

Poonam Sharma, Ph.D.
Licensed Psychologist
Psychotherapy, Coaching, & Psychological Testing

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CONFIDENTIAL CLIENT INFORMATION

Welcome to my practice. Please fill out the following questions as completely as possible. PLEASE PRINT OR WRITE LEGIBLY.

PERSONAL INFORMATION:

YOUR NAME

LAST

FIRST

MIDDLE

Social Security # _____ Sex M F Date of Birth _____ Age _____

Address _____
STREET CITY STATE, ZIP CODE)

Home Phone _____ Cell Phone _____ Employer _____

Marital Status **S M W D** Referred by _____ Phone _____

Primary Physician _____ Phone _____

Date of Injury (if applicable) _____ Allergies _____

Medications & Prescribing Physicians _____

Reason for Seeking Help _____

SPOUSE'S NAME

LAST

FIRST

MIDDLE

Address _____
STREET CITY STATE, ZIP CODE)

Social Security # _____ Sex M F Date of Birth _____ Age _____

Spouse's Occupation _____ Employer _____

RESPONSIBLE PARTY/PARENT NAME

LAST

FIRST

MIDDLE

Address _____
STREET CITY STATE, ZIP CODE)

Social Security # _____ Sex M F Date of Birth _____ Age _____

Home Phone _____ Work Phone _____

EMERGENCY CONTACT _____ Relationship _____ Phone _____

INFORMED CONSENT TO PSYCHOLOGICAL SERVICES

Psychological services are based on a relationship between people that works partly because of clearly defined rights and responsibilities held by each person. You have a right to understand the evaluation and treatment procedure being used with you. It is important to be an informed and knowledgeable client and it is always appropriate to ask questions about your psychologist, his or her therapeutic approach, and your progress with the evaluation and/or treatment process. You are free to stop psychological services at any time.

It is often helpful to have a written copy of office policies that you may refer to at your convenience. This document contains important information about my professional services and business policies. If you have any questions after reading this form, please feel free to discuss them with me before signing the attached agreement.

Confidentiality

Naturally, I will need to know a great deal about you. Except for the situations described below, you have the right to privacy during our work together. Anyone at my office involved in your care is aware of the importance of confidentiality. Nearly all issues discussed in the course of treatment are strictly confidential. I cannot share any information about our work together without your prior written permission, except in the circumstances outlined below. You may direct me to disclose information with whomever you choose, and you can change your mind and revoke that permission at any time.

You may ask anyone you wish to attend a therapy session with you, but let me know in advance so we can decide what information, if any, you want to be kept confidential during that session. Any individual you invite into session is not legally my client, so I cannot have any outside contact with this person without your signed consent. If you are participating in couples or family therapy, please be aware that both you and other individuals in therapy with you are considered to be the "client." It is my policy to openly discuss and agree on how information you provide me individually will be managed. In most cases, I believe it is best to avoid secrets among participants.

It is important that you fully understand the limitations of confidentiality in order for you to make an informed decision regarding what you tell me. By law, I am required to disclose confidential information to the appropriate persons and/or agencies if any of the following conditions exist:

- I evaluate you to be a danger to yourself or others.
- You are a minor, elderly, or disabled and I believe you are the victim of abuse or if you divulge information about such abuse.
- You are involved in legal proceedings in which the court subpoenas your mental health records.
- You waive your rights to privilege or give consent to disclosure of information.

Benefits and Risks of Psychotherapy

Psychotherapy can have benefits and risks. Since therapy sometimes involves discussing difficult aspects of your life, you may at times experience uncomfortable feelings such as sadness, guilt, anger, frustration, loneliness, or helplessness. Obviously I will do my best to

support you in coping with these emotional challenges. Although there is no guarantee, psychotherapy has been shown to have considerable benefits for people who go through it. Therapy often leads to better relationships, solutions to specific problems, and significant reductions in feelings of distress. The more truthful you are with me, the easier it will be for me to help you. I do my best to create an atmosphere in which it feels safe to disclose your true thoughts and feelings.

Minors

If you are under 18 years of age, please be aware that the law may provide parents with the right to examine your psychological records. Because psychotherapy requires trust and privacy to work effectively, it will be important for the therapist, parent(s), and minor to agree on how information will be exchanged during the course of treatment. With adolescents, the clinical goal is typically to maximize privacy, with the exception of issues that compromise the physical safety of the minor. Parents/guardians will be provided with general information on how treatment is proceeding. Before giving parents/guardians any information, I will discuss the matter with the minor and will do my best to resolve any objections the minor may have about what I am prepared to discuss.

Record-keeping

I normally keep brief records, noting your participation and a brief discussion of what occurred during our session. You have a right to review your mental health record and to correct any errors in your file. You can request in writing that I send information to any other health care professional. I maintain your records in a secure location to protect your privacy.

Termination of Services

In an ideal situation, we will jointly make a decision regarding when you will end services. If your care is being paid for by a third-party payer (e.g. insurance company), we will have to work with the benefits of your policy and the time frame dictated by your insurance.

You have a right to terminate services at any time. I respectfully request that you inform me directly if you would like to end so that I can take the necessary steps to discharge you from my care and close your file. **If you do not show up for a scheduled appointment and I do not have any contact from you for four weeks, I will assume that you are ready to terminate services and will discharge you automatically.** Please note that if you leave without informing me, I may not be willing to consider restarting services with you.

Fees

The full fee is collected at the end of each session unless other acceptable arrangements have been made in advance. I will make every effort to keep the number of your visits to a minimum. In general, the number of sessions you require and the length of each session will depend on the issues you are working on, the amount of between-session effort you put into your therapy goals, and the complexity of the problems. In unusual circumstances, you may become involved in litigation that may require my participation. You will be expected to pay for the professional time required even if I am compelled to testify by another party.

My fees generally average \$150 per hour. In addition, there may be charges for:

- Administration, scoring, and interpretation of any psychological tests.
- Reports, letters, or extended consultations on behalf of clients to physicians, agencies, employers, etc.
- Lengthy between-session phone calls.

You will be assessed a \$25 charge for any check that is returned by the bank because of insufficient funds. Please be aware that unpaid accounts may be referred to an outside agency for collection. However, this action will only be taken as a last effort to collect fees after other means of collection have been unsuccessful. No clinical information will be shared with the collection agency in this effort.

I will be happy to discuss any questions you may have about fees.

Canceled/Missed Appointments

Your appointment time is reserved exclusively for you. **Late cancellations and not showing for your appointment makes it impossible for me to offer your reserved time slot to another waiting person. Consequently, if you miss or cancel your appointment with less than 24 hours notice, you will be billed a \$50 late cancellation fee.** Your health plan does NOT cover payment for missed appointments, so please note that you are responsible for payment in full.

Insurance

Many insurance plans cover psychological services. In order to set realistic treatment goals and priorities, it is important to evaluate what resources are available to pay for your treatment. Generally, it is your responsibility to understand your insurance benefits and to file necessary paperwork for reimbursement. However, I will try to assist you as much as possible. You, not your insurance company, are responsible for full payment of the fee to which we have agreed. Payment is due at the end of the session unless other arrangements have been made in advance. If this policy causes you undue hardship, please talk with me about other options. Please be sure to fill out insurance/insured information accurately on my office intake form. I will not be responsible for erroneous claims due to incomplete insurance information.

The escalation of health care costs has resulted in an increasing level of complexity about insurance benefits which sometimes makes it difficult to determine exactly how much mental health coverage is available. "Managed Health Care Plans" such as HMOs and PPOs often require advance authorization before they will provide reimbursement for mental health services. Such plans are often oriented toward short-term treatment approaches that are designed to resolve specific problems interfering with one's usual level of functioning. It may be necessary to seek additional approval after a certain number of sessions. In my experience, while quite a great deal can be accomplished in short-term therapy, many clients feel that more services are necessary after insurance benefits expire. Once I have all of the information about your insurance coverage, we will discuss what we can expect to accomplish with the benefits that are available and what will happen if the insurance benefits run out before you feel ready to end our sessions. Some managed care plans will not allow me to provide services to you once your benefits are no longer available. If this is the case, we can discuss alternate ways of receiving services, including finding another provider who will help you continue your care or paying for services privately.

