signature:

Date:

PRACTICE DESCRIPTION

Please read and sign

Welcome to Rogue Valley Counseling. The following information addresses important and frequently asked questions concerning my practice, please read it carefully. If you have any questions, bring them to our first session. **Please be sure to sign the last page**.

Treatment Approach: I use a treatment process that shifts from the traditional problem-oriented psychotherapy framework to a solution-oriented approach. Together you and I determine what you want from counseling and how best to achieve it. Your first session begins with an evaluation of your needs, and a mutual determination of whether our work together can provide treatment in alignment with your goals. During the course of your therapy, I will draw on various psychological approaches according to the identified problems and an assessment of what will best benefit you. This can include cognitive-behavioral, psychodynamic, existential, mindfulness-based, developmental, or psycho-educational techniques.

Scheduling: Consistency in attending counseling appointments is crucial to a successful outcome. If there is a special time that will work best for you, it is wise to reserve it for three sessions ahead. 24 hours notice is required for rescheduling or cancellation of an appointment. If you cancel your session with less than 24 hours prior notice, the full fee will be charged. Most insurance companies do not reimburse for missed sessions. If you desire to consult with me outside of the session, I will bill after the first five minutes at my usual rate. Typically, insurance companies will not pay those charges.

Urgency/Emergency Procedures: If you are experiencing an urgent situation, you may contact me by leaving a detailed message at **(541) 821-1083**, and I will get back to you as soon as possible. However, I cannot always provide a quick or immediate response. My practice does not have the capability to respond to counseling emergencies, as there are times when I am unavailable. If you need help more urgently, call Jackson County Mental Health at **(541) 774-8201**, or go to a hospital emergency room, or call 911 if the situation warrants it. If you need a counselor who is available in emergencies, please let me know at our first session so that I can help refer you to one.

Health Insurance: If you are using a health insurance benefit as partial payment, please pay at each session the portion not covered by your insurance including any unpaid deductible. I will bill your primary insurance. The contract is with you, not your insurance carrier; you are responsible for payment for any treatment expenses your insurance does not cover. Your health plan requires cooperation between patient, provider, and the insurance company to provide services as efficiently as possible. It is your responsibility to learn about the nature and extent of your coverage. Health insurance companies generally limit mental health coverage to:

- Services that are determined to be "medically necessary". Medically necessary is often defined as a mental condition that fits specific diagnostic criteria.

- Conditions that can be treated by short-term, focused, goal-oriented approaches.

The insurance company will require some information about the nature of your condition. For standard indemnity insurance policies, this usually includes a diagnosis, type of counseling service provided, and the duration of the session. However, managed care plans may require even more information and oversight into the work that we do together. This means your insurance company may only cover a limited number of sessions with the focus on eliminating acute symptoms. The plan may require that we request their permission for sessions beyond their standard allowance, by submission of a written treatment summary. In such cases, a significant amount of confidential information may be shared with the managed care organization without any guarantee of approval of additional sessions. Submitting a mental health invoice for reimbursement carries a certain amount of risk of loss of confidentiality.

Confidentiality: I respect your privacy the laws and rules regarding confidentiality are complex. I abide by the laws and ethical principles that govern privilege and confidentiality. All information disclosed within sessions and the written records pertaining to those sessions will not be revealed to anyone without your written permission, except where disclosure is required by law. Upon your written request, I will release information to any agency/person you specify unless I conclude that releasing such information might be harmful.

When Disclosure Is Required By Law: Some of the circumstances where disclosure is required by the law include 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.
When Disclosure May Be Required: Disclosure may be required pursuant to a legal proceeding or if a court issues a subpoena. 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. I will use my best clinical judgment when revealing such information to family members, generally I do not believe holding secrets are beneficial.

Emergencies: If there is a time, where I become concerned about your personal safety, the possibility of you injuring someone else, or about you receiving proper psychiatric care, I will do whatever I 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, I may also contact the person whose name you have provided on the intake form or other relevant authorities.

Health Insurance & Confidentiality of Records: Disclosure of confidential information may be required by your health insurance carrier or HMO/PPO/MCO/EAP in order to process the claims. I have no control or knowledge over how insurance companies utilize the information I submit or who has access to this information. 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 is reported to the National Medical Data Bank. Accessibility to computer databases is always in question, as computers are inherently vulnerable to break-ins and unauthorized access. Medical data has been reported to have been lost, stolen, or accessed by law enforcement agencies.

Confidentiality of E-mail, Cell Phone, and Fax Communication: Unauthorized people can access e-mail and cell phone communication and faxes can be sent erroneously to the wrong number. Please notify me at the beginning of treatment if you wish to avoid or limit in any way the use of any or all of the above-mentioned communication devices. Please do not use e-mail for clinical information.

Litigation Limitation: If you become involved in the legal system (divorce, custody, civil or criminal litigation, etc.) I will not make recommendations or testify. It is a conflict of interest for a treating professional to provide evaluations or opinions in legal matters. If a client has these expectations, it can affect their willingness to disclose personal information vital to their treatment. In signing this agreement, you agree that you will not call me as a witness to testify or make recommendations in any legal proceedings.

