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1. Office Policies & General Information, Agreement for Psychotherapy Services or Informed Consent for Psychotherapy

2. Biographical Information – Intake Form (4 pages)

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5. Initial Assessment after the First Session

Office Policies & General Information Agreement for Psychotherapy Services
***Or* Informed Consent for Psychotherapy**

Dr. Carey, PSY.D. Licensed Clinical Psychologist, PSY 20871

Office Policies & General Information Agreement for Psychotherapy Services or Informed Consent for Psychotherapy

This form provides you, the client, with information that is additional to that detailed in the Notice of Privacy Practices and it is subject to HIPAA preemptive analysis.

CONFIDENTIALITY: All information disclosed within sessions and the written records pertaining to those sessions are confidential and may not be revealed to anyone without your written permission except where disclosure is required by law.

WHEN DISCLOSURE IS REQUIRED OR MAY BE REQUIRED BY LAW: Some of the circumstances where disclosure is required or may be required by law are: where there is a reasonable suspicion of child, dependent, or elder abuse or neglect; where a client presents a danger to self, to others, to property, or is gravely disabled; or when a client's family members communicate to Dr. Carey that the client presents a danger to others. Disclosure may also be required pursuant to a legal proceeding by or against you. If you place your mental status at issue in litigation initiated by you, the defendant may have the right to obtain the psychotherapy records and/or testimony by Dr. Carey. In couple and family therapy, or when different family members are seen individually, even over a period of time, confidentiality and privilege do not apply between the couple or among family members, unless otherwise agreed upon. Dr. Carey will use his/her clinical judgment when revealing such information. Dr. Carey will not release records to any outside party unless s/he is authorized to do so by all adult parties who were part of the family therapy, couple therapy or other treatment that involved more than one adult client.

EMERGENCY: If there is an emergency during therapy, or in the future after termination, where Dr. Carey becomes concerned about your personal safety, the possibility of you injuring someone else, or about you receiving proper psychiatric care, s/he will do whatever s/he can within the limits of the law, to prevent you from injuring yourself or others and to ensure that you receive the proper medical care. For this purpose, s/he may also contact the person whose name you have provided on the biographical sheet.

HEALTH INSURANCE & CONFIDENTIALITY OF RECORDS: Disclosure of confidential information may be required by your health insurance carrier or HMO/PPO/MCO/EAP in order to process the claims. If you so instruct Dr. Carey, only the minimum necessary information will be communicated to the carrier. Dr. Carey has no control over, or knowledge of, what insurance companies do with the information s/he submits or who has access to this information. You must be aware that submitting a mental health invoice for reimbursement carries a certain amount of risk to confidentiality, privacy or to future capacity to obtain health or life insurance or even a job. The risk stems from the fact that mental health information is likely to be entered into big insurance companies' computers and is likely to be reported to the National Medical Data Bank. Accessibility to companies' computers or to the National Medical Data Bank database is always in question as computers are inherently vulnerable to hacking and unauthorized access. Medical data has also been reported to have been legally accessed by law enforcement and other agencies, which also puts you in a vulnerable position.

LITIGATION: Sometimes patients become involved in litigation while they are in therapy or after therapy has been completed. Sometimes patients (or the opposing attorney, in a legal case) want the records disclosed to the legal system. Due to the nature of the psychotherapeutic process and the fact that it often involves making a full disclosure with regard to many matters, clients' records are generally confidential and private in nature. Patients should know that very serious consequences can result from disclosing therapy records to the legal system. Such disclosures may negatively affect the outcome of custody disputes or other legal matters and may negatively affect the therapeutic relationship. If you or the opposing attorney are considering requesting Dr. Carey's disclosure of the records, Dr. Carey will do his/her best to discuss with you the risks and benefits of doing so. As noted in this document, you have the right to review your own psychotherapy records anytime. (See also relevant section above: "WHEN DISCLOSURE IS REQUIRED OR MAY BE REQUIRED BY LAW")

CONSULTATION: Dr. Carey identity remains completely anonymous and confidentiality is fully maintained.

E–MAILS, CELL PHONES, COMPUTERS, AND FAXES: and unencrypted email, texts, and e-faxes communication (which are part of the clinical records) can be relatively easily accessed by unauthorized people and hence can compromise the privacy and confidentiality of such communication. Emails, texts, and e-faxes, in particular, are vulnerable to such unauthorized access due to the fact that servers or communication companies may have unlimited and direct access to all emails, texts and e-faxes that go through them. While data on Dr. Carey's laptop is encrypted, emails, texts and e-fax are not. It is always a possibility that e-faxes, texts, and email can be sent erroneously to the wrong address and computers. Dr. Carey backs up all confidential information from his computer on a regular basis onto an encrypted hard-drive. Also, be aware that phone messages are transcribed and sent to Dr. Carey via unencrypted emails. Please notify (Dr. Carey if you decide to avoid or limit, in any way, the use of email, texts, cell phones calls, phone messages, or e-faxes. If you communicate confidential or private information via unencrypted email, texts or e-fax or via phone messages, will assume that you have made an informed decision, will view it as your agreement to take the risk that

such communication may be intercepted, and he will honor your desire to communicate on such matters. Please do not use texts, email, voice mail, or faxes for emergencies.

RECORDS AND YOUR RIGHT TO REVIEW THEM: Both the law and the standards of Dr. Carey profession require that s/he keep treatment records for at least seven years. Please note that clinically relevant information from emails, texts, and faxes are part of the clinical records. Unless otherwise agreed to be necessary, Dr. Carey retains clinical records only as long as is mandated by California law. If you have concerns regarding the treatment records, please discuss them with Dr. Carey. As a client, you have the right to review or receive a summary of your records at any time, except in limited legal or emergency circumstances or when Dr. Carey assesses that releasing such information might be harmful in any way. In such a case, Dr. Carey will provide the records to an appropriate and legitimate mental health professional of your choice. Considering all of the above exclusions, if it is still appropriate, and upon your request, Dr. Carey will release information to any agency/person you specify unless Dr. Carey assesses that releasing such information might be harmful in any way. When more than one client is involved in treatment, such as in cases of couple and family therapy, Dr. Carey will release records only with signed authorizations from all the adults (or all those who legally can authorize such a release) involved in the treatment.

TELEPHONE & EMERGENCY PROCEDURES: If you need to contact Dr. Carey between sessions, please leave a message at the answering service (209) 265-8931 and your call will be returned as soon as possible. Dr. Carey checks his/her messages a few times during the daytime only, unless s/he is out of town. If an emergency situation arises, indicate it clearly in your message and if you need to talk to someone right away call Psychiatric Emergency Services in Tracy do not use email or faxes for emergencies. Dr. Carey does not always check his/her email or faxes daily.

PAYMENTS & INSURANCE REIMBURSEMENT: Clients are expected to pay the standard fee of $130.00 per 45 minute or $180.00 per hour session at the end of each session or at the end of the month unless other arrangements have been made. Telephone conversations, site visits, writing and reading of reports, consultation with other professionals, release of information, reading records, longer sessions, travel time, etc. will be charged at the same rate, unless indicated and agreed upon otherwise. Please notify Dr. Carey if any problems arise during the course of therapy regarding your ability to make timely payments. Clients who carry insurance should remember that professional services are rendered and charged to the clients and not to the insurance companies. Unless agreed upon differently, Dr. Carey will provide you with a copy of your receipt on a monthly basis, which you can then submit to your insurance company for reimbursement, if you so choose. As was indicated in the section, *Health Insurance & Confidentiality of Records*, you must be aware that submitting a mental health invoice for reimbursement carries a certain amount of risk. Not all issues/conditions/problems, which are dealt with in psychotherapy, are reimbursed by insurance companies. It is your responsibility to verify the specifics of your coverage. If your account is overdue (unpaid) and there is no written agreement on a payment plan, Dr. Carey can use legal or other means (courts, collection agencies, etc.) to obtain payment.

THE PROCESS OF THERAPY/EVALUATION AND SCOPE OF PRACTICE:
Participation in therapy can result in a number of benefits to you, including improving interpersonal relationships and resolution of the specific concerns that led you to seek therapy. Working toward these benefits, however, requires effort on your part. Psychotherapy requires your very active involvement, honesty, and openness in order to change your thoughts, feelings, and/or behavior. Dr. Carey 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. During evaluation or therapy, remembering or talking about unpleasant events, feelings, or thoughts can result in you experiencing considerable discomfort or strong feelings of anger, sadness, worry, fear, etc., or experiencing anxiety, depression, insomnia, etc. Dr. Carey may challenge some of your assumptions or perceptions or propose different ways of looking at, thinking about, or handling situations, which can cause you to feel very upset, angry, depressed, challenged, or disappointed. Attempting to resolve issues that brought you to therapy in the first place, such as personal or interpersonal relationships, may result in changes that were not originally intended. Psychotherapy may result in decisions about changing behaviors, employment, substance use, schooling, housing, or relationships. Sometimes a decision that is positive for one family member is viewed quite negatively by another family member. Change will sometimes be easy and swift, but more often it will be slow and even frustrating. There is no guarantee that psychotherapy will yield positive or intended results. During the course of therapy, Dr. Carey is likely to draw on various psychological approaches according, in part, to the problem that is being treated and his/her assessment of what will best benefit you. These approaches include, but are not limited to, behavioral, cognitive-behavioral, cognitive, psychodynamic, existential, system/family, developmental (adult, child, family), humanistic or psycho-educational. **Dr. Carey p**rescription recommendation nor legal advice, as these activities do not fall within his scope of practice.

TREATMENT PLANS: Within a reasonable period of time after the initiation of treatment, Dr.Carey objectives, and his/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, Dr. Carey's expertise in employing them, or about the treatment plan, please ask and you will be answered fully. You also have the right to ask about other treatments for your condition and their risks and benefits.

TERMINATION: As set forth above, after the first couple of meetings, Dr. Carey will assess if he can be of benefit to you. Dr. Carey does not work with clients who, in his opinion, he cannot help. In such a case, if appropriate, he will give you referrals that you can contact. If at any point during psychotherapy Dr. Carey either assesses that he is not effective in helping you reach the therapeutic goals or perceived you as non-compliant or non-responsive, and if you are available and/or it is possible and appropriate to do, he will discuss with you the termination of treatment and conduct pre-termination counseling. In such a case, if appropriate and/or necessary, he would give you a couple of referrals that may be of help to you. If you request it and authorize it in writing, Dr. Carey will talk to the psychotherapist of your choice in order to help with the transition. If at any time you want another professional's opinion or wish to consult with another therapist, Dr. Carey will give you a couple of referrals that you may want to contact, and if he has your written consent, he will provide her or him with the essential

information needed. You have the right to terminate therapy and communication at any time. If you choose to do so, upon your request and if appropriate and possible, Dr. Carey will provide you with names of other qualified professionals whose services you might prefer.

DUAL RELATIONSHIPS: Despite a popular perception, not all dual or multiple relationships are unethical or avoidable. Therapy never involves sexual or any other dual relationship that impairs Dr. Carey's objectivity, clinical judgment or can be exploitative in nature. Dr. Carey will assess carefully before entering into non-sexual and non-exploitative dual relationships with clients. It is important to realize that in some communities, particularly small towns, small communities, military bases, university campuses, spiritual and rehabilitation communities, etc., multiple relationships are either unavoidable or expected. Dr. Carey will never acknowledge working with anyone without his/her written permission. Many clients have chosen Dr. Carey as their therapist because they knew him/her before they entered therapy with him/her, and/or are personally aware of his/her professional work and achievements. Nevertheless, Dr. Carey will discuss with you the often-existing complexities, potential benefits and difficulties that may be involved in dual or multiple relationships. Dual or multiple relationships can enhance trust and therapeutic effectiveness but can also detract from it and often it is impossible to know which ahead of time. It is your responsibility to advise Dr. Carey if the dual or multiple relationship becomes uncomfortable for you in any way. Dr. Carey will always listen carefully and respond to your feedback and will discontinue the dual relationship if s/he finds it interfering with the effectiveness of the therapy or your welfare and, of course, you can do the same at any time.

SOCIAL NETWORKING AND INTERNET SEARCHES: At times, Dr. Carey may conduct a web search on my clients before the beginning of therapy or during therapy. If you have concerns or questions regarding this practice, please discuss them with me. I do not accept friend requests from current or former clients on social networking sites, such as Facebook. I believe that adding clients as friends on these sites and/or communicating via such sites can compromise their privacy and confidentiality. For this same reason, I request that clients not communicate with me via any interactive or social networking web sites.

AUDIO OR VIDEO RECORDING: Unless otherwise agreed to by all parties beforehand, there shall be no audio or video recording of therapy sessions, phone calls, or any other services provided by Dr. Carey.

CANCELLATION: Since the scheduling of an appointment involves the reservation of time specifically for you, a minimum of 48 hours (2 days) notice is required for re-scheduling or canceling an appointment. Unless we reach a different agreement, the full fee will be charged for sessions missed without such notification. Most insurance companies do not reimburse for missed sessions.

I have read the above Office Policies and General Information, Agreement for Psychotherapy Services or Informed Consent for Psychotherapy carefully (a total of 7 pages); I understand them and agree to comply with them:

Client's Name (print) _____

Signature _____ Date _____

Client's Name (print) _____

Signature _____ Date _____

Psychotherapist's Name (print) _____

Signature _____ Date _____

Biographical Information - Intake Form

Dr. Carey, PSY.D., Licensed Clinical Psychologist, PSY 20871
652 West 11the Street, Suite 129
Tracy, CA 95304
209 265-3981

Biographical Information – Intake Form

Please fill out this biographical background form as completely as possible. It will help me in our work together. Information is confidential as outlined in the Office Policy form and the HIPAA Notice of Privacy Practices. If you do not desire to answer any question, merely write, "Do not care to answer." Please print or write clearly and bring it with you to the first session.

NAME: _____ MALE/FEMALE: _____ DATE: _____

DATE OF BIRTH and PLACE OF BIRTH: _____ AGE: _____

ADDRESS: _____

TELEPHONES: H: _____ Cell: _____ Work/Off: _____ Fax: _____

FOR ROUTINE MESSAGES: Phone #_____ Email: _____

FOR CONFIDENTIAL/PRIVATE MESSAGES: Phone #_____ Email: _____ Text: _____

HIGHEST GRADE/DEGREE: _____ TYPE OF DEGREE: _____

PERSON & PHONE NO. TO CONTACT IN EMERGENCY: _____

REFERRAL SOURCE: _____

OCCUPATION (former, if retired): _____

PRESENTING PROBLEM (be as specific as you can: when did it start, how does it affect you.):

_____

_____

Estimate the severity of above problem: Mild ____ Moderate ____ Severe ___Very severe ____

CURRENT: Marital status: ____ Live with someone: ____ Name: _____Years: ____

PAST & PRESENT MARRIAGE/S (names, years together, and statement about the nature of the relationship(s), i.e., friendly, distant, physically/emotionally abusive, loving, hostile.):

_____

_____

_____

PRESENT SPOUSE/PARTNER: Education: _____

Occupation: _____

CHILDREN/STEP/GRAND (names/ages & brief statement on your relationship with the person.)

1. _____
2. _____
3. _____

PARENTS/STEPPARENTS (Name/age or year of death/cause of death, occupation, personality, how did s/he treat you, brief statement about the relationship.):

Father:_____

_____

_____

Mother: _____

_____

_____

Stepparents:_____

_____

_____

SIBLINGS (name/age, if deceased: age and cause of death and brief statement about the relationship.):

1. _____
2. _____
3. _____

MEDICAL DOCTOR (S) (name/phone): _____

_____

_____

PAST/PRESENT MEDICAL CARE (major medical problems, surgeries, accidents, falls, illness, etc.):

_____

_____

_____

SPECIFY MEDICATION you are presently taking and for what. PRINT clearly:

_____

_____

PAST/PRESENT DRUG/ALCOHOL USE/ABUSE (AA, NA, treatments):

_____

_____

SUICIDE ATTEMPT/S or VIOLENT BEHAVIOR (describe: ages, reasons, circumstances, how, etc.)

_____

_____

FAMILY MEDICAL HISTORY (Describe any illness that runs in the family: e.g., cancer, epilepsy, etc):

_____

_____

FRIENDSHIPS, COMMUNITY, & SPIRITUALITY:

_____

_____

PAST/PRESENT PSYCHOTHERAPY (specify: month year(s) (beginning—end), estimated no. of sessions, name, degree, phone & address, initial reason for therapy, Individual/Couple/Family, medication, brief description of the relationship and how helpful it was, and how/why it ended):

1. _____

_____

2. _____

_____

3. *USE OTHER SIDE OF PAGE TO ADD MORE INFORMATION ABOUT PSYCHOTHERAPISTS, IF NEEDED.*

DESCRIBE YOUR CHILDHOOD, IN GENERAL (Relationships with parents, siblings, others, school, neighborhood, relocations, any school/behavioral/problems, abusive/alcoholic parent):

_____

_____

IF PARENTS DIVORCED: Your age at the time: _____.
Describe how it affected you at the time

_____

_____

ESTIMATE HOW MANY HOURS/DAY YOU SPEND ONLINE (Facebook, YouTube, internet gaming, texting, browsing, etc.):
Facebook: _____ YouTube: _____ Gaming: _____ Texting: _____ Browsing: _____
Work/School: _____ Other: _____

DO YOU FEEL YOUR TECHNOLOGY USE IS BALANCED AND HEALTHY OR COULD IT USE IMPROVEMENT? Please explain:

FAMILY HISTORY OF ALCOHOLISM, MENTAL ILLNESS, OR VIOLENCE (including suicide, depression, hospitalizations in mental institutions, abuse, etc.):

_____

_____

ARE YOU INVOLVED IN ANY CURRENT OR PENDING CIVIL OR CRIMINAL LITIGATION/S, LAWSUIT/S OR DIVORCE OR CUSTODY DISPUTE/S? (if you answer Yes, please explain):

_____

_____

What gives you the most joy or pleasure in your life?

_____

What are your main worries and fears?

_____

What are your most important hopes or dreams?

_____

Please add, on the other side of the page or on a separate page, any other information you would like me to know about you and your situation.

Biographical Information - Intake Form
Dr. Carey, PSY.D., Licensed Clinical Psychologist, PSY 20871
652 West 11th Street, Suite 129 Tracy, CA 95304
209 265-3981

Electronic Biographical Information – Intake Form

Please fill out (each client) as completely as possible and bring with you to our first session. It will help me in our work together. If you wish, you can either email it back to me at (your email address) as an email attachment or fax it to (your fax number) at least a couple of days prior to the first session. You can also bring it with you to our first session. If you do not choose to answer any question, merely write "Do not care to answer."

DATE:

NAME:

MALE/FEMALE:

DATE OF BIRTH/PLACE:

AGE:

ADDRESS:

TELEPHONE:

Home:

Office:

Fax:

EMAIL:

FOR CONFIDENTIAL/PRIVATE MESSAGES: If same as above, write, "Same as above"

Address:

Phone:

Email:

HIGHEST GRADE/DEGREE:

TYPE OF DEGREE:

PERSON AND PHONE NO. TO CALL IN EMERGENCY:

REFERRAL SOURCE:

OCCUPATION (former, if retired):

PRESENTING PROBLEM (Be as specific as you can: When did it start, how does it affect you.):

Estimate the severity of the above problem:

Mild Moderate Severe Very severe

CURRENT: Marital status:

Live with someone:

Name:

Years:

PAST & PRESENT MARRIAGE/S (years together, names & statement about the nature of the relationship/s, i.e., friendly, distant, physically/emotionally abusive, loving, hostile.):

PRESENT SPOUSE/PARTNER:

Education:

Occupation:

CHILDREN/STEP/GRAND (names/ages & brief statement on your relationship with the person.)

PARENTS/STEPPARENTS (Name/age or year of death/cause of death, occupation, personality, how did s/he treat you, brief statement about the relationship.):

Father:

Mother:

Stepparents:

SIBLINGS (name/age, & brief statement about the relationship. If deceased: age and cause of death.):

MEDICAL DOCTOR/S (name /phone):

PAST/PRESENT MEDICAL CARE (major medical problems, surgeries, accidents, falls, illness):

Specify all MEDICATION you are presently taking and for what. PRINT clearly:

PAST/PRESENT DRUG/ALCOHOL USE/ABUSE (AA, NA, treatments):

SUICIDE ATTEMPT/S or VIOLENT BEHAVIOR (Describe: ages, reasons, circumstances, how, etc.)

PAST LEGAL/LITIGATION HISTORY (Describe past incarcerations, lawsuits and other criminal or civil litigations.):

ARE YOU PRESENTLY INVOLVED IN ANY CURRENT OR PENDING CIVIL OR CRIMINAL LITIGATION, LAW-SUITES OR DIVORCE AND CUSTOY DISPUTES? (if you answer *Yes*, please, explain.):

FAMILY MEDICAL HISTORY (Describe any illness that runs in the family: cancer, epilepsy, etc.):

FRIENDSHIPS, COMMUNITY, & SPIRITUALITY (Describe quality, frequency, activities, etc.):

PAST/PRESENT PSYCHOTHERAPY (specify: month year/s (beginning—end), estimated no. of sessions, therapist's name, degree, phone & address, initial reason for therapy, Individual /Couple/Family, medication, brief description of the relationship, how helpful the therapy was, and how/why it ended.):

DESCRIBE YOUR CHILDHOOD, IN GENERAL (Relationships with parents, siblings, others, school, neighborhood, relocations, any school/behavioral/problems, abusive/alcoholic parent):

IF PARENTS DIVORCED:

Your age at the time:

Describe how it affected you at the time:

ESTIMATE HOW MANY HOURS/DAY YOU SPEND ONLINE (Facebook, YouTube, internet gaming, browsing, etc.):
Facebook: _____ YouTube: _____ Gaming: _____ Browsing: _____ Other: _____

FAMILY HISTORY OF ALCOHOLISM, MENTAL ILLNESS, OR VIOLENCE (including suicide, depression, hospitalizations in mental institutions, abuse, etc.):

What gives you most joy or pleasure in your life?

What are your main worries and fears?

What are your most important hopes or dreams?

DR. Carey, PSY.D., Licensed Clinical Psychologist, PSY 20871
652 West 11th Street, Suite 129
Tracy, CA 95376
209 265-3981

Intake Form (one Page)

NAME: _____ MALE/FEMALE: _____DATE: _____

ADDRESS: _____

TELEPHONE: H: _____ W/OFF.: _____ D.O.B.: _____ Age: _____

HIGHEST GRADE/DEGREE: _____ REFERRAL BY:_____

PERSON AND TEL. NO. TO CALL IN EMERGENCY: _____

MARITAL STATUS: _____ FORMER/PRESENT MARRIAGE(S) (years): _____

SPOUSE NAME: _____ AGE: _____ OCCUPATION: _____

CHILDREN/STEP/GRAND (names/ages): _____

SIBLINGS (names/ages): _____

PARENTS/STEPPARENT(s) (Ages or year of death): _____

OCCUPATION/POSITION: _____

INSURANCE INFO: _____

PRESENTING PROBLEM: _____

MEDICAL DOCTOR(S): _____ PHONE(S): _____ LAST EXAM: _____

PAST/PRESENT MEDICAL CARE (Specify: major problems, accidents, hospitalizations, current medication): _____

PAST/PRESENT COUNSELING/PSYCHOTHERAPY/MENTAL HOSPITALS:

1. Therapist: _____ Dates: __ to __Phone: _____ Address: _____

Initial reason: _____ Process and outcome: _____

2. Therapist: _____Dates: __ to ___ Phone: _____ Address: _____

Initial reason: _____ Process and outcome: _____

PAST/PRESENT DRUG/ALCOHOL USE/ABUSE (any addiction, AA/NA, etc.):

_____

FAMILY HISTORY OF ALCOHOLISM, MENTAL ILLNESS, VIOLENCE, SUICIDE:

_____

Use the space on the back of this form if you need to give further information.

Dr. Carey, PSY.D., Licensed Clinical Psychologist, PSY 20871
652 West 11th Street, Suite 129
Tracy, CA 95376
209 265-3981

Initial Assessment After First Session

CLIENT(S) NAME(S) _____

DATE: _____ DATE OF FIRST CONTACT: _____DATE 1ST SESSION: _____

REFERRED BY: _____

REASON FOR REFERRAL (see also biographical page)**:**

_____

_____

_____

___ Read, signed, and submitted Office Policies before 1st session.
___ Filled out and submitted Biographical background questionnaire.
___ Reviewed & discussed Office Policies at first session.
___ All questions answered regarding the office policies.
___ Additional materials given/presented to client at first session:

_____

Focus of consultation/treatment (ICD Dx is optional, Dx can be developmental, familial, etc.):

_____

DANGEROUS BEHAVIOR (self/others, means/plans/past dangerous behavior, family history):

_____

ABUSE/NEGLECT (child/elderly/mentally ill): _____

INAPPROPRIATE APPEARANCE/EXPRESSION/BEHAVIOR: _____

_____

PECULIARITIES IN QUALITY OF TALK:

_____

EMOTIONAL STATE/AFFECTIVE REACTIONS (depressed/manic/anxious):

_____

ABNORMAL CONTENT OF THOUGHTS (hallucinations/delusions/obsessions):

_____

ORIENTATION (person/place/time):

_____

MEMORY DEFICIT (short/intermediate/long):

_____

GENERAL INTELLECTUAL ABILITIES & JUDGEMENT:

_____

FURTHER EVALUATION OR CONSULTATIONS NEEDED - INDICATE CONCERN OR QUESTION THAT NEEDED TO BE ADDRESSED:

Medical: _____

Psychiatric: _____

Vocational/educational: _____

Testing: psych. tests or other: _____

Other: _____

HOSPITALIZATION CONSIDERATIONS (voluntary, involuntary):

_____

<u>TREATMENT PLAN</u>

GOAL/S, SHORT TERM: _____

_____

INTERVENTION: _____

_____

GOAL/S, INTERMEDIATE OR LONG TERM: _____

_____

INTERVENTION: _____

_____

INFORMATION/RECORDS TO BE OBTAINED (past therapies, physicians, testing, etc.):

_____

REFERRALS: _____

_____

PAYMENT SCHEDULE: _____

_____

FREQUENCY OF SESSIONS - INITIAL: _____

_____

OTHER COMMENTS: _____

_____

_____

_____

SECTION B

Addendums to Office Policies

Dr. Carey, PSY.D., Licensed Clinical Psychologist, PSY 20971
652 West 11th Street, Suite 129
Tracy, CA 95376
209 265-3981

Social Networking and Online Search Policies

SOCIAL NETWORKING AND INTERNET SEARCHES

At times, Dr. Carey may conduct a web search on his/her clients before the beginning of therapy or during therapy. If you have concerns or questions regarding this practice, please discuss it with Dr. Carey. Dr. Carey does not accept friend requests from current or former clients on social networking sites, such as Facebook due to the fact that these sites can compromise clients' confidentiality and privacy. For the same reason, Dr. Carey requests that clients do not communicate with him/her via any interactive or social networking websites.

Dr. Carey, PSY.D., Licensed Clinical Psychologist, PSY 20871
652 West 11th Street, Suite 129
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209 265-3981

Dual Relationships

Despite a common misconception, not all dual relationships are unethical or avoidable. Therapy never involves sexual or any other dual relationship that impairs Dr. Carey's objectivity, clinical judgment or therapeutic effectiveness or can be exploitative in nature. Dr. Carey will assess carefully before entering into non-sexual and non-exploitative dual relationships with clients. It is important to realize that in some communities, particularly small towns, small communities, military bases, university campuses, spiritual and rehabilitation communities, etc., multiple relationships are either unavoidable or expected. Dr. Carey will never acknowledge working with anyone without his/her written permission. Many clients have chosen Dr. Carey as their therapist because they knew him/her before they entered into therapy with him/her and/or were aware of his/her stance on the topic. Nevertheless, Dr. Carey will discuss with you, the often-existing complexities, potential benefits and difficulties that may be involved in such relationships. Dual or multiple relationships can enhance therapeutic effectiveness but can also detract from it and often it is impossible to know which ahead of time. It is your responsibility to communicate to Dr. Carey if the dual relationship becomes uncomfortable for you in any way. Dr. Carey will always listen carefully and respond accordingly to your feedback. Dr. Carey will discontinue the dual relationship if he finds it interfering with the effectiveness of the therapeutic process or your welfare and of course you can do the same at any time. For overview of different types of multiple relationships, click here.

Dr. Carey, PSY.D., Licensed Clinical Psychologist, PSY 20871
652 West 11th Street, Suite 129
Tracy, CA 95376
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Phone or Email Therapy

Consulting with clients exclusively over the phone or via text or email rather than in person (face-to-face) in the therapist's office brings additional complexities and potential disadvantages to the therapeutic process. When appropriate, Dr. Carey may recommend that the client/s first choice is to find a local therapist with whom the client/s can meet face to face. If Dr. Carey is not aware of a local referral, one way to find such a therapist is to call the local Psychological Association chapter/ local NASW chapter / local Counseling chapter, etc. Treating clients exclusively via phone consultations or emails may put therapists at a disadvantage because they cannot detect nonverbal cues, may not be able to accurately diagnose, may not always be aware of the resources available locally, and may not be able to intervene as effectively as necessary in emergency situations. Acute crises and severe psychological disturbances, such as schizophrenia, dissociation, bipolar or some types of personality disorders may not be effectively handled exclusively via phone, email or other web based communications. As was noted in the Termination section, above, if Dr. Carey assesses, at any point, that s/he is not effective in helping you reach the therapeutic goals via the telephone sessions, s/he is obligated to discuss it with you and, if appropriate, to terminate treatment. For more information on the topic you can go to: http://psychcentral.com/best.

Dr. Carey, PSY.D., Licensed Clinical Psychologist, 20871 652 West 11th Street, Suite 129, Tracy, CA 95376 209 265-3981

Minors in Therapy

If you are under eighteen years of age, please be aware that the law may give your parents or guardians the right to obtain information about your treatment and/or examine your treatment records. It is my policy to request a written agreement from your parents or guardians indicating that they consent to give up access to such information and/or, to your records. If they agree, I will provide them only with general information about our work together subject to your approval, or, if I feel it is important for them to know in order to make sure that you and people around you are safe. If I think it is appropriate, I will involve them if I feel that there is a high risk that you will seriously harm yourself or another/others. Before giving them any verbal or written information, I will discuss the matter with you, if possible. I will do the best I can to resolve any differences that you and I may have about what I am prepared to discuss.

Group Therapy
Dr. Carey, PSY.D., Licensed Clinical Psychologist, PSY 20871
652 West 11th Street, Suite 129
Tracy, CA 95376
209 265-3981

Group Therapy

In group therapy, it is of utmost important that all members maintain confidentiality and neither disclose the content of sessions nor the identity of fellow group members. It is highly recommended that any meaningful exchange outside the group also be discussed in the group. In group therapy, the other members of the group are not therapists. They are not regulated by the same ethics and laws that bind your therapist. The limits of confidentiality and the reporting laws have been outlined earlier in this document. While the expectation is that all group members will maintain confidentiality regarding anything said in the group, you cannot be certain that they will. You are ultimately responsible for what you say and what you think, feel, or do with the feedback you receive in the group.

Touch Therapy
Dr. Carey, PSY.D., Licensed Clinical Psychologist, PSY 20871
652 West 11th Street, Suite 129
Tracy, CA 95376
209 265-3981

Touch Therapy

Dr. Carey may also incorporate non-sexual touch as part of psychotherapy. Sexual touch of clients by therapists is unethical and illegal. Dr. Carey will ask your permission before touching you and you have the right to decline or refuse to be touched without any fear or concern of a negative response or reaction from your therapist.

Touch can be very beneficial but can also unexpectedly evoke emotions, thoughts, physical reactions, or memories that may be upsetting, depressing, evoke anger, etc. Sharing and processing such feelings with the therapist, if they arise, may be a helpful part of therapy. You may request not to be touched at any time during therapy without needing to explain it, if you choose not to, and without fear of a negative response or reaction from your therapist. For more on Touch and the Standard of Care, click here.

Home Office
Dr. Carey, PSY.D., Licensed Clinical Psychologist, PSY 20871
652 West 11th Street, Suite 129
Tracy, CA 95376
209 265-3981

Home Office

Dr. Carey psychotherapy office is located in his/her private residence, which is located in the ___ neighborhood. Please park your car in front of the house or on the same side of the street where the house is located. Please use the main door to the house; just walk in (no need to knock or ring the bell) and proceed to the waiting room, which is also the residence living room. Depending on the time of the day, you may encounter one of Dr. Carey children, his/her spouse or roommate, or his/her dog. Please let Dr. Carey know if you have an immediate concern with this arrangement or if a concern arises in the future.

Dr. Carey, PSY.D., Licensed Clinical Psychologist, PSY 20871
652 West 11th Street, Suite 129
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Bartering

Dr. Carey and client have agreed on the following bartering-fee agreement:

Following are some examples of options:

- Client will pay with one chicken for each therapy session of 50 minutes.
- Client, who is a professional cleaner, will clean (therapist's name) office and waiting room once a week, which is likely to take about one hour, in exchange for one session of 50 minutes.
- Client will sell therapist his painting, titled, Meadow, which was appraised by a professional art appraiser for $1,200.00 in exchange for 10 psychotherapy sessions; each one is valued at $120.

SECTION C

Consents and Authorizations

14. Coaching Informed Consent
15. Consent for Treatment of Minors & Others
16. Consent to Use Touch in Psychotherapy
17. Authorization Consenting to Release Information – pre-HIPAA
18. Authorization to Release Information - HIPAA version
19. Responsibility to Pay for Sessions
20. Consent for a Visitor to Attend a Session
21. Collateral Therapy Consent
22. Permission to Record or Photograph Psychotherapy Session
23. Consent to Record or Videotape Training Session

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652 West 11th Street, Suite 129
Tracy, CA 95376
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Coaching Informed Consent

Life Coaching and Psychotherapy

- I understand that life coaching neither treats mental disorders nor conducts mental health evaluations.
- I understand that if my life coach detects or suggests that I suffer from a metal disorder or determines that I need to be evaluated for mental health concerns he/she should refer me to a licensed mental health practitioner.
- I fully understand that life coaching is not psychotherapy or counseling and that professional referrals will be given if needed.
- I certify that if I am currently in therapy or counseling, or otherwise under the care of a mental health professional, that I have consulted with this professional about my working with a life coach. I further certify that this mental health professional is aware of my decision to enter into a life coaching relationship.
- I understand that life coaching is not a substitute for counseling, psychotherapy, psychoanalysis, mental health care or substance abuse treatment and I will not use it in place of any form of psychotherapy.

The Nature of the Life Coach Relationship

- I understand that the purpose of my relationship with my life coach is to create, develop, and facilitate my personal, professional or business goals.
- I understand that the purpose of life coaching is to develop and to implement a strategy, plan, and/or program that is designed to achieve those goals.
- I understand that life coaching is not to be used in lieu of professional advice. I will seek professional guidance for legal, medical, financial, business, spiritual or other matters. I understand that all decisions in these areas are exclusively mine and I acknowledge that my decisions and my actions regarding them are my responsibility.
- I am aware that I can choose to discontinue coaching at any time.
- I understand that although life coaching is a process that may involve several areas of my life, including career and work, finances, health, and personal and professional relationships, deciding how to manage these issues and implement my choices is solely my responsibility.
- I am aware that I can read more about coaching online or on the web site of the International Coach Federation (ICF) at www.coachfederation.org.

Records & Confidentiality

- I understand that information transmitted by me in this life coaching relationship will be kept strictly confidential unless I give explicit, specific permission to release it to specifically designated persons. I understand that the only exception to this confidentiality will occur if the release of personal information is required by law.

I have read and agree to the above.

Client Name: _____ Client Signature: _____ Date:

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652 West 11th Street, Suite 129
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Consent For Treatment Of Minor(s) & Others

I _____ give my consent that Dr. Carey will be conducting psychotherapy with (_____).

My relationship to the client (parent, uncle, etc.): _____

I was notified that the holder of the privilege is (parent, guardian, etc.) _____ .

I was also notified that all material discussed during the psychotherapy sessions is confidential and can be released only with the permission of the holder of the privilege. I have been informed of the limitation to confidentiality in the Office Policies form, which I have read and signed.

In the case of a minor, special sensitivity may be required in releasing information about certain topics such as drugs and sex. I will accept Dr. Carey's judgment in regard to releasing or sharing information obtained during the course of psychotherapy with the minor that may endanger or jeopardize the client's wellbeing.

_____	_____	_____	_____
Name (print)	Relationship	Signature	Date

_____	_____	_____	_____
Name (print)	Relationship	Signature	Date

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Tracy, CA 95376
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Consent To Use Touch In Psychotherapy

Informed Consent to Use (Insert name of technique/style here)

When appropriate, and according to my clinical judgment, I will use _____ in our work together. _____ is a _____ [describe here the most essential features of the approach]. It may involve _____.

For more information about Dr. Carey please note the following references/websites:
http://www.xxxx .

(Insert technique/style) can result in a number of benefits to you, such as _____. Like any other treatment, it may also have unintended, negative "side effects." It is important that you are aware that there are other forms of body-oriented and somatic psychotherapy modalities that may also be helpful to you, such as EMDR, Sensorimotor Psychotherapy, Bo dynamics, _____ or _____. Obviously, there are also many non-somatic focused forms of psychotherapy and counseling that you can choose from. My own education and training in SE includes:

It is your responsibility to tell me when you are uncomfortable with any part of the treatment. If you have any questions about _____ or other treatments, please ask and I will do my best to answer your questions in full. You have the right to refuse or terminate treatment at all times, or to refuse touch, _____techniques, or any other intervention I may propose or employ.

I have read the above informed consent, understand, and agree to it.
Name of Client (print)_____ Date _____

Client's Signature _____

Dr. Carey, PSY, Licensed Clinical Psychologist, PSY 20871
652 West 11th Street, Suite 129
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Authorization Consenting To Release Of Information

I authorize Dr. Carey to **discuss** (verbally or in writing) anything that has been brought up during our psychotherapy or evaluation **with** any person/s or staff of clinic, office, agency, or institution/s named below and **receive** any relevant information **from** them.

1. _____
2. _____
3. _____
4. _____

For the following reason(s):

____ Consultation/Psychotherapy,

____ Evaluation,

____ Other: _____

I may revoke this consent at any time. This consent is in effect for five years from the date of the last session, unless revoked in writing earlier or renewed. This consent is also subject to all conditions outlined in the Office Policies (Form #1).

_____ _____ _____
Name (print) Date Signature

_____ _____ _____
Name (print) Date Signature

Dr. Carey, PSY.D., Licensed Clinical Psychologist, PSY 20871
652 West 11th Street, Suite 129
Tracy, CA 95376
209 265-3981

Authorization To Release Information

I, (name of client), (hereinafter "Client") hereby authorize Dr. Carey, (hereinafter "Provider") to disclose mental health treatment information and records obtained in the course of psychotherapy treatment of Client, including, but not limited to, therapist's diagnosis of Client, to:

_____

I understand that I have a right to receive a copy of this authorization. I understand that any cancellation or modification of this authorization must be in writing. I understand that I have the right to revoke this authorization at any time unless Provider has taken action in reliance upon it. And, I also understand that such revocation must be in writing and received by Provider at 652 West 11th Street, Suite 133, Tracy, CA 95376 to be effective.

This disclosure of information and records authorized by Client is required for the following purpose: _____

The specific uses and limitations of the types of medical information to be discussed are as follows (be as specific as you choose to):

_____

_____

Such disclosure shall be limited to the following specific types of information:

_____

_____

Therapist shall not condition treatment upon Client signing this authorization and Client has the right to refuse to sign this form.

Client understands that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by the HIPAA Privacy Rule, although applicable California law may protect such information.

This authorization shall remain valid until: _____

Client's signature: _____ Date:_____

Informed Consent to Assume Responsibility for Payment for Psychotherapy Services
Dr. Carey, PSY. D, Licensed Clinical Psychologist, PSY 20871
652 West 11th Street, Suite 129
Tracy, CA 95376
209 265-3981

Informed Consent to Assume Responsibility for Payment for Psychotherapy Services

I, _____ agree to pay for psychotherapy services and other clinical services for _____ according to the fee agreement between the therapist and the client.

I understand the following terms apply to this agreement:

- Payment will be made as follows ; (check one):

  _____ At the time of service

  _____ Within two weeks of receiving an invoice

  _____ Other (specify): _____

- The fee for psychotherapy, psychological testing and interpretation, consultation, letter or report writing or other clinical services is $ _____ per _____ minute session unless otherwise specified. For more details, see previous informed consent.
- Please inform the therapist as soon as you know if there are changes in your ability or willingness to pay.
- Services will be terminated if timely payment is not made as agreed to by this consent.
- Consent to assume financial responsibility for these services does not entitle the third-party payer access to confidential information unless otherwise agreed in writing by the above named client.
- Upon your request and upon obtaining the client's written permission, if appropriate, you will be provided with a bill, which is suitable for presenting to your insurance carrier for possible reimbursement. Not all conditions are reimbursable.
- This agreement supplements previous informed consents.

Signature of Client: _____ Date: _____

Signature of Payee: _____ Date: _____

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652 West 11th Street, Suite 129
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Informed Consent For A Visitor To Attend A Psychotherapy Or Consultation Session

I, _____, understand that if I choose to invite a person or persons to be present during a session with my psychotherapist or consultant my confidentiality may be compromised. I do so with the understanding that my therapist will use his/her clinical discretion when s/he chooses to share or reveal confidential and/or sensitive information. I understand that my therapist will use his/her clinical discretion and reasoning in sharing any information. I also understand that this may be upsetting or uncomfortable for me. Unless specified in writing, this consent does not give permission to the therapist to discuss any confidential information with the visitor any time after the visit.

I have clarified to my therapist that the following topics should NOT be mentioned during the time that the visitor is present at the session:

_____

_____

_____

This agreement supplements previous informed consents.

Signature: _____ Date: _____

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Collateral Therapy Consent

I, _____, (the collateral participant) have been invited by

_____ (client) to attend one or more of the client's psychotherapy sessions with [Therapist]. I understand that the purpose of my attending is to assist the client and [Therapist] in the client's treatment and **not** to seek psychotherapy for myself. I understand that my role as a collateral ally in the client's psychotherapy is to:

a) provide information about the client, both factual and from my personal perspective;
b) participate in exercises during sessions that are intended to help further the client's treatment;
c) support the client during treatment in other ways.

I understand that my participation is voluntary, and that at any time I can withdraw, decline to answer any question or to participate in any exercise. I certify that I do not have a personal or client relationship with [Therapist]. I am not responsible for any therapy fees with [Therapist], except in those cases, such as parent or legal guardianship, in which I would normally be responsible for the client's therapy fees.

I understand that what I say in session(s) may be discussed between [Therapist] and the client. (**Note:** It is sometimes possible to maintain the privacy of our communications. If you wish to maintain some privacy concerning some aspects of our communications, we should discuss it before any information is communicated by you).

As a collateral ally I understand that I have certain rights and requirements pertaining to confidentiality, as well as some limits to that confidentiality. I am expected to maintain the confidentiality of the client. I understand that although [Therapist] will not maintain a chart on me nor make any diagnosis, notes about me which pertain to my relationship with the client may be entered into the client's chart, as well as some of my comments about the client. Because the client has rights to his/her confidentiality, I may not request to access that chart without the written consent of the client. The client however, pursuant to state and federal laws, **can** access his/her chart. I understand the following exceptions to confidentiality, which pertain to both the client and myself:

- If [Therapist] suspects abuse or neglect of a child or a vulnerable adult, he is required to file a report with the appropriate agency.
- If [Therapist] believes that I am a danger to myself (suicidal) he is required take actions to protect my life.
- If I threaten serious bodily harm to another [Dr. Carey] is required to take necessary actions to protect that person.
- If a court requires that [Dr. Carey] submit information or testify in a case involving me or the client, he must comply. Please note that [Dr. Carey] will do so only if the court requires it, not merely if an attorney requests information.
- If insurance is used to pay for the treatment, the insurance company may require [Dr. Carey] to submit information about the treatment before they will pay for treatment.

I understand that my role as a collateral may create some anxiety or emotional distress in me. It may also expose or create some emotions in my relationship with the client. I understand that, if I find myself experiencing any emotional difficulties, and I am not currently in psychotherapy, I should let [Dr. Carey] know so that he can suggest resources or referrals for me.

I certify that all of the above information has been explained and discussed with me by [Dr. Carey], and that I have had an opportunity to ask any questions.

I, _____ (client) give permission for _____ (collateral participant) to attend one or more of my psychotherapy sessions.

Signature of Client:_____ Date:_____

Printed Name - Collateral: _____

Signature of Collateral participant:_____

Date:_____

Printed Name: _____

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652 West 11th Street, Suite 129
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Permission To Record Or Photograph A Psychotherapy Session

I, _____, authorize _____ to

_____ Photograph

_____ Audiotape

_____ Videotape

_____ Myself

_____ Others _____

These recordings may be used for the following purposes (check as many as apply):

_____ Feedback to be used for psychotherapeutic intervention

_____ Supervision

_____ Research

_____ Educational

_____ Others: (Explain) _____

While the photograph or videotapes may show the faces, the therapist agrees to not reveal names in order to maintain his/her anonymity or that of others named above to the degree possible.

Name: _____

(If minor) Parent/Guardian's Signature: _____ Date: _____

Therapist's Signature: _____ Date: _____

Dr. Carey, PSY.D., Licensed Clinical Psychologist, PS20871
652 West 11th Street, Suite 129
Tracy, CA 95376
209 265-3981

Permission To Record Or Photograph A Training Session

I, _____, hereby authorize _____ to videotape/record the training session at (insert place and date). I understand that the training includes _____ and will be observed and viewed by _____. I also understand that this is not therapy or counseling but is an educational demonstration for didactic purposes only. I realize that while there will be no names, people videotaped can be easily recognized by others.

I understand that I have a choice and that I do not need to reveal what I do not want to be recorded on the tape, or to be heard by other people. Ultimately, I am responsible for what I say, reveal, or discuss during the training session.

I was informed that the tape will be stored at _____ and will be viewed by _____ under the following circumstances_____ _____.

Access to the tape will be limited to_____. The holder of the copyright is _____ and the total number of copies that will be reproduced is _____.

Generally, the benefits to me for participating in the taped training are _____ and the risks are _____. If necessary, a short debriefing immediately after the taping will be available in case any strong feelings are evoked or triggered. Referrals to licensed psychotherapists are available upon request.

I understand that this consent is voluntary and whether or not I choose to be videotaped, will not affect my standing in the program.

I have read the above, have understood it, and agree to the terms.

Name _____ Date _____

Signature: _____

SECTION D

Termination Forms and Letters

Dr. Carey, PSY.D., Licensed Clinical Psychologist, PSY 20871
652 West 11th Street, Suite 129
Tracy, CA 95376
209 265-3981

Termination Summary

NAME: _____ DATE: _____ DATE OF LAST SESSION:_____

Main reason for termination

❒ The treatment was completed.
❒ This is a planned pause as part of an intermittent long-term treatment.
❒ The client refused to continue in therapy.
❒ There was little or no progress in treatment.
❒ The client needs services not available here and must be referred out.
❒ Others,_____

_____

The decision to terminate was:
❒ Client initiated.
❒ Therapist-initiated.
❒ A mutual decision.
❒ Other (specify): _____

_____

Kinds of services rendered:

❒ Individual ❒ Couple ❒ family ❒ Group
❒ Other: _____

_____

General description of Treatment:

_____

_____

_____

Treatment goals, outcomes and progress:

Goal _____ *Achievement/Outcome* _____

Diagnostic impression at termination/General description of client's state at termination:

_____

_____

_____

Concerns with danger, meds, compliance, etc.

_____

_____

_____

Referrals/Reason for referrals

- _____
- _____
- _____

Follow-up (letters, calls, contacts, and future appointments):

- _____
- _____
- _____

Additional comments:

_____

_____

_____

Dr. Carey, PSY.D., Licensed Clinical Psychologist, PSY 20871
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Premature Discontinuation Of Therapy – Letter To Client

Dear (client's name),

I have noticed that it has been more than _____ weeks/months since our last appointment. I hope you (and your family) are doing well. I have contacted you by phone and left messages but I have not heard back from you. I am assuming that you have chosen to discontinue therapy and will consider your case closed if I have not heard from you within two weeks of the date of this letter.

If you do choose to resume therapy, I would be pleased to continue working with you. If you have any questions or concerns about our previous work together or future therapeutic goals please call me - I would be happy to discuss them with you. If you prefer to schedule a final appointment to review the work we did together and envision where you might go from this point, I would also be pleased to arrange this with you.

I do not necessarily believe that this is the appropriate point for you to discontinue therapy but I respect your right to decide otherwise. If you choose to work with another therapist, I am willing to give you a number of referrals and help you with the transition. I am also willing to speak with any future therapist if you ask me to do so and give me your written authorization to release information to the therapist of your choice.

If I may be of any further assistance, please give me a call. I wish you all the best.

Sincerely,

Dr. Carey, PSY.D., Licensed Clinical Psychologist, PSY 20871
652 West 11th Street, Suite 129
Tracy, CA 95376
209 265-3981

_ _

Treatment Is Being Terminated Due To Lack Of Progress And Lack Of Benefit To Patient

Dear _____,

As we discussed during the last several sessions, it is clear to me that our ongoing work together has not been beneficial to you. Although I understand your desire for your treatment under my care to continue, I strongly believe it to be in your best interest for us to end our work together. It is my ethical mandate to appropriately discontinue therapy if it is not beneficial to my clients.

As we discussed, I am hereunder providing you with the names, addresses, and telephone numbers of a number of psychotherapists. Each of these professionals is licensed, has training and experience in the areas outlined below, and is located in your local area. I hope you will contact them and make arrangements to begin treatment with one of them. If you would like me to discuss your situation and our treatment with them - and give me written permission to do so - I would be happy to speak to them. If any difficulties are experienced, I will be happy to assist in this transition.

Name/Degree/License/Phone/Area of expertise

Name/Degree/License/Phone/Area of expertise

Name/Degree/License/Phone/Area of expertise

Again, as we agreed, I will meet with you up to four more times to assist you during this time of transition. Please discuss these, or any other issues that concern you, during our upcoming meetings.

Sincerely,

Dr. Carey, PSY.D., Licensed Clinical Psychologist, PSY 20871
652 West 11th Street, Suite 129
Tracy, CA 95376
209 265-3981

Treatment Is Being Terminated Due To Adverse Utilization Review Decision

Dear (client's name)

As we discussed during your most recent appointment, your insurance company - managed care company _____, has rejected the treatment plan we submitted stating that your treatment needs are not found to be medically necessary according to their utilization review or other criteria. As I explained to you when we met, this means that _____ will not reimburse any additional treatment expenses at this time. This does not mean, however, that additional treatment is not needed or that you would not benefit from it. I have given you the "Beware of Your Managed Care" brochure, which further explains some of the potential reasons for such denial of treatment.

To review, this is the plan of action we agreed on: I will file a written appeal of the utilization review decision immediately. While we await the outcome of the appeal process, we will continue your treatment with you paying me the reduced _____ rate. If authorization is granted, treatment will continue and any fees due you will be reimbursed. If the appeal is denied, I will provide you with up to four additional sessions at one-half my usual rate. Upon your request, I will assist you to obtain more affordable services elsewhere. Or, if desired, we can work out a payment plan so you can continue treatment under my care.

Please rest assured that I am committed to ensuring that your ongoing treatment needs are met regardless of utilization review decisions made by _____ I look forward to continuing our work together at our next appointment on _____.

Sincerely,

Dr. Carey, PSY.D., Licensed Clinical Psychologist, PSY 20871
652 West 11th Street, Suite 129
Tracy, CA 95376
209 265-3981

Overdue Payment Notice

Dear _____:

My records indicate that you have an overdue payment of $_____. This is a payment for services rendered for the period of _____ to _____.

Please let me know if you have different figures in regard to the amount owed or are having difficulties in making the payment. I am willing to develop a payment plan that will be agreeable for both of us.

I am looking forward to hearing from you soon.

Sincerely,

SECTION E

Billing

Dr. Carey, PSY.D., Licensed Clinical Psychologist, PSY 20871
652 West 11th Street, Suite 129
Tracy, CA 95376
209 265-3981

INVOICE

To:

Address:

Invoice Date:

CPT CODE	SERVICE	DIAGNOSIS	DATE OF SERVICE	FEE	BALANCE
90834	Therapy Session	Enter ICD-10-CM Code	08/01/2015	$125.00/Session	$125.00
90834	Therapy Session	Enter ICD-10-CM Code	08/08/2015	$125.00/Session	$125.00
90834	Therapy Session	Enter ICD-10-CM Code	08/15/2015	$125.00/Session	$125.00
Balance					$375.00
Amount Paid ……. Paid in Full on July 21, 2015					$375.00
Balance Due ……..					**$0.00**

Dr. Carey, PSY.D., Licensed Clinical Psychologist, PSY 20871
652 West 11th Street, Suite 129
Tracy, CA 95376
209 265-3981

SUPER BILL

THERAPIST'S INFORMATION

Name of therapist/Degree _____
Address _____
Office phone number _____ State license number _____
Tax ID number _____NPI number _____

CLIENT'S INFORMATION

Client Name _____
Address _____
DOB_____
Name of Policy Holder _____
Insurance ID #_____ Group # _____

PAYMENT & TREATMENT INFORMATION

Previous Balance _____
Balance Due _____
Payment _____
Remaining Balance _____
Place of Service ( ) Office ( ) Hospital _____( ) Other _____

DATE OF SERVICE _____

CPT CODE	SERVICE	FEE
90832	Individual Psychotherapy (30 mins.)	
90834	Individual Psychotherapy (45 mins.)	
90837	Individual Psychotherapy (53 mins.)	
	Total for Period	$

DIAGNOSIS, ICD-10-CM: _____
THERAPIST'S SIGNATURE _____

AUTHORIZATION TO PAY BENEFITS TO CLINICAL PSYCHOLOGIST: I hereby authorize that the Medical Benefits, if any, which would otherwise be payable to me, be paid directly to the undersigned psychotherapist, but are not to exceed the reasonable and customary charge for these services.

Signed (Insured Person) _____ Date _____

AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize the undersigned psychotherapist to release any information acquired in the course of my examination or treatment.
Signed (Client or Parent if for Minor): _____ Date _____

Dr. Carey, PSY.D., Licensed Clinical Psychologist, PSY 20871652 West 11th Street, Suite 129,Tracy, CA 95376

209 265-3981

CLIENT'S ACCOUNT LEDGER

NAME _____ ACCOUNT #_____ PAGE # _____

ADDRESS _____ SOC. SEC. # _____

CLIENT'S INSURANCE POLICY # _____

CLIENT'S EMPLOYER _____

PHONE #s: HOME _____ WORK _____

PRIMARY DIAGNOSIS (IDC-10-CM code): _____

DATE	SERVICE	# OF HOURS	FEE	PAID	BALANCE DUE

SECTION F

Private Practice Management Forms

32. Intern Evaluation
33. Progress Notes (& SOAP)
34. Phone Consultation Form
35. Tax Deductible Expenses
36. Confidentiality Statement, Employees
37. Tracking Referral Source
38. Marketing Plan, Outline
39. FAX Cover Sheet
40. Email Signature, Re: Confidentiality
41. Outlines for a Letter Resigning from Managed Care Panels
42. Number of Sessions-Update
43. Telehealth Disclosure

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652 West 11th Street, Suite 129
Tracy, CA 95376
209 265-3981

Intern/Assistant Periodical Evaluation Form

To be filled out by <u>both</u> supervisor and supervisee

Supervisor name: _____

Supervisee name: _____

Evaluator: _____

Date of Evaluation: _____

Period of Evaluation: From _____ to _____

Number of meeting since last evaluation: _____

Dates of meetings since last evaluation: _____

Describe strengths of supervisor/supervisee: _____

Describe weaknesses or area(s) that should be improved by supervisor/ supervisee:

_____

Describe any positive or negative changes in supervisor/supervisee since last evaluation:

Add any other comments: _____

I, _____ agree to pay for psychotherapy services and other clinical services for _____ according to the fee agreement between the therapist and the client.

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652 West 11th Street, Suite 129
Tracy, CA 95376
209 265-3981.

Progress Notes - Confidential

PATIENT'S NAME _____

PAGE # _____ DATE _____

PROGRESS NOTES

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Progress Notes - Confidential

Subjective – Client's report
Objective – Therapist's observation of client
Assessment – Therapists assessment and interpretations
Plan – Interventions

Date: _____

S: _____

O: _____

A: _____

P: _____

Date: _____

S: _____

O: _____

A: _____

P: _____

Date: _____

S: _____

O: _____

A: _____

P: _____

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652 West 11th Street, Suite 129
Tracy, CA 95376
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Phone Consultation Agreement

Please fill-out and fax/mail/email to: _____

DATE: _____

NAME: _____

ADDRESS: _____

_____

EMAIL: _____

PHONE: _____

FAX: _____

Please check the appropriate box on left:

- ❒ 30 minutes phone consultation for $150.00
- ❒ 45 minutes phone consultation for $200.00
- ❒ 1.0 hour phone consultation for $250.00
- ❒ Reading and research at rate of $150.00/hour

Please charge my card for the amount checked above:

CREDIT CARD INFORMATION

Please check the appropriate box on left:

- ❒ Visa
- ❒ MasterCard

C/C # _____ *Expiration Date:* _____

Signature: _____

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652 West 11th Street, Suite 129
Tracy, CA 95376
209 265-3981

DEDUCTIBLE BUSINESS EXPENSES

ACCOUNTING		
PROFESSIONAL		
TAX		
ADVERTISING		
PRINT AND MEDIA		
ART & PHOTOGRAPHY		
OTHER		
BUSINESS ENTERTAINMENT		
MEALS		
MEETING		
CONTINUING EDUCATION, PROF. TRAINING (lectures, workshops, conferences)		
FEES		
TRAVEL EXPENSES		
PARKING		
LODGING		
OTHER		
EDUCATIONAL MATERIAL		
BOOKS		
JOURNALS, NEWSLETTERS		
AUDIO AND VIDEO TAPES		
INSURANCE		
MALPRACTICE		
OFFICE		
W.C.		
OTHER		
INTERNET EXPENSES		
INTERNET PROVIDER		

OTHER INTERNET RELATED FEES		
LEGAL & PROFESSIONAL SERVICE		
SECRETARIAL		
CONSULTING		
SUPERVISION		
ATTORNEYS		
OTHER LEGAL EXPENSES		
OTHER		
LICENSE FEES		
PROFESSIONAL		
BUSINESS		
MAILING AND SHIPPING		
POSTAGE		
FAX		
MISCELLANEOUS		
BUSINESS GIFTS		
OTHER		
OFFICE EXPENSES & OFFICE SUPPLIES		
RENT OR MORTGAGE/LOAN		
WAITING ROOM FURNITURE		
REPAIR, REMODELING & MAINTENANCE		
OFFICE MANAGEMENT		
OFFICE UTILITIES		
GAS & ELECTRICITY		
WATER		
PROFESSIONAL FEES		
LIBRARY		
ORGANIZATIONS DUES		
BANK FEES (FOR BUSINESS ACCOUNT)		
OFFICE CLEANING SERVICES		
DEBT COLLECTION SERVICES		
PHONE		
ANSWERING SERVICES		
BEEPER – PAGERS		
REFUNDS		
CLIENTS		

OTHER		
TAXES		
BUSINESS		
PROPERTY		
SALE		
TRANSPORTATION/CAR EXPENSES		
FUEL		
MAINTENANCE/REPAIR		
PARKING		
TOLLS		
INSURANCE		
REGISTRATION FEES		
LOAN		
SUPPLIES		

IF YOU HAVE A HOME OFFICE, and it is used exclusively for your work, consider the following items deducted at the appropriate **percentage (%)** according to the size of your home office and your entire home (again, verify appropriateness and legality).

HOME OFFICE		
MORTGAGE INTEREST		
PROPERTY TAXES		
CABLE TV		
GARBAGE		
ELECTRICITY		
GAS		
HOUSE CLEANING		
GARDEN, REPAIR, MAINTAINANCE		
OTHER		

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PSY 20871
652 West 11th Street, Suite 129
Tracy, Ca 95376
209 265-3981

Statement Of Confidentiality

I, _____, have been informed that all documents and/or names that I work on or am aware of that pertain to (therapist's name) psychotherapy practice are **highly private and confidential.** I intend to keep any such information completely private and confidential and understand it is never to be read by, shared with, mentioned or referred to anyone except (therapist's name).

Name _____ Date _____

Signature: _____

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652 West 11th Street, Suite 129
Tracy, CA 95376
209 265-3981

Track Your Referral Sources

Psychotherapists and mental health workers: _____

_____

Online Searches, Internet, Psychology Today, Facebook: _____

_____

Physicians (MD's) and other health care practitioners: _____

_____

Professionals – Non-therapists, non-physicians (Pastors, accountants, attorneys, etc.): _____

_____

Non-professionals - Non-clients: _____

_____

Former or present clients or their families or friends: _____

_____

Yellow pages or phone book: _____

_____

Insurance lists, panels, Managed Care, etc.: _____

_____

Return clients (Those who return after completing a phase in therapy): _____

_____

Lectures, seminars, newspaper columns: _____

_____

People who know you from the community/neighborhood/school/church: _____

_____

Specific category for your practice *(Such as divorce attorneys if you are in divorce mediation, ob/gyn physicians if you deal with infertility, or judges if you do forensic work):* _____

_____

Other _____

Marketing Plan

1. **What is the market I wish to penetrate or the niche I want to occupy?**

2. **What outcome/s will I deliver (relief from depression or anxiety, increased love, assessment, etc.)?**

This is what I need to do to become an expert in this field:
Read as much as is available of the professional and lay literature on the subject; Talk to practitioners and clients in the field of my interest; Take internship, practicum, or perform volunteer work in the field. Get training, supervision, or mentoring; Take courses and seminars; Interview clients and other professionals in the field; Review or subscribe to the professional literature, such as magazines in the field; Join, at least for the first period, some of the local and national professional organizations in the field:

1. **Who are the consumers or the ultimate clients I would directly serve?**

2. **What is the flow of referrals in this field?**

3. **How do clients come to call a therapist?**

4. **Are there gatekeepers?** If yes, who are they? Who may be the primary referral sources to me? Who needs to know about me so they will refer to me? (Identify as many positions/names as possible).

5. **Web Site: Personal, informative, SEO?**

6. **How can I help the gatekeepers or the referral sources?** What is in it for them? How will they benefit by referring to me?

7. **How am I going to reach the consumers and/or gatekeepers?** (Website, E-Mails, free or for fee presentations, letters, lunches, brochures, articles, newsletter columns, talk shows, brown bag lunches, etc.)

8. **What is the exact amount of time, during the working week, that I choose to allocate to the execution this marketing plan?**

Time line (put specific goals and dates by which to achieve them):

Detailed budget:

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652 West 11th Street, Suite 129
Tracy, CA 95376
209 265-3981

Fax Cover Sheet

C O N F I D E N T I A L

This fax transmission may contain confidential information, may be protected by Federal statute, and may be legally and clinically privileged. It is intended only for the use of the individual or entity named in this facsimile transmission. If the reader of this transmission is not the intended recipient, you are hereby notified that any use, dissemination, distribution, or copying of this transmission is strictly prohibited. If you received this transmission in error, please notify me immediately by phone and mail the original transmission to me. Thank you.

Date: _____

To: _____

From: _____

Reference: _____

Total number of pages including cover sheet: _____

C O N F I D E N T I A L

Dr. Carey, PSY.D., Licensed Clinical Psychologist, PSY 20871
652 West 11th Street, Suite 129
Tracy, CA 95376
209 265-3981

Email Signature
Re: Email Confidentiality

Notice of Confidentiality: This email, and any attachments, is intended only for use by the addressee(s) and may contain privileged private or confidential information. Any distribution, reading, copying, or use of this communication and any attachments, by anyone other than the addressee is strictly prohibited and may be unlawful. If you have received this email in error, please immediately notify me by email (by replying to this message) or telephone (707-____-_____) and permanently destroy or delete the original and any copy or printout of this email and any attachments.

It is important to be aware that email communication can be relatively easily accessed by unauthorized people and hence can compromise the privacy and confidentiality of such communication. Emails, in particular are vulnerable to such unauthorized access due to the fact that servers have unlimited and direct access to all emails that go through them. It is important that you be aware that emails are part of the medical records. Un-encrypted emails, such as this are even more vulnerable to unauthorized access. Please notify (therapist's name) if you decide to avoid or limit in any way the use of email. Please do not use email for emergencies. Phone messages and emails are checked frequently but may not be checked daily, particularly if I am out of town.

Name: _____

Address: _____

_____

Phone: _____

Fax: _____

Email:

_____

Letter Announcing Therapist's Resignation From Managed Care Panels

Make sure that all the following reasons that led you to resign are covered in the letter.

- Confidentiality and privacy
- Control of treatment
- Continuity/interruption of treatment
- Availability for follow-ups
- Your conflict of interests when you are put in a situation in which you must choose between care for your clients and economic or employment security.
- The moral, ethical, and clinical problems with a capitation contract, if appropriate. Include a short explanation of capitation.
- Include some documents that support your letter, such as: "Beware of your Managed Care" brochure, by Dr. Zur (one of the many articles in which managed care is critiqued) or other articles by organizations critical of managed care.
- **Ensure that your letter clearly states your moral, ethical, and clinical stance.**
- People appreciate it when they see that you are prepared to fight and take risks for your convictions.

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652 West 11th Street, Suite 129
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Number Of Sessions Update

Date: _____

To: _____

_____

This is to inform you that as of _____ your insurance carrier, _____ authorized _____ sessions commencing on _____ and must be completed by _____.

If medically necessary and possible within the limits of your coverage, I will request more sessions. There is no guarantee that any sessions beyond the approved number will be authorized. We must plan to complete the treatment by the last authorized session, unless we come to a mutual agreement that we will continue our work, on agreed terms (i.e. fee, frequency), after your coverage expires.

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Telehealth Disclosure

Telemedicine Informed Consent

I _____ hereby consent to engage in telemedicine (e.g., internet, email or telephone based therapy) with (therapist's name) as the main mode of my psychotherapy treatment. I understand that telemedicine includes the practice of health care delivery, including mental health care delivery, diagnosis, consultation, treatment, transfer of medical data, and education using interactive audio, video, and/or data communications. I understand that telemedicine also involves the communication of my medical/mental health information, both orally and visually, to other health care practitioners.

I understand that I have the following rights with respect to telemedicine:

(1) I have the right to withhold or withdraw consent at any time without affecting my right to future care or treatment or risking the loss or withdrawal of any program benefits to which I would otherwise be entitled.

(2) The laws that protect the confidentiality of my medical information also apply to telemedicine. As such, I understand that the information disclosed by me during the course of my therapy is generally confidential. However, there are both mandatory and permissive exceptions to confidentiality including, but not limited to: reporting child, elder, and dependent adult abuse; expressed threats of violence towards an ascertainable victim; and where I make my mental or emotional state an issue in a legal proceeding. (See also Office Policies and HIPAA Notice of Privacy Practices forms, provided to me, for more details of confidentiality and other issues.)

I also understand that the dissemination to researchers or other entities, of any personally identifiable images or information from the telemedicine interaction shall not occur without my written consent.

(3) I understand that there are risks and consequences from telemedicine. These may include, but are not limited to, the possibility, despite reasonable efforts on the part of my psychotherapist, that: the transmission of my medical information could be disrupted or distorted by technical failures; the transmission of my medical information could be interrupted by unauthorized persons; the electronic storage of my medical information could be accessed by unauthorized

persons; and/or misunderstandings can more easily occur, especially when care is delivered in an asynchronous manner.

In addition, I understand that telemedicine-based services and care may not yield the same results nor be as complete as face-to-face service. I also understand that if my psychotherapist believes I would be better served by another form of psychotherapeutic service (e.g. face-to-face service), I will be referred to a psychotherapist in my area who can provide such service. Finally, I understand that there are potential risks and benefits associated with any form of psychotherapy and that, despite my efforts and the efforts of my psychotherapist, my condition may not improve and in some cases may even get worse.

(4) I understand that I may benefit from telemedicine, but results cannot be guaranteed or assured. The benefits of telemedicine may include, but are not limited to: finding a greater ability to express thoughts and emotions; transportation and travel difficulties are avoided; time constraints are minimized; and there may be a greater opportunity to prepare in advance for therapy sessions.

(5) I understand that I have the right to access my medical information and copies of medical records in accordance with California law, that these services may not be covered by insurance, and that, if there is intentional misrepresentation, therapy will be terminated.

I have read and understand the information provided above, which has also been explained to me verbally. I have discussed it with my psychotherapist and all of my questions have been answered to my satisfaction.

Name _____ Date _____

Signature: _____

SECTION G

Treatment Plans

44. Treatment Plan-Initial

45. Update - Treatment Plan

Dr. Carey, PSY.D, Licensed Clinical Psychologist, PSY 20871
652 West 11th Street, Suite 129
Tracy, CA 95376
209 265-3981

Treatment Plan - Initial

Client: _____

Date: _____ Date of initial evaluation: _____

DIAGNOSIS OR FOCUS OF TREATMENT

_____

_____

Short-term Goals:

_____

_____

Interventions:

_____

_____

Referrals: _____

Intermediate Goals:

_____

_____

I**nterventions:**

_____

_____

Referrals: _____

Long-term Goals:

_____

_____

Interventions:

_____

Frequency of visits: _____

Additional information: _____

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652 West 11th Street, Suite 129
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Update - Treatment Plan

Client: _____ Date: _____

Goals Achieved (fully/partly/not achieved):

_____

_____

_____

Dx or Dx Impressions (specify changes from previous Dx):

_____

_____

_____

Next Set of Goals:

_____

_____

_____

Interventions & Modalities:

_____

_____

_____

Frequency: _____ Payments: _____

SECTION H

Subpoena & Forensic Related Forms

Dr. Carey, PSY.D., Licensed Clinical Psychologist, PSY 20871
652 West 11th Street, Suite 129
Tracy, CA 95376
209 265-3981

Response To Subpoena

Re: XX v. XX
Civil Action File No. _____

Dear [Attorney]:

In regard to the Subpoena I received on [date], please be advised that all psychotherapeutic and counseling communications between a licensed psychologist/social worker/counselor/MFT and a client/patient) are legally privileged communications and cannot be released without a written permission by the client/patient or proper legal authority. [State] law is also clear with respect to the matter of privileged communication between client/patient and psychotherapist, as stated in

(enter state statute here)

With respect to federal law, all communication between a psychotherapist and client is protected from compelled disclosure under Rule 501 of the Federal Rules of Evidence. Furthermore, the United States Supreme Court has upheld psychotherapist-patient privilege in *Jaffee v. Redmond* (WL 315 841 US 1996). The Court noted that all 50 states and the District of Columbia have psychologist-patient privilege.

Given the above [state] and federal laws, I cannot, and will not, release any privileged communication without a court order signed by a judge or written authorization from the person or persons holding the privilege.

Sincerely,

Dr. Carey, PSY.D., Licensed Clinical Psychologist, PSY 20871
652 West 11th Street, Suite 129
Tracy, CA 95376
209 265-3981.

Request For Confidential Records Cover Letter

To: _____

_____

From: _____

Re: _____

Attached please find a release of confidential information signed

by _____ .

I would appreciate your sending me copies of all notes, summaries, tests, and other records related to your treatment of above-mentioned person that may be helpful to me in consulting with this person.

Sincerely,

_____

(Name)

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652 West 11th Street, Suite 129
Tracy, CA 95376
209 265-3981

Workers' Compensation Medical – Legal Report Sample Letter

Dear _____,

Enclosed please find copies of two reports regarding the comprehensive psychological evaluation requested on this claimant. This evaluation falls under the guidelines as a Basic Medical-Legal Evaluation (ML102). The evaluation includes the following elements:

a) 2 hour diagnostic interview with claimant
b) 2 hour medical record review
c) 2- hour report writing

In addition, the complexity of the psychological issues at hand required a basic level of psychological testing (4 hours) to be completed on the claimant.

Should you have any additional questions regarding this evaluation or the enclosed reports, please do not hesitate to contact this office.

Sincerely,

_____

(Name)

The contents of this report are for medical-legal purposes only. Any observations made or opinions expressed should be done in the industrial context, and not, unless otherwise stated, as a guide to health care treatment outside the Workers' Compensation system.
In compliance with Labor Code Section 4628, I personally provided the psychological services noted above and composed and drafted the conclusions of this report.

I declare under penalty of perjury that the information contained in this report is true and correct to the best of my knowledge and belief, except as to information that I have indicated I received from others. As to that information, I declare under penalty of perjury that the information accurately describes the information provided to me and, except as noted herein, that I believe it to be true.

Certification: I declare that I have not offered, delivered, received, nor accepted any rebates, refunds, commission, preference, patronage, dividend, discount, or other consideration, money or otherwise [monetary or otherwise], as compensation or inducement for any referral, examination, or evaluation.

INITIAL COMPREHENSIVE MEDICAL - LEGAL PSYCHOLOGICAL REPORT

DIAGNOSTIC IMPRESSION & TREATMENT CONSIDERATION

NAME OF INJURED WORKER: _____
WC INSURER: _____
REFERRAL SOURCE: _____
DATE OF INJURY: _____
DATE OF BIRTH: _____
DATE OF EVALUATION: _____
EVALUATOR: _____
PLACE OF EVALUATION: _____
HISTORY OF PRESENT ACCIDENT: _____

RATIONALE FOR THE REFERRAL: _____

SYMPTOMS, BEHAVIORS, AND COMPLAINTS: _____

DIAGNOSIS (ICD-10-CM): _____

PSYCHOLOGICAL TESTING:
Qualitative procedures: _____
Neuropsychological Questionnaire – _____
Pain Interview _____

Quantitative procedures: _____

TREATMENT OBJECTIVES: _____

TREATMENT RECOMMEDATION, GOALS, AND STRATEGIES: _____

PSYCHOTROPHIC MEDICATION: _____

Forensic Expert Witness Agreement

Date: _____

To: _____(Attorney)_____

Re: Consultation & Expert Witness Services by

This is to confirm our agreement regarding (therapist's name)'s psychological-forensic consulting services. (Therapist's name)'s charges are detailed in the fee schedule, below. It is understood and agreed that (therapist's name) is retained by the attorney rather than the litigant; that timely payment for (therapist's name)'s service and expenses will be solely the responsibility of the attorney (or law firm); and, that it is in no way contingent upon the outcome of any litigation or settlement. It is also understood that (therapist's name)'s duty includes being honest and objective in his/her work, and that his/her findings may or may not support the litigant's cause. (Therapist's name)'s billing relationship is with the individual attorney that retains his services and is neither with the client, whom the attorney represents, nor with any other attorney or law firm who may share the cost of the expert with the attorney retaining (therapist's name)'s services. (Therapist's name) does not provide forensic and consulting services on a contingency or lien basis. As articulated in the fee scheduled below, his compensation is based on time and expenses, not on the outcome of the case.

Services may include an initial consultation, psychiatric interview or evaluation, interviews with family members or other persons, consultation with counsel, review of records, and report preparation. If travel from (therapist's name)'s office is necessary to perform any of these services, the hourly rates will apply to portal-to-portal travel time, and all travel expenses will be reimbursed. Missed appointments by clients or attorneys will be charged for unless 48-hour notice of cancellation is given. It is understood and agreed that the retaining attorney will pay all out-of-pocket expenses in connection with this matter, including travel, secretarial services, postage, literature research, photocopying, messenger services, etc.

An initial retainer of $3,000 is due at the time the request for services is made. This retainer will serve as a credit balance until exhausted. Thereafter, if it appears that substantial services are yet to be rendered, (therapist's name) may require an additional retainer. Any credit balance remaining will be refunded upon the termination of (therapist's name)'s services.

It is further understood and agreed that should a decision be made to call (therapist's name) as a witness at any deposition or court proceeding, compensation for his time in giving testimony shall be as outlined in the attached fee schedule. (Therapist's name) shall be given 2 weeks notice before the deposition or trial in order to make adequate preparation. A retainer in the amount of $3,000.00 for each day and $500.00 for each overnight of the anticipated deposition will be paid seven (7) working days prior to commencement of testimony. If notification of cancellation is made less than two (2) working days before the scheduled deposition or trial, no refund of the retainer deposit will be made. Deposition or trial testimony will not be scheduled or finalized until balance and/or retainers are paid in full.

It is further understood and agreed that failure of any other party or counsel in any litigation to pay expenses or witness fees, expert or otherwise, as prescribed by statute, court rule, court order or agreement, shall not relieve the attorney's obligation to pay (therapist's name)'s fees and expenses for time spent in testifying or preparing to testify. Nor shall such failure relieve the attorney's obligation to have on deposit, prior to (therapist's name)'s testimony, the retainer discussed above. It is further understood that (therapist's name) cannot guarantee any result of the case/s for which he is providing services.

(Therapist's name) will send the attorney a monthly statement and any excess over the retainer balance is due upon receipt. Attorney agrees to pay (therapist's name) in full within thirty (30) days of receipt of the invoice. (Therapist's name) has no obligation to provide services unless the balance and/or retainer are fully paid. An interest charge at the rate of 18% per annum will be assessed for payments past due. (Therapist's name) reserves the right to withdraw from the case in the event that any invoice is unpaid after sixty (60) days of receipt by the attorney.

If the foregoing fee basis meets with the attorney's approval, please so indicate by signing this agreement and returning it to (therapist's name) and, when applicable, with the retainer.

Fee Schedule – Forensic Services -- (Therapist's name)

Retainer: $3,000.00

Review of records; conferencing; in-person or phone consultation; interviews; writing reports, etc.: $350.00 per hour or portion of an hour

Deposition, trial, arbitration, court room appearance less than 50 miles away from (name of town, state) (including waiting and meeting time): $400.00 per hour or portion of an hour

Transportation (excluding travel expenses, which are extra) billed in ¼ hr. increments: $200.00 per hour

Expenses: As incurred

Services requiring flights or travel more than 50 miles away from (name of town, state) (travel expenses, board, and food are extra) with up to 8 hours of work per day (in lieu of hourly fee): $3,000.00 per day or portion of a day and $500.00 per each overnight

AGREED AS TO FEE AND EXPENSE BASIS

_____	_____	_____
Attorney Name (print)	**Attorney Signature**	**Date**

Affidavit Of Merit

Note: The form, content and requirements of Affidavit of Merit differ among states. While, some states require such Affidavit before a medical malpractice suit can be filed in court, other states do not have such a requirement. Generally, an Affidavit of Merit includes: a. a statement of the expertise and professional background of the expert; b. a statement that the affiant has reviewed all medical records reasonably available to the plaintiff concerning the allegations contained in the complaint; c. a statement that the affiant is familiar with the applicable standard of care; d. the opinion of the affiant that the standard of care was breached by one or more of the defendants to the action and that the breach caused injury to the plaintiff.

Delete all text above this line and insert your letterhead here.

Affidavit Of Merit

MEDICAL LIABLITY CLAIM

STATE OF _____)

AFFIDAVIT

COUNTY OF _____)

(Name/Degree), an adult, being first duly sworn according to law, deposes and states as follows:

1. I am a psychologist/counselor/social worker/psychiatrist licensed to practice by the licensing authority of the State of _____, and I devote ____% of my professional time to the active clinical practice of psychology. I have been in practice since _____.
2. In addition to my private practice as a psychotherapist/licensed psychologist/social worker since (date), I have been a forensic consultant/expert, ethicist, and expert witness consulting with _____
3. I am the author of _____
4. I am the director of _____
5. I am familiar with and competent to testify concerning issues arising from the medical care rendered to Mr./Mrs. _____, during the time period from _____and after _____ to _____.
6. I have reviewed the following medical records and documents reasonably available to the Plaintiff, _____, which records and documents include the following:_____
7. I am familiar with the standards of care applicable to psychiatrists/social workers/psychologists/_____ and other healthcare providers who attended to _____, for the care in question.
8. I hold the opinion, to a reasonable degree of medical certainty, that the standard of care was breached by Defendants, _____, _____, and other health care practitioners who attended to Mr./Ms. _____, during the time period from _____ to _____, and, further, that their departures from the applicable standard of care proximately caused injury to _____.

9. I reserve the right to modify my opinion based on the receipt of additional information.

10. FURTHER AFFIANT SAYETH NAUGHT.

(Name/Degree), SWORN TO BEFORE ME and subscribed in my presence on this _____ day of _____, [year]

_____

Notary Public

Directive To Protect Mental Health Information

This "Directive to Protect Mental Health Information" intends to increase the probability that clients' mental health records will stay private and confidential after their deaths and decrease the possibility that these confidential records will be accessed or reviewed by the executor of the estate, descendants, or other people or agencies. While therapists should keep the original signed Directive in the clients' files, it is recommended that clients include a copy of the Directive in their medical will and/or living trust. Clients are advised to discuss this directive with the executor of their estate. Therapists must explain to clients that this Directive does NOT assure that records would not ultimately be released to the executor of the estate, descendants, coroner's office, or other people or agencies who may request to review the records. Patients should understand that a coroner or other people or agencies may have the legal right to access the records and should discuss the Directive and their intentions with their attorney, their descendants, executor of their estate or other appropriate people.

Delete all text above this line and insert your letterhead here.

The first form, 50-A, is designed for California psychotherapists and the second, 50-B, for therapists in states other than California.

Form No. 51 - A

DIRECTIVE TO PROTECT MENTAL HEALTH INFORMATION

[CA Version]

I hereby appoint (therapist's name) as custodian of my mental health records after my death. This Directive refers to confidential records created while I was under his/her care. I authorize (therapist's name) to refuse to disclose any Protected Health Information under the Standards for Privacy of Individually Identifiable Health Care Information (45 CFR Parts 160 and 164) under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), the California Confidentiality of Medical Information Act ("CMIA"), and the Lanterman-Petris-Short Act, whether now existing or hereafter created, related to my mental health.

Such Protected Health Information or mental health records shall not be provided to my spouse, my lineal ancestors or descendants, my Personal Representative, my Personal Representative's respective attorneys, any court, attorney, licensing board, coroner's office or medical examiner's personnel, other governmental, state or other agency, or any other persons, or entities.

If I have authorized someone to receive my Protected Health Information under the Standards for Privacy of Individually Identifiable Health Care Information under HIPAA, CMIA, or the Lanterman-Petris-Short Act, such authorization shall not apply to (therapist's name).

Name of Client _____ Date _____

Client's Signature _____

Form No. 51 - B

DIRECTIVE TO PROTECT MENTAL HEALTH INFORMATION

[States other than CA version]

I hereby appoint (therapist's name) as custodian of my mental health records after my death. This Directive refers to confidential records created while I was under his/her care. I authorize (therapist's name) to refuse to disclose any Protected Health Information under the Standards for Privacy of Individually Identifiable Health Care Information (45 CFR Parts 160 and 164) under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") or other confidential medical records, as defined in (State) law, whether now existing or hereafter created, related to my mental health.

Such Protected Health Information or mental health records shall not be provided to my spouse, my lineal ancestors or descendants, my Personal Representative, my Personal Representative's respective attorneys, any court, attorney, licensing board, coroner's office or medical examiner's personnel, other governmental, state or other agency, or any other persons, or entities.

If I have authorized someone to receive my Protected Health Information under the Standards for Privacy of Individually Identifiable Health Care Information under HIPAA, or other state's laws, such authorization shall not apply to (therapist's name).

Name of Client _____ Date _____

Client's Signature _____

Therapist's Professional Will

THERAPIST'S NAME: _____

PLACE OF PRACTICE:_____

PLACE/S WHERE RECORDS ARE STORED AND WAYS TO ACCESS THEM (KEYS, COMBINATION LOCKS, ETC.): _____

PLACE/S WHERE LIST OF PRESENT CLIENTS' NAMES, ADDRESSES OR PHONE NO.'S ARE LOCATED: _____

DIGITAL RECORDS: WHERE LOCATED, ACCESS TO COMPUTER, BACKUPS:

This document intends to direct the executor of my estate, as stated in my Living Trust, in matter of dealing with the confidential records of my psychotherapy clients in the event of my death.

After my death, the executor should contact (therapist's name) and give him/her the list of clients in order to notify them ASAP about my death and give them a couple of referrals who they may wish to contact. (Therapist's name) should notify the referral sources about my death and check for their availability to consult with new clients.

All the clinical records should be given, in full, to (therapist's name) who is aware of his/her clinical, ethical, and legal responsibilities and duties in regard to the clinical records. Neither the executor nor anyone else except (therapist's name) should read the clinical records or any part of them. Contact details are as follows:

Therapist's name: _____

Phone: _____ FAX: _____ Email: _____

Address: _____

Alternate to Therapist's name: _____

Phone: _____ FAX: _____ Email: _____

Address: _____

Referrals:

1. _____
2. _____
3. _____

(Copies of this document should be given to: Living Trust Attorney, Executor, and (Therapist's name).)

D

Personal Injury Doctor's Lien

ATTORNEY:

CLIENT'S NAME:
DATE OF INJURY:

I do hereby authorize (therapist's name) to furnish you, my attorney, with a full report of his/her examinations, diagnosis, treatment, prognosis, etc. of myself in regard to the accident in which I was involved.

I hereby authorize and direct you, my attorney, to pay to said therapist such sums as may be due and owing him/her for medical services rendered me by reason of this accident, and to withhold such sums from any settlement, judgment or verdict as may be necessary to adequately protect (therapist's name). And I hereby further give a lien on my case to (therapist's name) against any settlement, judgment, or verdict which may be paid to you, my attorney, or myself as the result of the injury for which I have been treated or injuries in connection therewith. This constitutes, but is not limited to the fee for all psychological evaluations, reports, consultations, and all rehabilitative therapy and activities as well as interest.

Client's Signature _____ Date _____

Attorney's Signature _____ Date _____

SECTION I

Clinical Related Forms

54. Obsessive/Compulsive/Drug Abuse Log

55. Suicide Check List

56. Suicide Contract

Obsession – Compulsion Log

Name: _____ Page #: _____

Date_____ Time _____ Place _____

Describe your thoughts, feelings, impulses, behaviors:

Just before During After/End result

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Suicidality Check List

Client's Name _____ Date of Evaluation _____

__ Past suicide attempts:

__ Age (risk increases with age):

__ Expression of wish to die (cs/ucs, verbal or nonverbal):

__ Means, availability, access to means of guns, pills, knives, etc:

__ Suicidal thoughts, feelings, plan of action:

__ Past suicide attempts or suicides by family members or close friends:

__ Level of depression (1-5) (e.g. hopelessness, helplessness, sleep/eating patterns):

__ Recent loss of a loved one (especially loss of a child or elderly spouse):

__ Major psychiatric disorders (other than depression):

__ Major recent physical illness, recent accident/crisis, chronic illness:

__ Past bouts with depression or hospitalizations, etc...:

__ Financial problems:

__ Recent or chronic stressors (e.g. loss, separation, illness, life transition):

__ Marital status (increased risk with single):

__ Level of social support (increased risk with isolation):

__ Sleep patterns (increased risk with too much or too little sleep):

__ General level of impulse control:

__ Volatility of mood:

__Drug and alcohol use/abuse/dependency:

__Physical or sexual abuse in the family:

_ Sexual orientation (increased risk w/ bisexual, sexually active homosexual, celibate):

_ Sense of humor, or ability to reflect cognitively on one's situation:

_ Level of cooperation with treatment (1-5) (e.g. readiness to sign a "No suicide contract"):

_ Recent involvement in risky activities:

_ Excessively dependent on others:

_ Inability to take care of self or others:

_ Additional remarks:

SUMMARY OF PATIENT'S SUICIDE RISK (circle one):

High Medium Low None

Explain: _____

_____

PLAN OF ACTION (see also Treatment Plan)**:**

_ No action required

_ Suicide contract

_ Frequency of contact: sessions, phone, etc.

_ Voluntary hospitalization

_ Involuntary hospitalization

_ Further evaluation

_ Medication, medication evaluation

_ Obtain medical/psych. records, consultations

_ Others:

Suicide Contract

I, _____ agree that I will not take any action to harm myself or others. If I feel an impulse to hurt myself or others, I will call (therapist's name) at (___) ___-_____ and /or (___) ___-_____ or whoever covers for (therapist's name) at (insert tel. no. and email address) and/or the police at 911, and/or _____ County Mental Health at (___) ____-_____, or the hot line (___) ____-_____ according to the severity of the situation. I am aware that (therapist's name) may not respond to my call right away in which case I will then need to contact one of the other numbers mentioned above or other emergency services. I have also read, signed, and have had explained to me the limits of confidentiality outlined in the Office Policies form, especially in regard to clients who pose a danger to themselves or others. If I choose to retract this contract, I will discuss it first with (therapist's name) in person.

Name: _____

Signature: _____ Date: _____

Therapist: _____ Date: _____

SECTION J

Therapist's Self-assessment & Professional Development

Discover Your Vocation – Infusing Your Life With Joy

1a: At what do you excel? Identify your gifts, talents, and abilities, either in-born or acquired during your lifetime.

1b: What are you not at all good at? Identify what you do not excel at and in general are not your gifts.

2a: What kinds of tasks or activities give you joy, delight, or pleasure? What would you do if you had all the money, time, health, and love you need?

2b: What kinds of tasks or activities deplete or bore you? What do you hate to do?

3a: In what areas are you most disciplined? At what types of activities are you consistent and methodical, neither procrastinating nor regularly avoiding?

3b: What activities do you regularly avoid or delay? In what areas are you not disciplined?

4a: What, in your opinion, does the world, the region, the state, or your community need? What type of contribution does the world, the environment, people, children, animals, etc. need these days?

4b: What, in your opinion, does the world need less of these days?

Explore Your Relationships To Money And Marketing Therapist's Self-Assessment

When I think about the word "Marketing," the first few things that come to mind are:

_____

How do you feel about 'selling' or 'promoting' yourself?

_____

What is your general relationship to earning, collecting money or demanding or expecting to be paid?

_____

What is your attitude toward:

1. Setting realistically high fees:

   _____

2. Expecting to be paid on time:

   _____

3. Earning "a lot of" money:

   _____

What kind of messages and modeling did you receive while growing up from father, mother, grandfather, etc. in regard to making, saving, and having money; being comfortable or even being rich? Who gave what message?

_____

Are you comfortable with public speaking?

_____

How have you marketed yourself so far, if at all?

_____

Reflecting on the above answer, how would you define the challenges and obstacles to successfully marketing your private practice?

_____

_____

_____

Therapist's Self-Assessment: Treating Different Aspects Of Life

Please rate yourself in each of the following areas to determine your comfort zone for working with people with these issues. Take into consideration 1. your assessment of your own in-depth experience, exploration, and investment in each of these areas, as well as 2. your capacity/skill to guide or facilitate others through their journeys in these areas.

Use a scale of 1-10:

1 = not comfortable/incapable of helping or consulting with people in this area

10 = very comfortable/capable/expert in this area

Score

_____Health/healing, psychological aspects of physical illness
_____Work and vocation or calling
_____Love/intimacy
_____Marriage, crises, affairs, communication, etc.
_____Parenting: babies/toddlers
_____Parenting: adolescents
_____Friendships/community
_____Spirituality and religion
_____Death, dying, conscious dying, grief and bereavement
_____Gender issues, men/women
_____Guilt, shame
_____Anxiety, depression
_____Creativity, play, blocks to creativity
_____$, financial arrangements, trusts, wills, IRA's, 401K's
_____Midlife transition & menopause - women
_____Midlife transition, men
_____Retirement
_____Parenting one's parents, taking care of parents
_____Drug and alcohol addiction, AA, Alanon
_____Eating disorders
_____Food, medication, sex, gambling and other addictions
_____Ethics and moral issues in everyday life
_____Leisure, recreation
_____Solitude
_____Meditation, relaxation, stress reduction
_____Meaning in life

_____Gay & lesbian issues
_____Pre-nuptial counseling
_____Conflict resolution, mediation
_____Disabilities (e.g. deafness)
_____Military psychology
_____Forensic psychology (prisons, jails, insanity evaluation, etc.)
_____Pain management, chronic pain
_____Chronic & terminal illness (e.g., MS, cancer)
_____Aging: psychological/physiological
_____Severe chronic mental illness (i.e. Schizophrenia, Bipolar)
_____Personality disorders (i.e. Borderline)
_____Other/s:

_____

_____

_____

_____

_____

_____

_____

_____

_____

Therapist's Self-Assessment: Consulting And Clinical Skills

Please rate yourself in each of the following areas/approaches, for your level of expertise or scope of practice. Expertise or scope of practice is determined by your education (courses, seminars, reading), supervised experience, and most importantly your personal investment in the subject area and clinical experience.

Use a scale of 1-10:
1 - Not an expert in that approach to, 10 - Highest degree of expertise

Score
_____Psychoanalytic, Psychodynamic
_____Cognitive
_____Behavioral
_____Existential
_____Family system
_____Humanistic
_____Intermittent long term
_____Organizational development
_____Crisis intervention
_____Body-mind approaches
_____Adult development & family life cycle
_____Mediation
_____Transpersonal
_____Philosophical counseling
_____Spiritual direction
_____Hospice/grief/bereavement counseling
_____Meditation
_____Psychopharmacology (psych-meds)
_____Cross cultural
_____MultiModal
_____Sand tray
_____Jungian
_____Gestalt
_____Forensic evaluations (e.g. custody, sanity)
_____Others:

SECTION K

Online Courses for CE credits & Private Practice material

AVAILABLE ONLINE AT:
http://www.zurinstitute.com

HIPAA Compliance Kit and HIPAA Forms:
http://www.zurinstitute.com/hipaakit.html

Instantaneous download of HIPAA Kit and Forms as part of online course for CE credits:
http://www.zurinstitute.com/hipaacourse.html

Over 170 Online Courses for CE Credits
http://www.zurinstitute.com/homeonlineoverview.html

- **Ethics, Dual Relationships, Touch**
- **Termination, Internet Addiction**
- **Telehealth, Supervision**
- **Record Keeping, Treatment Planning**
- **Domestic Violence, Coaching**
- **Psychology of Victims, Dreams, Aging**

For free articles, guidelines and resources or to Invite Dr. Zur to lecture in your area for your organization,
http://www.zurinstitute.com