TISH HOLUB TAYLOR, Ph.D., LC

LICENSED PSYCHOLOGIST
www.tishtaylor.com

INFORMATION FORM

Client Information (Child / Adolescent)

Name: _____ Gender: _____

Address: _____ City: _____ State: ____ Zip _____

Home Phone: _____ DOB: _____ Age: _____

School: _____ Grade: _____ Teacher: _____

Responsible Party

Mother/Guardian: _____ Best Phone Number:_____

Address: _____ City: _____ State: ____ Zip _____

Employer: _____ Work Phone: _____

E-mail: _____ DOB: _____

Father/Guardian: _____ Best Phone Number:_____

Address: _____ City: _____ State: ____ Zip _____

Employer: _____ Work Phone: _____

E-mail: _____ DOB: _____

Parents are currently: __ Married __Divorced __Separated __ Remarried __Never Married

Child lives with: ____Mother ____ Father ___Relative ___ Guardian ____ Other

Who has legal custody of this child? _____

Emergency Information

Name: _____ Relationship to Client: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Signature: _____ Date: _____

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CONSENT TO TREATMENT

Welcome
Welcome to my practice. Please read this document as it contains important information about my services and business policies. If you have any questions, please make note of them so that we can discuss them. **Once you sign this, it will constitute a binding agreement between us.**

Psychological Services
Psychotherapy is not easily described in general terms. It varies depending on the personality of both the therapist and the client and the particular issues that the client wants to address. There are a number of different approaches that can be used. It is not like visiting your medical doctor in that psychotherapy requires an active effort on your part. In order to be most successful, you will have to work both during sessions and at home.

Psychotherapy has both benefits and risks. Risks sometimes include experiencing uncomfortable levels of feelings such as sadness, guilt, anxiety, anger, frustration, loneliness, and helplessness. Psychotherapy sometimes requires recalling unpleasant aspects of your history. It is important that you discuss these issues in an honest and forthright manner. Psychotherapy has been shown to have benefits for those who undertake it. It often leads to significant reductions in feelings of distress, improved relationships, and resolutions to specific problems. There are no guarantees about what will happen.

By the end of the first few sessions, I will be able to offer you some initial impressions of what your work will include and an initial treatment plan. You should evaluate this information along with your own assessment about whether you feel comfortable continuing. Therapy involves a large commitment of time, money, and energy, so you should be very careful about the therapist you select.

Evaluations
Evaluations include formal and informal measures designed to elicit information and data related to the area of concern. A psychological diagnosis may or may not result from an evaluation. However, information regarding current strengths and weaknesses, areas of behavioral and/or psychological concern, and current functioning are provided. At the conclusion of an evaluation, I will meet with parents and/or the client to review the evaluation results, provide a written report, and recommendations for interventions. In some instances, other individuals may be contacted for information. However, this will only occur with your written permission. I understand that these services include face-to-face interviewing, administering tests, checklists, questionnaires, and other assessment methods. The fees also include the psychologist's time required for reading of records, consultation with other professionals, scoring of tests, interpreting the results, constructing a report, and any other service associated with your particular evaluation. The total cost for an evaluation depends on the amount of time and tasks needed to complete the evaluation.

Sessions
If psychotherapy is initiated, a 50 minute meeting will be scheduled at mutually agreed upon times. It is your responsibility to make every effort to attend all scheduled sessions. If you do not cancel an appointment 24 hours prior to its scheduled date and time, you will be assessed the full rate as a no show fee (unless there is a circumstance beyond your control).

Fees
My hourly fee for individual therapy is 175.00. It is 175.00 for the initial appointment. I charge this amount for other professional services you may need, though I will break down the hourly cost if I work periods for less than an hour. Other services include report writing, phone conversations lasting longer than 10 minutes, consulting with other professionals you have authorized, mileage, preparation of records or treatment summaries, and time spent performing any other service you may request of me. If you become involved in legal proceedings that require my participation, you will be expected to pay for my professional time, including preparation and transportation costs, even if I am called to testify by another party. My fee for legal proceedings is 350.00 per hour.

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Social Media Policies

I do not accept friend or contact requests from current or former clients on social networking sites (Facebook, LinkedIn, etc.). I believe that adding clients as friends or contacts on these sites can compromise your confidentiality and our respective privacy. *It may also blur the boundaries of the therapeutic relationship.*

Billing and Payments

You will be expected to pay for each session at the time it is held.

Insurance Reimbursement

If you have a health insurance policy, it will usually provide some coverage for in and out of network mental health treatment. I can provide a superbill, if needed, for out of network reimbursement. If I am not a participating provider with your insurance company, you should carefully read the section in your insurance coverage booklet that describes out of network mental health services. If you have questions about the coverage, call your plan administrator. I will provide you with whatever information I can.

Professional Records

The laws and standards of my profession require that I keep protected health information about you in your clinical record. You are entitled to receive a copy of your clinical record when you make a written request unless I believe that seeing them would be emotionally damaging to you and others; they make reference to another person (other than a health care provider) and I believe that access is reasonably likely to cause substantial harm to the other person; or if disclosure could reasonably be expected to lead to the patient's identification of a person who provided information to me in confidence under circumstances where confidentiality is appropriate. Because these are professional records, they can be misinterpreted and/or upsetting to untrained readers. I recommend that you review them in my presence so that we can discuss the contents. Patients will be charged an appropriate fee for any time spent on information requests.

Minors

If you are under 18 years of age, please be aware that the law may allow your parents the right to examine your treatment records. It is sometimes my policy to request parents agree to give up access to your records. If they agree, I will provide them only with general information about our work together, unless I feel there is a high risk that you will seriously harm yourself or someone else. In this case, I will notify them of my concern. I will also provide them with a summary of your treatment when it is complete. Before giving them any information, I will discuss the matter with you, if possible, and do my best to handle any objections you have.

I recommend that both parents/guardians agree to psychological treatment of a child before services are sought. In some cases, consent by both parents may be required.

Confidentiality

In general, the confidentiality of all communications between a client and psychologist is protected by law. Psychologists can release information only with written permission with some exceptions. These exceptions include:

- In some proceedings involving child custody and those in which your emotional condition is an important issue, a judge may order my testimony if he/she determines that the issues demand it.
- If you are involved in a court proceeding and a request is made for information concerning your diagnosis and treatment, such information is protected by the psychologist-patient privilege law. I cannot provide information without your (or your legal representative's) written authorization or a court order. If you are involved in a contemplating litigation, you should consult with your attorney to determine whether a court would be likely to order me to disclose information.
- If a government agency is requesting the information for health oversight activities, I may be required to provide it for them.

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- If a client files a complaint or lawsuit, I may disclose relevant information regarding that client in order to defend myself.
- If a client files a worker's compensation claim, and I have examined or treated the client in regard to such claim, I must, upon appropriate request, provide a report and/or copy of the client's record to the appropriate authority, state agency, the client's employer, and/or the employer's insurance company.
- There are some situations in which I may be legally required to take action to protect others from harm, even though that requires revealing some information about a client's treatment. If I believe that a child, an elderly person, or a disabled person is being abused, I am required to file a report with the appropriate state agency.
- If I believe that you are a serious threat to another person, I am required to take protective actions, which may include notifying the potential victim, notifying the police, and seeking appropriate hospitalization. If a client threatens to harm him/herself I may be required to seek hospitalization for the client or to contact a family member or others who can provide protection.

I have read the above information and understand what it contains. I give full consent for treatment.

Print Name	Witness
Signature	Date

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Notice of Psychologist's Policies and Practices to Protect the Privacy of Your 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

I may *use* or *disclose* your *protected health information (PHI)*, for *treatment, payment and health care operation* purposes with your consent. To help clarify these terms, here are some definitions:

- "PHI" refers to information in your health record that could identify you.
- "Treatment, Payment, and Health Care Operations"
    - *Treatment* is when I provide, coordinate, or manage your health care and other services related to your health care. An example of treatment would be when I consult with another health care provider, such as your family physician or another therapist.
    - *Payment* is when I obtain reimbursement for your healthcare. Examples of payment are when I disclose your PHI to your health insurer to obtain reimbursement for your health care or to determine eligibility or coverage.
    - *Health Care Operations* are activities related to the performance and operation of my practice. Examples of health care operations are quality assessment and improvement activities, business-related matters such as audits and administrative services, and case management and care coordination.
- "Use" applies only to activities within my office such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.
- "Disclosure" applies to activities outside of my office, such as releasing, transferring, or providing access to information about you to other parties.

II. Uses and Disclosures Requiring Authorization

I may use or disclose PHI for purposes outside of treatment, payment or health care operations when your appropriate authorization is obtained. An "authorization" is written permission above and beyond general consent that permits only specific disclosures. In those instances when I am asked for information for purposes outside of treatment, payment or health care operations, I will obtain an authorization from you before releasing this information. I will also need to obtain an authorization before releasing your Psychotherapy Notes. "*Psychotherapy Notes*" are notes I have made about our conversations during a private, group, joint or family counseling session, which I have kept separate from the rest of your medical record. These notes are given a greater degree of protection than PHI. I will also obtain an authorization from you before using or disclosing PHI in a way that is not described in this Notice.

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) I have relied on that authorization; or (2) if the authorization was obtained as a condition of obtaining insurance coverage, the law provides the insurer the right to contest the claim under the policy.

Breach Notification Addendum to Policies & Procedures

1. When the Practice becomes aware of or suspects a breach, as defined in Section 1 of the breach notification Overview, the Practice will conduct a Risk Assessment, as outlined in Section 2.A of the Overview. The Practice will keep a written record of that Risk Assessment.
2. Unless the Practice determines that there is a low probability that PHI has been compromised, the Practice will give notice of the breach as described in Sections 2.B and 2.C of the breach notification Overview.

3. The risk assessment can be done by a business associate if it was involved in the breach. While the business associate will conduct a risk assessment of a breach of PHI in its control, the Practice will provide any required notice to patients and HHS.
4. After any breach, particularly one that requires notice, the Practice will re-assess its privacy and security practices to determine what changes should be made to prevent the re-occurrence of such breaches.

III. Uses and Disclosures with Neither Consent nor Authorization
I may use or disclose PHI without your consent or authorization in the following circumstances:

Child Abuse – If I have reason to suspect that a child has been injured as a result of physical, mental or emotional abuse or neglect or sexual abuse, I must report the matter to the appropriate authorities as required by law.

Adult and Domestic Abuse – If I have reasonable cause to believe that an adult is being or has been abused, neglected or exploited or is in need of protective services, I must report this belief to the appropriate authorities as required by law.

Health Oversight Activities – I may disclose PHI to the Kansas Behavioral Sciences Regulatory Board if necessary for a proceeding before the board.

Judicial and Administrative Proceedings – If you are involved in a court proceeding and a request is made for information about the professional services I provided you and/or records thereof, such information is privileged under state law, and I will not release information with the written authorization from you or your legally appointed representative 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 in the case.

Serious Threat to Health or Safety – If I believe there is a substantial likelihood that you have threatened an identifiable person and that you are likely to act on that threat in the foreseeable future, I may disclose information in order to protect that individual. If I believe that you present an imminent risk of serious physical harm or death to yourself, I may disclose information in order to initiate hospitalization or to family members or others who might be able to protect you.

Worker's Compensation – I may disclose PHI as authorized by and to the extent necessary to comply with laws related to worker's compensation or other similar programs, established by law, that provide benefits for work-related injuries or illnesses without regard to fault.

When the use and disclosure without your consent or authorization is allowed under other sections of Section 164.512 of the Privacy Rule and the state's confidentiality law. This includes certain narrowly-defined disclosures to law enforcement agencies, to a health oversight agency (such as HHS or a state department of health), to a coroner or medical examiner, for public health purposes relating to disease or FDA-regulated products, or for specialized government
functions such as fitness for military duties, eligibility for VA benefits, and national security and intelligence.

IV. Patient's Rights and Psychologist's Duties
Right to Request Restrictions – You have the right to request restrictions on certain uses and disclosures of protected health information. However, I am 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 that you are seeing me. On your request, I will send your bills to another address.)

Right to Inspect and Copy – You have the right to inspect or obtain a copy (or both) of PHI in my mental health and billing records used to make decisions about you for as long as the PHI is maintained in the

record. I may deny your access to PHI under the certain circumstances, but in some cases you may have this decision reviewed. On your request, I will discuss with you the details of the request and denial 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. I may deny your request. On your request, I 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. On your request, I 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 me upon request, even if you have agreed to receive the notice electronically.

Right to Restrict Disclosures When You Have Paid for Your Care Out-of-Pocket - You have the right to restrict certain disclosures of PHI to a health plan when you pay out-of-pocket in full for my services.

Right to Be Notified if There is a Breach of Your Unsecured PHI - You have a right to be notified if: (a) there is a breach (a use or disclosure of your PHI in violation of the HIPAA Privacy Rule) involving your PHI; (b) that PHI has not been encrypted to government standards; and (c) my risk assessment fails to determine that there is a low probability that your PHI has been compromised.

Psychologist's Duties:
I am required by law to maintain the privacy of PHI and to provide you with a notice of my legal duties and privacy practices with respect to PHI.

I reserve the right to change the privacy policies and practices described in this notice. Unless I notify you of such changes, however, I am required to abide by the terms currently in effect.

If I revise my policies and procedures, I will provide you with a revised information at your next scheduled appointment.

V. Questions and Complaints
If you have any questions about this notice, disagree with a decision I make about access to your records, or have other concerns about your privacy rights, you may contact me.

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
This notice will go into effect on 9/23/13.

I HAVE READ THE ABOVE INFORMATION AND UNDERSTAND WHAT IT CONTAINS.

_____ _____
Print Name Witness

_____ _____
Signature Date

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Financial Responsibility Statement

Name: _____

(Please print)

Hourly Fee: $175.00 (per 50 minute session)

I agree to be responsible for the charges I incur as a result of services provided by Tish Holub Taylor, Ph.D., LC. I understand that charges are based on the amount of professional time used. I understand that if I fail to give a 24 hour notice of cancellation, I will be charged the rate for the time that has been reserved for me. Other professional services may also be billed at the normal hourly rate. I understand that all payments are due at the time services are rendered unless other arrangements have been made in writing in advance.

I agree to notify Tish Holub Taylor, Ph.D., LC, of any changes in my insurance or financial information. I will also notify my service provider of any changes in my address or telephone number. If my account should remain unpaid for more than 60 days, I understand that interest may be charged on the outstanding balance and my account may be turned over to a collection agency for collection. Tish Holub Taylor, Ph.D., LC, in turn, may communicate account information about my unpaid account to a credit bureau. I agree to pay all reasonable attorney fees and collection expenses incurred in the collection of my account. If I provide a check as payment, I authorize Tish Holub Taylor, Ph.D., LC to collect a state allowable fee through electronic fund transfer from my account if my check is return unpaid. If I pay with my credit card, I understand that my card will be charged for any bank fees related to charge backs and insufficient funds.

_____

Signed (Client or Guarantor) Date

_____

Witness Date