Colleague Consultation: On occasion, I may consult with colleagues about my work. If your case were discussed it would be confidential and anonymous. While specific identifying information is not shared the dynamics of the problems as well as treatment approaches is discussed. Although, I share this office with other therapists, each of us works independently, and each alone is responsible for the quality of care each provides.

THE PROCESS OF THERAPY/EVALUATION

Participation in therapy can result in a number of benefits to you, such as improving interpersonal relationships and resolution of the specific concerns that led you to seek therapy. In order to achieve these benefits, psychotherapy requires your active involvement, honesty, and openness. I will ask for your feedback on your therapy progress, and expect you to respond forthrightly. Sometimes more than one approach can be helpful and we can explore options.

Psychotherapy has both benefits, risks, and requires investment of your time and energy in order to make the therapy process successful. Patients may go through periods of emotional discomfort, relationship difficulties, or even a worsening of symptoms. Typically, this will subside as therapy progresses but there are no guarantees. Remember you always retain the right to request changes in treatment or discontinue treatment at any time.

Remembering or talking about unpleasant events, feelings, or thoughts can result in feelings of anger, sadness, worry, fear; or experiencing discomfort, anxiety, depression, insomnia, etc. The therapeutic process may challenge some of your assumptions or perceptions or propose different ways of looking at, thinking about, or handling situations. Attempting to resolve issues that brought you to therapy, such as personal or interpersonal relationships, may result in changes that were not originally intended. Therapy may result in decisions about changing behaviors, employment, substance use, schooling, housing, or relationships. Sometimes another family member may view a decision that is positive for one family member as quite negative. There is no guarantee that psychotherapy will yield positive or intended results. In most cases, a mental health diagnosis is assigned during the assessment process. If you have any questions about any of the procedures used in the course of your therapy, I will address these as fully as possible.

Therapeutic Relationship:

It is inappropriate for a patient and counselor to spend time together socially or to bestow gifts. Not all dual relationships are unethical or avoidable. Our therapy will never involve sexual or any other dual relationship that impairs the therapist's objectivity, clinical judgment, therapeutic effectiveness or can be exploitative.

The Rogue Valley is a relatively small area and sometimes clients know each other or me in the community. Consequently, you may encounter someone you know in the waiting room or me in the community. I do not acknowledge working therapeutically with anyone without his or her permission. The purpose of these boundaries is to ensure that confidentiality is maintained. Many patients select me as their therapist, because they know my work or have seen me speak in public presentations.

If there is ever a time when you believe that you have been treated disrespectfully, please discuss this with me. It is never my intention to cause this to happen, but sometimes misunderstandings can inadvertently result in hurt feelings. I want to address any issues that might get in the way of your progress. This also includes financial issues.

Concluding Therapy:
I believe that how long you remain in therapy is a matter best discussed openly from the beginning of our work together. There are many aspects to such a decision, including progress made, financial concerns, or major life changes. I encourage you to speak candidly with me about your readiness to end counseling. Many people find that ending a counseling relationship satisfactorily is an important aspect of the therapeutic process. Typically, in our final session, we will review what changes you have made and what issues might arise in the future.

If at any time, you want another professional's opinion or wish to consult with another therapist, I will assist you in finding someone qualified. If I have your written consent, I will provide that therapist with the information needed. You have the right to terminate therapy at any time. I reserve the right to refer a patient

to another therapist if his or her needs are not a good match for my practice.

Consent is hereby given of the undersigned for treatment under the terms described above.
Your signature below indicates you have read and understand the above office policies and practice information, have had any questions or concerns answered, and received a copy.

Patient Signature: Date:

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Allan Weisbard L.C.S.W. LLC

Notice of Privacy Practices
Please read and sign.

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 about you that may identify you and that 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 we may use and disclose your PHI in accordance with applicable law, including the Health Insurance Portability and Accountability Act ("HIPAA"), regulations promulgated under HIPAA including the HIPAA Privacy and Security Rules, and the *NASW Code of Ethics*. It also describes your rights regarding how you may gain access to and control your PHI.

We are required by law to maintain the privacy of PHI and to provide you with notice of our legal duties and privacy practices with respect to PHI. We are required to abide by the terms of this Notice of Privacy Practices. We reserve the right to change the terms of our Notice of Privacy Practices at any time. Any new Notice of Privacy Practices will be effective for all PHI that we maintain at that time. We will provide you with a copy of the revised Notice of Privacy Practices by posting a copy on our website, sending a copy to you in the mail upon request or providing one to you at your next appointment.

HOW WE 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. We may disclose PHI to any other consultant only with your authorization.

For Payment. We may use and disclose PHI so that we 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, we will only disclose the minimum amount of PHI necessary for purposes of collection.

For Health Care Operations. We may use or disclose, as needed, your PHI in order to support our business activities including, but not limited to, quality assessment activities, employee review activities, licensing, and conducting or arranging for other business activities. For example, we 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, we must disclose your PHI to you upon your request. In addition, we must make disclosures to the Secretary of the Department of Health and Human Services for the purpose of investigating or determining our compliance with the requirements of the Privacy Rule.

