

Intake Form for Beth Christopherson, LCSW, PLLC

General Information

Client Name _____

Today's Date _____

Birthdate (Mo/Day/Yr) ____/____/____ Age _____

Marital Status (Circle one): Single Married Divorced Widowed Other _____

Current Status: Student Employed Unemployed Homemaker Retired
 Other _____

If a student, circle one: full time part time

School Attending: _____

If working, please give occupation and name of employer (no address or phone needed):

Address and Contact Information

Home Address: _____

Home Phone _____

Cell Phone _____

Okay to call? Yes / No

Okay to call? Yes / No

Leave a message? Yes / No

Leave a message? Yes / No

Emergency Contact Name and Phone Number:

May we contact your designated emergency contact in case if there is an emergency? Yes / No

Mental Health

How did you find Beth Christopherson, LCSW, PLLC?

Psychology Today

Internet Search

Referral

Other

If Referral or Other, please explain: _____

Mental Health, continued

List other therapy or counseling you have received in the past or are receiving now:

| Therapist's Name | Address | Approximate Dates |
|------------------|---------|-------------------|
| | | |
| | | |
| | | |

In your lifetime, have you ever been in a state hospital or psychiatric facility? Yes (explain below) No

Have you ever thought about suicide? Yes (explain below, and how often) No

Have you ever attempted suicide? Yes No

If yes, please explain when and any context you feel comfortable sharing

Do you feel suicidal now? Yes (please explain below) No

Medical Information

Do you have a physical disability? Yes No

If yes, please explain _____

Please list any medications you are taking below:

| Medication | Strength | How Many | Taken How Often |
|------------|----------|----------|-----------------|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

What is the name of the physician whose care you are under?

Have you had a serious illness in the last 12 months? If yes, please explain:

Have you ever suffered a head injury or lost consciousness? Yes No
If yes, when and how?

Do you have a brain injury diagnosis? Yes No
If yes, please explain:

Do you make use of any community-based support groups (e.g., 12-Step Programs, Social Support Groups) ? Yes No

If yes, please explain:

Please describe the people in your life who currently play a supportive, influential or friendship role

Symptoms

Please review these items, and circle the number that best describes how these symptoms have bothered you recently:

| | Not at all | Mildly | Moderately | Severely |
|---|------------|--------|------------|----------|
| 1. Depressed, sad, or crying | 0 | 1 2 3 | 4 5 6 7 | 8 9 10 |
| 2. Guilty feelings | 0 | 1 2 3 | 4 5 6 7 | 8 9 10 |
| 3. Suicidal thoughts, plans, or attempts Have you <i>ever</i> thought about, planned or attempted suicide? Thought about Y N Planned Y N Attempted Y N If yes to any of these, when was this? _____ | 0 | 1 2 3 | 4 5 6 7 | 8 9 10 |
| 4. Changed sleep patterns <input type="checkbox"/> Difficulty falling asleep <input type="checkbox"/> Difficulty staying asleep <input type="checkbox"/> Can't get up in a.m. <input type="checkbox"/> Nightmares | 0 | 1 2 3 | 4 5 6 7 | 8 9 10 |
| 5. Change in weight or eating habits <input type="checkbox"/> Increase <input type="checkbox"/> Decrease | 0 | 1 2 3 | 4 5 6 7 | 8 9 10 |
| 6. History of restrictive eating, dieting or purging | 0 | 1 2 3 | 4 5 6 7 | 8 9 10 |
| 7. Insecurity or inferiority | 0 | 1 2 3 | 4 5 6 7 | 8 9 10 |
| 8. Loss of interest or energy in pleasurable activities | 0 | 1 2 3 | 4 5 6 7 | 8 9 10 |
| 9. Anxious, nervous, or panicky feelings | 0 | 1 2 3 | 4 5 6 7 | 8 9 10 |
| 10. Avoiding places or situations | 0 | 1 2 3 | 4 5 6 7 | 8 9 10 |
| 11. Repetitive thoughts or behaviors | 0 | 1 2 3 | 4 5 6 7 | 8 9 10 |
| 12. Change in work habits <input type="checkbox"/> Increase <input type="checkbox"/> Decrease | 0 | 1 2 3 | 4 5 6 7 | 8 9 10 |
| 13. Change in spending habits <input type="checkbox"/> Increase <input type="checkbox"/> Decrease | 0 | 1 2 3 | 4 5 6 7 | 8 9 10 |
| 14. Anger or temper problems | 0 | 1 2 3 | 4 5 6 7 | 8 9 10 |
| 15. Flashbacks or intrusive memories | 0 | 1 2 3 | 4 5 6 7 | 8 9 10 |
| 16. Physical problems, pain, or illness | 0 | 1 2 3 | 4 5 6 7 | 8 9 10 |
| 17. Sexual worries or problems | 0 | 1 2 3 | 4 5 6 7 | 8 9 10 |
| 18. Brain fog, fuzzy thinking or dissociation | 0 | 1 2 3 | 4 5 6 7 | 8 9 10 |
| 19. Memory problems | 0 | 1 2 3 | 4 5 6 7 | 8 9 10 |
| 20. Confused or disorganized thoughts | 0 | 1 2 3 | 4 5 6 7 | 8 9 10 |
| 21. Periods of high energy/activity with less need for sleep | 0 | 1 2 3 | 4 5 6 7 | 8 9 10 |

Do the following concerns contribute to your symptom(s)? (*Check all that apply*)

- | | | |
|--|---|--|
| <input type="checkbox"/> Family move to a new home | <input type="checkbox"/> Death of a family member | <input type="checkbox"/> Developmental problems |
| <input type="checkbox"/> Birth of child or sibling | <input type="checkbox"/> Adjustment to new job | <input type="checkbox"/> Suspect physical/sexual abuse |
| <input type="checkbox"/> Fighting with spouse | <input type="checkbox"/> Adjustment to school | <input type="checkbox"/> Known physical/sexual abuse |
| <input type="checkbox"/> Post-divorce adjustment | <input type="checkbox"/> Law violations | <input type="checkbox"/> Alcohol/Substance abuse |
| <input type="checkbox"/> Financial stress | <input type="checkbox"/> Dishonesty | <input type="checkbox"/> Compulsive gambling/spending |
| <input type="checkbox"/> Marital unfaithfulness | <input type="checkbox"/> Career concerns/unemployment | <input type="checkbox"/> Pornography use |
| <input type="checkbox"/> Parenting problems | <input type="checkbox"/> Empty nest | <input type="checkbox"/> Anger/Violence |
| <input type="checkbox"/> Spiritual problems | <input type="checkbox"/> Previous therapy | <input type="checkbox"/> Other: _____ |

BETH CHRISTOPHERSON, LCSW, PLLC

4545 Post Oak Place Drive, Suite 210, Houston, TX 77027, Phone: (832)478-8897

CLIENT INFORMED CONSENT AND DISCLOSURE STATEMENT AGREEMENT FOR SERVICES

Thank you for your interest in working with Beth Christopherson LCSW, CST (“Beth”) as a client. Beth Christopherson LCSW, PLLC is providing you with the following information so you can make an informed choice about your decision to engage Beth’s services. Please read this information carefully and let Beth know if there is any part you do not understand.

Psychotherapy Services Offered

Beth offers an integrative approach to psychotherapy, working with clients (individuals, couples and adult family members) in a number of areas, including trauma, PTSD, anxiety, depression, low self-esteem, poor body image, and couples relationships. She also specializes in the treatment of sex and intimacy issues, such as low desire, sexual pain, and erectile and ejaculatory disorders. Another focus of Beth’s practice is helping those who are suffering from a loss of a loved one. For addressing grief, Beth uses a variety of modalities designed to decrease any negative intrusive images and thoughts, increase positive memories and feelings of peace, and helps clients continue to bond with the departed in a way that fits with their spiritual belief system and is optimal for them. With grief therapy, Beth also provides clients with complementary third-party non-psychotherapy resources that address spiritual and/or afterlife issues. She has found these resources to be beneficial to clients for dealing with the loss of a loved one.

The approaches Beth uses with a given client are based partly on the nature of the presenting complaint(s) or issues(s) as well as the preferences of the client. In addition to traditional psychotherapy approaches such as **Cognitive Behavioral Therapy**, Beth offers **Solution-Focused Therapy**, **EMDR (Eye Movement Desensitization and Reprocessing)**, and **Mindfulness Techniques**. If it would be helpful to incorporate any of these approaches into your psychotherapy, Beth would be happy to address that with you as you have the option of using individually or collectively any of the approaches she offers as part of your work with her.

Theoretical Approaches

Cognitive Behavioral Therapy

Cognitive Behavioral Therapy is the branch of psychology that studies mental processes including how people think, perceive, remember, and learn. The core focus of Cognitive Behavioral Therapy is on how people acquire, process and store information. Cognitive Behavioral Therapy focuses on challenging and changing distorted beliefs that lead to maladaptive and problematic behaviors. Strategies used in Cognitive Behavioral Therapy are easy to use but require commitment, patience and consistent effort.



Solution-Focused Therapy

Solution-Focused Therapy is future-focused, goal-directed, and focuses on solutions, rather than on the problems that brought clients to seek therapy. With Solution-Focused Therapy, the conversation is directed toward developing and achieving the client's vision of solutions. This reflects the basic belief that problems are best solved by focusing on what is already working, and how a client would like their life to be, rather than focusing on the past and the origin of problems.

EMDR (Eye Movement Desensitization and Reprocessing)

EMDR is a therapy that is designed to help people heal from the symptoms and emotional distress that are the result of disturbing life experiences, by activating the client's own natural healing processes. EMDR has shown that the mind can heal from psychological trauma much as the body recovers from physical trauma. If a foreign object or repeated injury irritates the wound, it festers and causes pain. Once the block is removed, healing resumes. Likewise, EMDR therapy demonstrates that a similar sequence of events occurs with mental processes: Once mental blocks are released, the brain's information processing system naturally moves toward mental health.

EMDR has been accepted as a therapy for the treatment of post-traumatic stress disorder (PTSD) and is a recommended treatment for trauma in the Practice Guidelines of the American Psychiatric Association, the Department of Veterans Affairs and Defense, SAMSHA, the International Society of Traumatic Stress Studies, and the World Health Organization. However, EMDR is considered an experimental therapy for all other indications based on the current state of the published research on EMDR.

Mindfulness Techniques

Mindfulness Techniques have evolved into a common form of complementary medicine, addressing a variety of health problems, by bringing together mindfulness meditation and stress management techniques. Scientific studies have clearly shown that stress can cause a host of physical and emotional problems. Mindfulness Techniques are ideal for cultivating greater awareness of the unity of mind and body, as well as of the ways that unconscious thoughts, feelings, and behaviors can undermine emotional, physical, and spiritual health.

Although Mindfulness Techniques appear to have promising emotional, spiritual, and physical health benefits supported by a growing amount of scientific research evidence, they remain to be extensively researched or supported by the Western academic, medical, and psychological communities and therefore, may be considered experimental. By signing this document, you understand that Mindfulness Techniques are considered "alternative" or "complementary" to the healing arts that are licensed by the State of Texas.

If you ever have questions or concerns about the nature of the theories, methods, approaches and/or techniques Beth uses, please feel free to ask her for further resources or references.

Outcome Expectations/Risk & Benefits

Although clients report positive outcomes, please note that it is not possible to guarantee any specific results, and neither Beth nor you know how you will personally respond to psychotherapy. However, Beth will work with you to achieve the best possible results for you. Participation in therapy can result in a number of important benefits to you, including improving interpersonal relationships and resolution of the specific concerns that led you to seek therapy, but working toward these benefits requires effort on your part. Psychotherapy requires your very active involvement, honesty, and openness in order to change your thoughts, feelings and/or behavior. You will have to work both in and out of the counseling sessions. Beth will ask for your feedback and views on your therapy, its progress, and other aspects of the therapy and will expect you to respond openly and honestly. Sometimes more than one approach can be helpful in dealing with a certain situation.

As with any intervention, there are risks associated with counseling and therapy. Risks during evaluation or therapy might include remembering, talking about, or experiencing unpleasant events that result in uncomfortable levels of feelings, such as sadness, guilt, anxiety, anger, frustration, worry; or experiencing anxiety, depression or insomnia; or having difficulties with other people. Beth may challenge some of your assumptions or perceptions or propose different ways of looking at things or handling situations that can cause you to feel upset, angry, depressed, challenged, or disappointed. Attempting to resolve issues that brought you to therapy in the first place, such as personal problems or interpersonal relationships, may result in changes that were not originally anticipated or intended. Being confronted with your difficulties can be very challenging. Some changes may lead to what seems to be worsening circumstances or even losses (for example, counseling can not necessarily keep a marriage intact.). Psychotherapy may also result in decisions about changing behaviors, employment, substance use, or relationships. Sometimes a decision that is positive for one family member is viewed negatively by another family member. Positive change will sometimes be easy and swift, but more typically it will be slow, challenging, and even frustrating.

Treatment Plan

Within a reasonable period of time after the initiation of treatment, Beth will discuss with you her working understanding of the problem(s), treatment plan, therapeutic objectives, and her view of the possible outcomes of treatment. If you have any unanswered questions about any of the procedures used in the course of your therapy, their possible risks, Beth's expertise in employing them, or the treatment plan, please ask, and you will be answered fully. You also have the right to ask about other treatments for your condition along with their risks and benefits. If you could benefit from any treatment that Beth's does not provide, she has an ethical obligation to assist you in obtaining those treatments.

Qualifications & Training

Beth has been licensed by the State of Texas as clinical social worker since 2011. In addition, she is a certified sex therapist through the American Association of Sexuality Educators, Counselors, and Therapists (AASECT) and completed sex addiction training through the International Institute of Trauma and Addiction Professionals. Beth is trained in the Pia Melody Post Induction Therapy (PIT) Model and is also EMDR-trained. Beth is a member of the Association of Death Education and Counseling (ADEC). Beth graduated from the University of Texas at Austin with a Bachelor of Science



degree in Biology and obtained her Master of Social Work (MSW) from the University of Houston. She taught college-preparatory science courses and has also worked with military families and service members to provide education and support services. She received the Albert Schweitzer Fellowship in support of her graduate training. Beth has had hundreds of hours of training in the field of sexual science and treatment, as well as thousands of hours of clinical experience successfully treating sexual issues. She is continually updating her education and skills.

Acknowledgment and Consent to Receive Services

You acknowledge that Beth, as the single member of Beth Christopherson, LCSW, PLLC, has disclosed to you in terms you understand the nature and purpose of the services to be rendered by her, and the limits and obligations associated with her services, including circumstances where confidential information may be requested and where disclosure of confidential information may be legally required. Further, you acknowledge that you have discussed with Beth, and you understand and agree to, the financial arrangements for Beth’s services, including her fees for standard services, and you have received a copy of Beth Christopherson, LCSW, PLLC’s **Office Policies, Client Information, Responsibilities and Rights** and **HIPAA Notices of Privacy Practices** documents, which are incorporated herein by reference and made part of this Client Informed Consent and Disclosure Statement/Agreement for services. You understand that your consent to the nature of your sessions is given voluntarily, without coercion, and may be withdrawn at any time in the future.

By signing in the space provided below, you knowingly, voluntarily, and intelligently assume these risks and, except in the case of gross negligence or malpractice, you and your representative(s) agree to release, indemnify, hold harmless and defend Beth Christopherson, LCSW, PLLC, its owners, members, principals, employees, staff members, agents, representatives, consultants, and others associated with Beth Christopherson, LCSW, PLLC, from and against any and all claims or liability, of whatsoever kind or nature, which you, or your representative(s), may have for any loss, damage, or injury, including without limitation, physical, emotional, mental, financial, or personal, arising out of or in connection with your sessions or arising out of or in connection with you voluntarily choosing to use a complementary third-party non-psychotherapy resource, if applicable.

Please sign both copies of this Client Informed Consent and Disclosure Statement/Agreement for Services. A copy for your records will be returned to you. Beth Christopherson, LCSW, PLLC, will retain a copy for its confidential records.

Client’s Signature

Date

Print Name



BETH CHRISTOPHERSON, LCSW, PLLC

4545 Post Oak Place Drive, Suite 210, Houston, TX 77027, Phone: (832)478-8897

Office Policies & Client Information, Responsibilities, and Rights

This form informs you of the policies of Beth Christopherson, LCSW, PLLC, as well as client responsibilities and rights. Please initial each section below to indicate your awareness of these policies, responsibilities, and rights.

Contacting Beth

Beth Christopherson, LCSW (“Beth”) can be contacted directly at (832)478-8897 via voicemail or text. Texting may be used only to schedule or cancel an appointment. Only include your first name in a text. Beth is often with clients continuously from 11am until 7pm, meaning that if you call during these hours, her phone will typically transfer you straight to voice mail. Beth checks her voice mail regularly and will return your call or text within 36 hours.

Initials: _____

Emergency Procedures

For life-threatening emergencies, call 911 or go to your nearest emergency room. Please note that as an independent practitioner, Beth does not offer after-hours services. While on vacation, Beth will give you names of other therapists you can contact if you would like a therapy appointment while she is away. If you require a level of support greater than the resources Beth can provide, she will refer you to a higher level of care program, such as an inpatient program or intensive outpatient program. Beth may also require that you seek additional care from a psychiatrist or group therapist to continue therapy with Beth Christopherson, LCSW, PLLC.

Initials: _____

Structure of and Fees for a Session

The initial session is 80 minutes, and the fee for this initial session is **\$260**. The first 10-15 minutes of the initial session will consist of collecting payment and highlighting some of the policies of Beth Christopherson, LCSW, PLLC, as well as the exceptions to confidentiality. Beth will also answer any questions you may have regarding the paperwork. You may schedule your next appointment during the initial session or call or text after the session to schedule your next appointment.



DBA Sex and Intimacy Therapy and Houston Grief Therapy

After the initial session, you have an option to schedule future 50-minute or 80-minute sessions. The fee for a 50-minute session is **\$160**, and the fee for an 80-minute session is **\$240**. The first five minutes of these sessions will be used to collect payment and to schedule the next session. You also have the option to book several appointments into the future, to minimize time in session used for scheduling. Please note that in fairness to you and to other clients, my sessions start and end at the scheduled times unless I have to attend to a clinical emergency.

Beth Christopherson, LCSW, PLLC, can on a case-by-case basis provide a phone session in the event of a crisis. The rates for a phone session are based on \$160 per 50 minutes.

Initials: _____

Texts

Texts to Beth's work cell phone at (832)478-8897 should only include information for the purpose of scheduling or cancelling appointments. Beth only needs your first name in a text. Do not include any other personal information in your texts, as texting is vulnerable to unauthorized access. You are not required to use texts when working with Beth Christopherson, LCSW, PLLC.

This texting option above for scheduling is provided for your convenience only if you so choose, while understanding the limitations of confidentiality: It is important to be aware that text communication can relatively easily be accessed by unauthorized people and hence can compromise the privacy and confidentiality of such communication.

Initials: _____

Missed Appointment Policy

It is the policy of Beth Christopherson, LCSW, PLLC, that you must call or text within 24 hours of your scheduled appointment to cancel the appointment. **If you do not provide at least a 24-hour notice, you will be charged for the full fee of the session.** Beth Christopherson, LCSW, PLLC also understands that emergencies arise and provides **one** "free" last-minute cancellation. That is, you will not be charged for your first last-minute cancellation. This one cancellation applies to your individual or couple session, but you cannot apply it to both. Beth understands that there are always good reasons when people need to cancel last minute. However, she only has the financial ability to provide **ONE** free late cancellation. 2 hours are reserved for new client appointments. A charge of \$160 will apply to a late cancellation of an initial appointment. Thank you for your understanding in this.

Initials: _____

Interactions Outside of Therapy

Occasionally clients and therapists run into each other outside of therapy. Beth's policy is to protect client confidentiality, and she will not acknowledge you unless if you acknowledge her first.

Initials: _____



Payment Collection and Insurance

Payment for services will be rendered during the first 5 minutes of your session. Beth Christopherson, LCSW, PLLC, accepts MASTERCARD, VISA, AMEX, and DISCOVER via the Square Register. Cash is accepted, but only if it is in the exact amount. Please no checks.

Beth Christopherson, LCSW, PLLC, **is not in network with any insurance carrier.** Beth Christopherson, LCSW, PLLC has rates of service that are very reasonable so that these specialized services are available to a larger number of people and because it is understood that many clients do not want to submit superbills to their insurance company for out-of-network benefit reimbursement. Although most people do not have negative consequences occur, please be aware of the potential challenges and consequences of submitting superbills or walk-out bills to your insurance carrier for out-of-network benefit reimbursement. These include:

1. Superbills require a diagnostic code which can be added to your mental health record if you submit them.
2. Having some mental health diagnoses may restrict you from being able to work for certain federal, state or law enforcement agencies.
3. Reimbursement from insurance carriers is often minimal or requires patients to meet a very high deductible. They often do not reimburse couple/family therapy.
4. Some diagnoses can affect a person's ability to qualify for long-term care or disability insurance.
5. Sexual dysfunction diagnoses are rarely reimbursed.

If you would like to see a therapist that is covered by your insurance instead, you will need to contact your insurance provider and ask them for a list of providers in your network. If you decide you want superbills, each one will be generated at the beginning of session after your payment is complete.

An administration fee at the rate of \$160 per hour will be charged for administrative work required of Beth Christopherson, LCSW, PLLC, outside of session including, but not limited to: Corresponding with your insurance company by phone or in writing, preparing and/or re-printing superbills in a quantity that would require more than the first five minutes of session.

Initials: _____

Referrals and Termination of Therapy

Beth Christopherson, LCSW, PLLC, has the ethical duty to provide referrals to other professionals or agencies, if Beth deems the treatment required to be beyond her level of training or resources as a solo practitioner. In the event that such referrals are, in her professional opinion, necessary for treatment to be effective, continuing therapy with Beth Christopherson, LCSW, PLLC, will require you to follow-up on such referrals. Such situations may include, but are not limited to: recurrent suicidality, high-risk alcohol or chemical abuse or dependency, domestic violence, psychosis, or self-

injurious behaviors. There are other situations that require that therapy be terminated between Beth Christopherson, LCSW, PLLC, and the client, such as if there is a conflict of interest or if Beth cannot provide the appropriate treatment modality or required level of care. In this case, Beth Christopherson, LCSW, PLLC, will provide you with at least three appropriate referrals and will help to assist the transfer of care.

Initials: _____

General Client Rights

- ♦To expect that Beth Christopherson LCSW, as the single member of Beth Christopherson, LCSW, PLLC (“Treatment Provider”) meets minimal qualifications of training and experience.
- ♦To be informed of the cost of services before receiving them.
- ♦To be free from sexual advances and/or other sexual conduct from the Treatment Provider
- ♦To be free of being the object of discrimination on the basis of age, gender, race, ethnicity, national origin, religion, sexual orientation, disability, socioeconomic status, or other protected category while receiving services
- ♦To be free from exploitation for the benefit of the Treatment Provider

Initials: _____

Specific Client Rights

- ♦The right to be informed of the various steps/activities involved in receiving services
- ♦The right to assist in the development of your treatment plan
- ♦The right to file a grievance
- ♦The right to dignity and privacy
- ♦The right to a humane and safe environment
- ♦The right to confidentiality under the HIPAA Act relating to receipt of services
- ♦The right to communicate with an attorney at any time
- ♦The right to refuse to participate in research without compromising access to services
- ♦The right to know about treatment parameters, e.g., length of stay or cost of treatment
- ♦The right to have a clear, non-technical explanation of client rights
- ♦The right to make an informed decision about whether to accept or refuse treatment

These rights are guaranteed to all consumers of treatment services. If you have any questions about these rights, you are encouraged to discuss it with your Treatment Provider. If you wish to make a complaint, you can write or call the Texas State Board of Social Work Examiners.

Initials: _____

Notice of Privacy Practices

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. 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. Beth Christopherson is the Privacy Officer for Beth Christopherson, LCSW, PLLC.

- **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, Beth Christopherson, 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.**

Notice of Privacy Practices Acknowledgment

I understand that under the Health Insurance Portability and Accountability Act of 1996, (HIPPA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- ◆ Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment, directly and indirectly
- ◆ Obtain payment from third-party payers
- ◆ Conduct normal healthcare operations, such as quality assessments and physician certifications

I have received, read and understand the "Notice of Privacy Practices" containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its "Notice of Privacy Practices" from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the "Notice of Privacy Practices."

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Client Name Printed: _____

Client Signature: _____

Date: _____



DBA Sex and Intimacy Therapy and Houston Grief Therapy