Family Perspectives, L.L.C.

Welcome to my practice, "Family Perspectives." I am honored that you have chosen to begin a process of change with me. It is my pleasure to help you reach your individual and/or family goals. This will take work on your part, but I am confident that the fruits of your labor will make it worth it.

This document contains important information about our professional services and business policies. It also contains summary information about the Health Insurance Portability and Accountability Act (HIPAA), a new federal law that provides new privacy protections and new patient rights with regard to the use and disclosure of your Protected Health Information (PHI) used for the purpose of treatment, payment, and health care operations. HIPAA requires that I provide you with a Notice of Privacy Practices (Arizona Notice Form) for use and disclosure of PHI for treatment, payment and health care operations. The Notice, which is attached to this Agreement, explains HIPAA and its applications to your personal health information in greater detail. The law requires that I obtain your signature acknowledging that I have provided you with this information. Although these documents are long and sometimes complex, it is very important that you read them carefully before our next session. We can discuss any questions you have about the procedures at that time. When you sign this document, it will also represent an agreement between us. You may revoke this agreement in writing at any time. That revocation will be binding on me unless I have taken action in reliance on it; if there are obligations imposed on me by your health insurer in order to process or substantiate claims made under your policy; or if you have not satisfied any financial obligations you have incurred.

Procedures and goals of treatment

The therapeutic process is not easily described in general statements. It varies depending on the personalities of the therapist, the client, and the issues the client is experiencing. There are many different methods I may use to deal with the problems that you hope to address. Psychotherapy is not like the passive experience of surgery or many other medical interventions in that therapy requires a very active effort on your part. In order for the experience to be most successful, you will have to work on things we talk about outside of the therapy session.

Therapy can have benefits and risks. Because therapy often involves discussing unpleasant aspects of life, you may experience uncomfortable feelings like sadness, guilt, anger, frustration, loneliness, and helplessness. Still, therapy has also been shown to have many benefits. Therapy often leads to improved relationships with self and others, solutions to specific problems, and significant reductions in or management of feelings of distress. The hope of therapy is that resolution of issues and personal growth comes at a faster rate than "braving it alone." But there are no guarantees of what you will experience.

There are some circumstances under which I am required to refer. For example, I do not have specialized training for working with substance addictions (meaning alcohol or other drugs) or process addictions (such as gambling or sex), therefore, to assure I am not working outside of my scope and you get the best treatment, I would refer you to someone who was qualified to the best of my ability and knowledge. Rules of confidentiality still apply, so I would not contact these people for a client but will let the client know how to contact them.

We will begin with one or more evaluation sessions and then we will develop a treatment plan. You have the right to participate in treatment decisions and in the development and periodic review and revision of your treatment plan. You have the right to refuse any recommended treatment or to withdraw informed consent to treatment and to be advised of the consequences of such refusal or withdrawal.

Limits of confidentiality

In most situations I can only release information about your treatment to others if you sign a written authorization form that meets certain legal requirements imposed by the Health Insurance

Portability and Accountability Act (HIPAA). However, there are some situations where I am permitted or required to disclose information without either your consent or authorization. These situations will be discussed in detail during your first visit. Finally, there are some situations in which I am legally obligated to take action in an attempt to protect others from harm and may have to reveal some information about a client's treatment.

- If I have reason to believe that a child under 18 is or has been the victim of injury, sexual abuse, neglect or deprivation of necessary medical treatment, the law requires that I file a report with the appropriate government agency, usually the Office of Child Protective Services. Once such a report is filed, I may be required to provide additional information.
- If I have reason to believe that any adult client who is either vulnerable and/or incapacitated and who has been the victim of abuse, neglect or financial exploitation, the law requires that I file a report with the appropriate state official, usually a protective services worker. Once such a report is filed, the counselor maybe required to provide additional information.
- If a client communicates an explicit threat of imminent serious physical harm to a clearly identified or identifiable victim and I believe that the patient has the intent and ability to carry out such threat, I must take protective actions that may include notifying the potential victim, contacting the police, or seeking hospitalization for the client.

It is common practice for therapists to discuss cases with other professional colleagues to facilitate continued professional growth and so that clients benefit from a variety of professional expertise. No identifying information is released in the peer consultation process. I reserve the right to share personally identifiable information with my associate, Matt Slavsky, or to whomever might be on-call for me (typically Matt Slavksy) for coordination of care or in the event that I am unavailable or out of town to facilitate the coverage of your care in my absence.

Fees

Fees are due at each meeting unless you have made prior arrangements with us. Payment can be made via cash or personal check. Missed appointments and appointments cancelled less than twenty-four hours in advance are charged at the rate of $55 and must be paid no later than the end of the next session. Balances are not carried for clients because this turns the therapeutic relationship into a debtor/creditor relationship. For cancellations within less than 24 hours, please cancel via phone verses email.

- In-office fees are $115 for a 50 minute appointment. The first session is usually 80 minutes. Longer or shorter sessions are prorated from this basic fee. When clients arrive to session late, the full session amount is still charged and the session will still end at the planned time.

- In-home rates given at a 50 minute hour for the first hour.
- $150 for a 50 minute appointment
- $220 for an 80 minute appointment
- $280 for a one hour 50 minute appointment

There is a $10 extra fee for each 1-5 miles from the Ahwatukee office. A minimum of an 80 minute session is required for in-home services. On-line counseling is charged at the in-office counseling rates.

Other services include coordination of care with other professionals you have authorized, preparation of records or treatment summaries, and the time spent performing any other service you may request of us. These along with telephone calls are charged at the case management rate of $20 per 15 minute increment rounded up from eight minutes or down from seven minutes. There will be a 15 minute charge for information that takes more than 5 minutes to review/work on. There is a $35 fee for bounced checks. We reserve the right to utilize a collections agency in the event of nonpayment.

Letter writing is charged at same rate as the in-office rate.

Court services/considerations

Some of our professionals are hired as expert witnesses to provide professional opinions about mental health issues. It is a conflict of interest for a therapist to provide opinions or recommendations and treat the same client. We can be hired as an expert witness or as a treating therapist, but we are not able to play both roles. If a client has these expectations, it can effect their willingness to disclose personal information vital to treatment. If a court appearance is required of us or the records the fee is $250 per hour for each hour of preparation time, related phone calls, travel from office to the court and back, deposition time, testimony time, and any unforeseen related expenses or uses of our time with a two hour minimum. Copying fees will be based on cost of copies and amount of time needed to complete and/or mail them.

A retainer of $2500 will be required at least ten business days before the court date. Since there is a large amount of time set aside for depositions or testimonies, $500 of the $2500 will not be returned if the deposition or testimony is cancelled or postponed within five business days. We accept cash, check, or money order as form of payment for retainers or any amounts over $500. If there is a balance due after the court service, the remaining amount must be paid to Family Perspectives within two weeks from the day of court. We have the right to charge 10% interest if the remaining amount is not paid on time.

Health Insurance

Family Perspectives is able to provide clients with a "superbill," which is a receipt of services that many insurance companies accept if a client has out of network benefits. It is the client's responsibility to check with their insurance company to see what their benefits are. Some insurance companies will not reimburse for in-home services. We at Family Perspectives have chosen not to be on any insurance panels at this time for several reasons from confidentiality to some insurance companies dictating treatment.

Payment method

Payment is required at the time services are rendered and may be made by check, money order, cash, credit card, debit, or HSA card.

Cancellation policy

If you are unable to keep an appointment, please notify the office immediately. You will be billed for appointments canceled or missed with less than 24 hours prior notice. The fee is $55.00. If 3 late cancellations or missed appointments occur within a 12 month period, I will discuss your options as scheduling appointments in advance will no longer be an option.

Professional records

The laws and standards for behavioral health professionals in Arizona require that the agency keeps treatment records. You are entitled to receive a copy of the records upon written request. Because these are professional records, they can be misinterpreted and/or upsetting to untrained readers. It is recommended that you review them in the counselor's presence in order to discuss the contents. Clients will be charged at the same rate as a regular counseling service prorated accordingly for any time spent in preparing information requests.

Contacting me

I offer a unique *phone support service* option that can be used between meetings. Some individuals or/and families feel assured to know that they have support between visits and that they have a place to call when things are especially difficult. It is easy to continue with the same habits when under pressure. You will be able to call for emotional support or coaching. This can be a great way to receive an extra "push" and encouragement.

Telephone support services are $20 per 15 minute increment rounded up from eight minutes or down from seven minutes. There will be a 15 minute charge for any telephone conversation lasting more than 5 minutes. I will make all necessary actions to be available as immediately as possible, but in certain circumstances I will not be able to return calls until the following business day. In situations where the person calls and gets my voice mail and feels they cannot wait for a response, a state crisis hotline (Maricopa Crisis) number is also available 24/7 and can be reached at 602-222-9444.

In most cases I will also be available to receive and send emails if needed to review information outside of sessions or for support outside of sessions. As with cordless telephones, internet communication is not 100% secure. Confidentiality can be compromised even in the best of circumstances. I take my responsibility to protect your privacy very seriously. I will do everything in my power to safeguard our interactions, whether in person, phone, or online.

Acknowledgement of that I have received, read and understood the above four-page document along with the HIPPA (Arizona Notice) form that was given to me. For minors, I understand that it is my responsibility to inform the child's other parent that I am seeking therapy services our child and that the other parent must agree to therapy.

_____	_____	_____
Print Name	Sign Name	Date
_____	_____	_____
Spouse/Guardian/Other (Print)	Sign Name	Date
_____	_____	_____
Witness Print Name	Witness Sign Name	Date

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Family Perspectives, L.L.C.

New Client Information

Referred By:_____ **Today's Date: _____/___/_____**

I. Client Information

Name:_____ Social Security #:_____

Birth Date:_____ Age: _____ Gender: Male Female

Address:_____ City:_____ State:_____ Zip: _____

Home Phone:_____ Cell Phone:_____ Fax #:_____

Email Address:_____

Work Phone:_____ Guardian's Work Phone (for minor):_____

Email:_____

Would you like to be added to our newsletter list?: yes / no

Would you be interested in completing a survey about your therapy experience? yes/ no

In case of emergency, please notify:

Name:_____ Phone:_____ Relationship:_____

Please complete this section for others residing in the client's home:

Name	Birth Date	Age	Relationship to Client	Gender

II. Occupational/Educational Status

Client currently employed? Yes/No If yes, Full-Time/Part-Time Occupation:_____

Spouse currently employed? Yes/No If yes, Full-Time/Part-Time Occupation:_____

For minor: Father currently employed? Yes/No If yes, Full-Time/Part-Time Occupation:_____

For minor: Mother currently employed? Yes/No If yes, Full-Time/Part-Time Occupation:_____

If guardian/s not employed, please check any of the following: Retired Unemployed Disability Student

III. Client's Health Status

Current or chronic medical issues: _____

Primary Care Doctor: _____ Phone:_____

IV. Client's Medication History

Have you previously taken medications for emotional/substance abuse problems? YES___ NO ___

Name:	Name:	Name:
Dose (mg):	Dose (mg):	Dose (mg):
Frequency:	Frequency:	Frequency:

Are you currently taking any medications for emotional/substance abuse problems? YES___ NO___

Name:	Name:	Name:
Dose (mg):	Dose (mg):	Dose (mg):
Frequency:	Frequency:	Frequency:

Other medications: _____

Prescribing Physician:_____ Phone:_____

V. Client's Mental Health History

Have you had prior mental health related services? YES____ NO____

	Therapist/Facility	Date	Duration	Outcome
Prior Therapy	1) 2) 3)	1) 2) 3)	1) 2) 3)	1) 2) 3)
Prior Hospitalization(s)	1) 2) 3)	1) 2) 3)	1) 2) 3)	1) 2) 3)

VI. Problem Category (please check all that apply):

Emotional Health	Family issues	Work-related	Financial
Substance use/abuse	Eating disorder	Children	Legal
Suicide Risk	Abuse/Violence	Health-related	Marital/Relationship issues
Parent-Child issues	Other:_____		

VII. Family history

Describe any family behavioral health issues or diagnosis.

_____

_____

_____

VIII. Client Background information

The following information is optional but will help us to better serve you.

Ethnicity American Indian/Alaskan Native — Caucasian/White Asian or Pacific Islander — Bi-Racial African-American/Black — Multi-Racial Hispanic/Latino/a — _____	**Highest Level of Education of primaryGuardian** No High school — Associate's Degree Some High school — Bachelor's Degree High School Diploma — Master's Degree Technical School — Doctoral Degree Degree in: _____
Marital Status of parent's Living Together/Not Married — Separated Married — Divorced Widowed	**Sexual Orientation** Heterosexual — Transgendered Gay/Lesbian — Not sure/questioning Bisexual
Religious/Spiritual Affiliation:	

Treatment Plan

Client Name:_____

Please rate each concern on a scale of 1-10 with 1 being the mildest symptom, 10 being the worst, and 0 being no symptoms.

___ADD/ADHD	___Anger Issues	___Anxious Mood
___Dependency	___Depressed Mood	___Employment Stressors
___Financial Stressors	___Grief	___Manic Symptoms
___Medical Problems	___ Obsessive Compulsive Behaviors	___Phobias
___Racing Thoughts	___Relational Conflict	___Sexual Abuse
___Sleep difficulties	___Substance Abuse/Dependency	___Other_____

___Child-behavior problems at school ___Child-disobeying at home ___Child-low grades at school

Other concerns not listed above/ specific symptoms of concern:

_____

_____

Goals for counseling:

_____

_____

_____

Interventions:

___Assertiveness training ___Anger Management ___Cognitive Restructuring ___Grief therapy ___Problem Solving ___Stress Management ____Solution Focused ___ Psychoeducation/Skills training ___ Individual therapy ___ Couples therapy ___ Family therapy

I acknowledge my participation in the development of this treatment plan.

_____	_____	_____	_____	_____
Client Signature	**Date**	**Review plan date**	**Client Signature for review**	**Date**
_____	_____	_____	_____	_____
Other Signature	**Date**	**Review plan date**	**Other Signature for review**	**Date**
_____	_____	_____	_____	_____
Kim Romen, LCSW, (Therapist)	**Date**	**Review plan date**	**Kim Romen, LCSW**	**Date**

ARIZONA NOTICE FORM

Notice of 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 operations* 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 psychologist.
  - *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 that relate 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, clinic, practice group, etc.] such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.
- *"Disclosure"* applies to activities outside of my [office, clinic, practice group, etc.], 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 treatrnent, payment, or 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 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 conversation 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.

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, law provides the insurer the right to contest the claim under the policy.

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* - I am required to report PHI to the appropriate authorities when I have reasonable grounds to believe that a minor is or has been the victim of neglect or physical and/or sexual abuse.

- *Adult and Domestic Abuse* - If I have the responsibility for the care of an incapacitated or vulnerable adult, I am required to disclose PHI when I have a reasonable basis to believe that abuse or neglect of the adult has occurred or that exploitation of the adult's property has occurred.

- *Health Oversight Activities* - If the Arizona Board of Psychological Examiners is conducting an investigation, then I am required to disclose PHI upon receipt of a subpoena from 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 the records thereof, such information is privileged under state law, and I will not release information without the written authorization of 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 is the case.

- ***Serious Threat to Health or Safety*** - If you communicate to me an explicit threat of imminent serious physical harm or death to a clearly identified or identifiable victim(s) and I believe you have the intent and ability to carry out such a threat, I have a duty to take reasonable precautions to prevent the harm from occurring, including disclosing information to the potential victim and the police and in order to initiate hospitalization procedures. If I believe there is an imminent risk that you will inflict serious harm on yourself, I may disclose information in order to protect you.

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

IV. Patient's Rights and Psychologist's Duties

Patient's Rights:

- ***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 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.

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 a copy during one of our sessions or in the mail.

V. Questions and Complaints

If you have 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 at (480) 277-0049.

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.

You have specific rights under the Privacy Rule. I will not retaliate against you for exercising your right to file a complaint.

VI. Effective Date, Restrictions, and Changes to Privacy Policy

This notice will go into effect on March 1st, 2007

I reserve the right to change the terms of this notice and to make the new notice provisions effective for all PHI that I maintain. I will provide you with a revised notice either in person or by mail.

Credit Card Authorization Form

Please complete the following information. This form will be securely stored in your clinical file and may be updated upon request at any time.

I authorize Family Perspectives, LLC, to charge my credit/debit/HSA card for professional services as follows:

Please Initial each of the following except the first sentence unless applies:

_____Recurring charges for services in the amount of $_____ per visit.

_____$55 for cancellations with less than 24 hours notice and for appointments I miss without notice.

_____Individual appointments I choose to pay by credit card.

_____I understand that my card will be charged for returned checks for the amount of the check plus $35 per check.

_____Balances of charges not paid including fees incurred in phone or internet treatment without payment rendered for 7 days.

_____ I will not dispute charges for sessions I have received, appointments I have missed, or charges due to bounced checks.

I, _____ , am authorizing Family Perspectives, LLC to bill my credit card in the even of any appropriate scenario initialed above.

Charges will appear on your credit card statement as familyperspectives@gmail.com 480-277-0049

Card Type (circle one): Visa MasterCard Discover American Express

Card #: _____

Expiration Date: _____

Name as Printed on Card: _____

Verification/Security Code (3-digit code on back by signature line-MC/Visa/Discover; code above card number, upper-right hand side-AmEx): _____

Billing Address: _____
(Street, City, State & Zip)

Signature: _____

Date: _____

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