Without Authorization. Following is a list of the categories of uses and disclosures permitted by HIPAA without an authorization. Applicable law and ethical standards permit us to disclose information about you without your authorization only in a limited number of situations.
As a social worker licensed in this state and as a member of the National Association of Social Workers, it is our practice to adhere to more stringent privacy requirements for disclosures without an authorization. The following language addresses these categories to the extent consistent with the *NASW Code of Ethics* and HIPAA.

Child Abuse or Neglect. We may disclose your PHI to a state or local agency that is authorized by law to receive reports of child abuse or neglect.

Judicial and Administrative Proceedings. We may disclose your PHI pursuant to a subpoena (with your written consent), court order, administrative order or similar process.

Deceased Patients. We may disclose PHI regarding deceased patients as mandated by state law, or to a family member or friend that was involved in your care or payment for care prior to death, based on your prior consent. A release of information regarding deceased patients may be limited to an executor or administrator of a deceased person's estate or the person identified as next-of-kin. PHI of persons that have been deceased for more than fifty (50) years is not protected under HIPAA.

Medical Emergencies. We may use or disclose your PHI in a medical emergency situation to medical personnel only in order to prevent serious harm. Our staff will try to provide you a copy of this notice as soon as reasonably practicable after the resolution of the emergency.

Family Involvement in Care. We may disclose information to close family members or friends directly involved in your treatment based on your consent or as necessary to prevent serious harm.

Health Oversight. If required, we may disclose PHI to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies and organizations that provide financial assistance to the program (such as third-party payors based on your prior consent) and peer review organizations performing utilization and quality control.

Law Enforcement. We may disclose PHI to a law enforcement official as required by law, in compliance with a subpoena (with your written consent), court order, administrative order or similar document, for the purpose of identifying a suspect, material witness or missing person, in connection with the victim of a crime, in connection with a deceased person, in connection with the reporting of a crime in an emergency, or in connection with a crime on the premises.

Specialized Government Functions. We may review requests from U.S. military command authorities if you have served as a member of the armed forces, authorized officials for national security and intelligence reasons and to the Department of State for medical suitability determinations, and disclose your PHI based on your written consent, mandatory disclosure laws and the need to prevent serious harm.

Public Health. If required, we may use or disclose your PHI for mandatory public health activities to a public health authority authorized by law to collect or receive such information for the purpose of preventing or controlling disease, injury, or disability, or if directed by a public health authority, to a government agency that is collaborating with that public health authority.

Public Safety. We may disclose your PHI if 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.

Research. PHI may only be disclosed after a special approval process or with your authorization.

Fundraising. We may send you fundraising communications at one time or another. You have the right to opt out of such fundraising communications with each solicitation you receive.

Verbal Permission. We may also use or disclose your information to family members that are directly involved in your treatment with your 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 at any time, except to the extent that we have already made a use or disclosure based upon your authorization. The following uses and disclosures will be made only with your written authorization: (i) most uses and disclosures of psychotherapy notes which are separated from the rest of your medical record; (ii) most uses and disclosures of PHI for marketing purposes, including subsidized treatment communications; (iii) disclosures that constitute a sale of PHI; and (iv) other uses and disclosures not described in this Notice of Privacy Practices.

YOUR RIGHTS REGARDING YOUR PHI

You have the following rights regarding PHI we maintain about you. To exercise any of these rights, please submit your request in writing to Allan Weisbard LCSW

☐ **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 is maintained in a "designated record set". A designated record set contains mental health/medical and billing records and any other records that are 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 or if the information is contained in separately maintained psychotherapy notes. We may charge a reasonable, cost-based fee for copies. If your records are maintained electronically, you may also request an electronic copy of your PHI. You may also request that a copy of your PHI be provided to another person.

☐ **Right to Amend**. If you feel that the PHI we have about you is incorrect or incomplete, you may ask us to amend the information although we are not required to agree to the amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us. We may prepare a rebuttal to your statement and will provide you with a copy. Please contact the Privacy Officer if you have any questions.
☐ **Right to an Accounting of Disclosures**. You have the right to request an accounting of certain of the disclosures that we make of your PHI. We 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. We are 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, we are 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 health matters in a certain way or at a certain location. We will accommodate reasonable requests. We may require information regarding how payment will be handled or specification of an alternative address or other method of contact as a condition for accommodating your request. We will not ask you for an explanation of why you are making the request.
☐ **Breach Notification**. If there is a breach of unsecured PHI concerning you, we 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 we have violated your privacy rights, you have the right to file a complaint in writing with our Privacy Officer Allan Weisbard or with the Secretary of Health and Human Services at 200 Independence Avenue, S.W. Washington, D.C. 20201 or by calling (202) 619-0257. We will not retaliate against you for filing a complaint.
The effective date of this Notice is September 2013.

I have read the above:

Patient Signature:

Date: