Haley D Erickson, LCSW LLC

11300 4th Street North, Suite 240A, St. Petersburg, FL 33716
727-510-7477

Please provide the following information and answer the questions below. Please note: Information you provide here is protected as confidential information.

Name: _____
(Last) (First) (Middle Initial)
Name of parent/guardian (if under 18 years):

_____
(Last) (First) (Middle Initial)

Birth Date: _____ /_____ /_____ Age: _____ Gender: ▫ Male ▫ Female

Address:
(Street and Number)

_____

_____
(City) (State) (Zip)

Home Phone: _____ May we leave a message? ▫Yes ▫No

Cell: _____ May we leave a message? ▫Yes ▫No

Work Phone: _____ May we leave a message? ▫Yes ▫No

E-mail: _____ May we email you? ▫Yes ▫No

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***Please note: Email correspondence is not considered to be a confidential medium of communication.**

Emergency Contact: _____ (Name & Relationship)

Emergency Contact Phone#: _____ May we leave a message? ▫Yes ▫No

Referred by (if any):

Insurance Carrier/Number _____

Marital Status:

▫ Never Married ▫ Domestic Partnership ▫ Married ▫ Separated

▫ Divorced ▫ Widowed

Please list any children/age:

_____

_____

Have you previously received any type of mental health services (psychotherapy, psychiatric services, etc.)?

▫ No

▫ Yes, previous therapist/practitioner:

_____

Are you currently taking any prescription medication?

▫ Yes

▫ No

Please list:

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_____

_____

Have you ever been prescribed psychiatric medication?

□ **Yes**

□ **No**

Please list and provide dates:

_____

_____

ADDITIONAL INFORMATION:

1. Employer:

_____

2. Occupation:

_____

3. Religious Preference:

_____

5. What would you like to accomplish out of your time in therapy?

_____

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Counseling Fees

The standard fee is $120 for a 50 minute session.

Payment is expected at each therapy session. All insurance payments are the responsibility of the client, not the insurance company. Any necessary information needed to forward to your insurance company will be provided. Typically this includes dates/amount of service, and diagnosis. Unpaid delinquent fees may be turned over to a collection agent.

Cash, check and all major credit cards via PayPal accepted for payment.

I understand that I will be expected to pay for the counseling session if I don't show or cancel with less than 24 hours notice, except in the case of an emergency.

Signed_____

Date_____

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Informed Consent for Psychotherapy

(Adolescents, Adults, Couples, Families)

Haley D Erickson, LCSW

This document contains important information about professional services and policies. Please read carefully and note any questions you might have so you can discuss them with me. Once you sign this consent form, it will constitute an agreement between you and me.

Nature of Counseling Services

Psychotherapy is the process where mental health distresses and disorders are assessed, prevented, evaluated and treated. There are a variety of techniques that can be utilized to deal with the problem(s) that brought you to therapy. These services require your active participation and cooperation.

Psychotherapy has both benefits and risks. Possible risks include the experience of uncomfortable feelings (such as sadness, guilt, anxiety, anger, frustration, loneliness, or helplessness) or the recall of unpleasant events in your life. Potential benefits include significant reduction in feelings of distress, better relationships, better problem-solving and coping skills, and the resolution of specific problems. However, psychotherapy remains an inexact science and no guarantees can be made regarding outcomes.

Statement of Confidentiality

State law and professional ethics protect the confidentiality of all communications between a client and a therapist, and I can release information to others about your therapy only with your written permission (Release of Information Form). However, there are exceptions where:

- There is suspected child abuse, elder abuse, or dependent adult abuse.
- A serious threat to a reasonably well-identified victim is communicated to the therapist.
- A threat to injure or kill oneself is communicated to the therapist.
- Client is required to sign a release of confidential information by your medical insurance.
- Court ordered release of information
- Client initiates a malpractice lawsuit
- Client is below age 18, parents have rights to therapeutic information.

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Social Media and Electronic Communication

Our primary concern with social media is that it could compromise your confidentiality and our respective privacy.

- Friending: We do not accept friend or contact requests from current or former clients on any social networking sites.
- Business Review Sites: You may find my practice on sites such as Yelp, Healthgrades, etc. Some of these sites include forums in which users rate their providers and add reviews. Please know that my listing is NOT a request for a testimonial, rating, or endorsement from you as a client. Due to confidentiality, we cannot respond to any review on these sites.
- Following: We have no expectation that you follow a blog or Twitter stream. However, we will not follow current or former clients on blogs or Twitter.
- Location-based Services: If you use location-based services on your mobile phone, you may wish to be aware of the privacy issues related to these services.
- Email: Email is not completely secure or confidential. If you choose to communicate with email or texts, these communications will be retained in your file. They are, in theory, available to be read by the System Administrator of the Internet service provider or phone provider.

Signature Verifying Agreement

Your signature below indicates that you have read the information in this document, that you have understood it, and that you agree to abide by its terms.

Client Signature _____ Date _____

Therapist Signature _____ Date _____

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Notice of Policies and Practices to Protect the Privacy of Patient's Health Information

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

I. Uses and Disclosures for Treatment, Payment, and Health Care Operations

The offices of Haley D Erickson, LCSW (hereafter known as HDE) may *use* or *disclose your Protected Health Information (PHI)* for the purposes of *treatment, payment, and health care operations* with your consent. The following definitions clarify these terms:

- *"PHI"* refers to information in your patient record that could identify you.

- *"Treatment, Payment and Health Care Operations"*
  - ***Treatment*** is when HDE provides, coordinates or manages your health care and other services related to your health care.
  - ***Payment*** is when HDE obtains reimbursement for your health care. Examples of payment are when your PHI is disclosed to your health insurer to obtain reimbursement for your health care or to determine eligibility or coverage.
  - ***Health Care Operations*** are activities that relate to the performance and operation of this business. Examples of health care operations are quality assessment and improvement activities, business-related matters such as audits and administrative services, and care coordination.

- *"Use"* applies only to activities such as sharing, applying, utilizing, examining, and analyzing information that identifies you.

- *"Disclosure"* applies to activities outside of this business such as releasing, transferring, or providing access to information about you to other parties.

II. Uses and Disclosures Requiring Authorization

HDE may use or disclose PHI for purposes outside of treatment, payment, and health care operations when your appropriate authorization is obtained. An *"authorization"* is written permission above and beyond the general consent that permits only specific disclosures. In those instances when information is sought for purposes outside of treatment, payment, and health care operations, an authorization will be obtained from you before releasing this

information. An authorization is also necessary before releasing psychotherapy notes. *"Psychotherapy notes"* are notes made about conversations during a private, group, joint, or family counseling session, which are kept separate from the rest of your patient record. These notes are given a greater degree of protection than PHI.

You may revoke all such authorizations (of PHI or psychotherapy notes) at any time, provided each revocation is in writing. You may not revoke an authorization to the extent that (1) HDE has relied on that authorization or (2) if the authorization was obtained as a condition of obtaining insurance coverage and the law provides the insurer the right to contest the claim under the policy.

III. Uses and Disclosures with Neither Consent nor Authorization

HDE may use or disclose PHI without your consent or authorization in the following circumstances:

- **Child Abuse:** If HDE knows, or has reasonable cause to suspect, that a child is abused, abandoned, or neglected by a parent, legal custodian, caregiver or other person responsible for the child's welfare, the law requires that HDE report such knowledge or suspicion to the Florida Department of Children and Families.
- **Adult and Domestic Abuse:** If HDE knows, or has reasonable cause to suspect, that a vulnerable adult (disabled or elderly) has been or is being abused, neglected, or exploited, HDE is required by law to immediately report such knowledge or suspicion to the Florida Abuse Hotline.
- **Health Oversight:** If a complaint is filed against HDE with the Florida Department of Health or other regulating board, the Department has the authority to subpoena confidential mental health information from HDE relevant to that complaint.
- **Judicial or Administrative Proceedings:** If you are involved in a court proceeding and a request is made for information about your diagnosis or treatment and the records thereof, such information is privileged under state law, and HDE will not release information without the written authorization of you or your legal representative, or a subpoena of which you have been properly notified and you have failed to inform HDE that you are opposing the subpoena or a court order. The privilege does not apply when you are being evaluated for a third party or where the evaluation is court ordered. You will be informed in advance if this is the case.
- **Serious Threat to Health or Safety:** When you present a clear and immediate probability of physical harm to yourself, to other individuals, or to society, HDE may communicate relevant information concerning this to the potential victim, appropriate family member, law enforcement, or other appropriate authorities.
- **Worker's Compensation:** If you file a worker's compensation claim, HDE must, upon request of your employer, the insurance carrier, an authorized qualified rehabilitation provider, or the attorney for the employer or insurance carrier, furnish your relevant records to those persons.

IV. Patient's Rights and HDE's Responsibilities

Patient's Rights:

- *Right to Request Restrictions* – You have the right to request restrictions on certain uses and disclosures of protected health information about you. However, HDE is not required to agree to a restriction you request

- *Right to Receive Confidential Communications by Alternative Means and at Alternative Locations* – You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations. (For example, you may not want a family member to know you are receiving services. Upon request, bills will be sent to another address).

- *Right to Inspect and Copy* – You have the right to inspect or obtain a copy (or both) of PHI in mental health and billing records used to make decisions about you for as long as PHI is maintained in the record. At your request, HDE will discuss with you the details of the request process.

- *Right to Amend*—You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. Your request may be denied. At your request, HDE will discuss with you the details of the amendment process.

- *Right to an Accounting* – You generally have the right to receive an accounting of disclosures of PHI regarding you. At your request, HDE will discuss with you the details of the accounting process.

- *Right to a Paper Copy* – You have the right to obtain a paper copy of the notice from HDE upon request, even if you have agreed to receive the notice electronically.

HDE's Responsibilities:

- HDE is required by law to maintain the privacy of PHI and to provide you with a notice of its legal duties and privacy practices with respect to PHI.

- HDE reserves the right to change the privacy policies and practices described in this notice. Unless HDE notifies you of such changes, however, it is required to abide by the terms currently in effect.

- If HDE revises its policies and procedures, it will provide you with a revised notice by mail as well as making that information available in all its offices.

V. Complaints

If you are concerned that your privacy rights have been violated or if you disagree with a decision that has made about access to your records, please feel free to discuss your concerns with your therapist.

You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services. I can provide you with the appropriate address upon request.

VI. Effective Date and Changes to Privacy Policy

This notice will go into effect on April 14, 2003.

HDE reserves the right to change the terms of this notice and to make the new notice provisions effective for all PHI that it maintains. HDE will provide you with a revised notice by mail as well as making that information available.

VII. Acknowledgment of Receipt of HIPAA Privacy Notice

HDE has explained A) the ways that my identifying information is protected, B) the times when information about me may be released without my specific permission, and C) my rights related to my medical information.

I hereby agree to protect the confidentiality and privacy of other patients at all times. I will not discuss any information concerning other patients with individuals, organizations, agencies or any person not directly employed by HDE.

Patient Signature_____ Date_____

Parent/Guardian Signature_____Date_____

Witness Signature_____ Date_____

This acknowledgment will be retained in your clinical record.

Patient Name_____

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Credit Card Authorization

Please note that even if you are not intending to pay by credit card, I ask that you fill out the credit card authorization. This authorization remains on file if you no-show for your scheduled appointment, do not give a 24 hour cancelation notice, or if a session is conducted by phone. Your card will be charged for this one time fee, as stated in my Practice Policies.

The information on this form will be securely entered and stored in a HIPAA compliant electronic record that is protected for your safety. While all secure methods to protect your information are in place, no company can guarantee 100% that any online/electronic system will be completely confidential. You are accepting responsibility and risk in giving your credit card for therapy charges.

I authorize Haley Erickson, LCSW to keep the following credit card on file and to charge my account for payment of my session in the amount established under the following circumstances

1. No-Show or missed session without a 24 hour cancellation notice.
2. Phone session.
3. Past due sessions.
4. Failure to provide payment in full at the time of my session.

I will be notified that the missed session or the past due session payment will be applied to my credit card.

I agree that this form is valid for the length of therapy and authorization for the use of this card will be canceled at the termination of therapy.

Client's Name:
_____

Card Holder's Name:
_____

Billing Address:
_____

City _____ State: _____ Zip: _____

Acct. # _____CVV# _____

Exp. Date: _____/_____

Signature: _____ Date: _____

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