You should also be aware that most insurance agreements require a clinical diagnosis, as well as additional clinical information such as treatment plan or summary. In rare cases, a copy of the entire record may be requested. This information will become part of the insurance company files, and, in all probability, some of it will be computerized. All insurance companies claim to keep such information confidential, but once it is in their hands, I have no control over what they do with it. In some cases they may share the information with a national medical information data bank. If you request it, I will provide you with a copy of any report that I submit.

It is important to remember that you always have the right to pay for my services yourself and avoid the complexities described.

Worker's Compensation, Medicare, and Medicaid

If your care is being paid for by Worker's Compensation benefits, Medicare, or Medicaid I must bill the insurance carrier for services. Please also be aware that your mental health records may be forwarded to the insurance company as documentation of the services provided before I can be reimbursed. Your records may also be forwarded to your primary physician. Any other requests for your records must be accompanied by a properly executed Release of Information, which is available in this office.

Email

If you choose to send me an email, please understand that email is not a secure form of communication, so I cannot guarantee the confidentiality of your communication. Also, due to the large amount of spam these days, I may not receive your email, so it is certainly best to call if you have a matter that needs my attention. If I receive an email from you, I typically will not respond in any detailed way due to the compromised security. **Please do NOT use email for rescheduling or canceling appointments.**

Loaned Books or Other Material

Occasionally I may loan you books or other material from my personal library for your review. I ask that you take care of these items and return them in a timely manner. If loaned material is not returned or is returned damaged, you will be charged the full replacement cost of the item.

Emergencies and Phone Calls

I may be unavailable outside regular business hours and cannot guarantee availability in the event of an emergency.

If you have an urgent matter after normal business hours that cannot wait until the next business day, you can try calling me on my business cell phone at 210.884.9092. If a life-threatening emergency arises, I ask that you seek help immediately from your physician, hospital emergency room, or by dialing 911.

I can generally be reached by phone (210.493.6554) during normal business hours. Please leave me a detailed confidential voice mail message with your name and the phone number where I may reach you. I make every effort to return your call within 24 hours, with the exception of days I am ill, weekends, vacation, and holidays.

Ethics and Professional Standards

As a licensed psychologist, I am regulated by the Texas State Board of Examiners of Psychologists and am accountable for my work with you. If you have any concerns about the course of evaluation or treatment, please discuss them with me. I look forward to working with you.

Agreement

Please sign and return the attached agreement page to indicate that you have read and understand the conditions and policies stated in this document. By signing the agreement, you indicate that you understand you are responsible for fulfilling your therapeutic and financial responsibilities.

AGREEMENT

I have been given a copy of Dr. Poonam Sharma's Informed Consent to Psychological Services, which provides information on Limits of Confidentiality, Fees, Canceled/Missed Appointments, and Other Financial Issues, Emergencies and Phone Calls, as well as General Office Policies. I understand and agree to the conditions and policies stated in that document.

By signing this agreement, I understand:

1. My appointment time is held exclusively for me. If I do not inform Dr. Sharma's office at least 24 hours in advance that I need to cancel, I will be charged a \$50 late cancellation fee.
2. By law, there are limits to the confidentiality that can be guaranteed by Dr. Sharma.
3. If I want information to be released to an unauthorized third party, I must sign a Release of Information form in Dr. Sharma's office.
4. Fees are collected at the end of the session, unless other acceptable arrangements have been made in advance.
5. I must call, not email, when I need to cancel or reschedule an appointment.
6. I am responsible for understanding my insurance coverage and paying for any fees not covered by my insurance carrier(s).
7. I must return books or other materials loaned to me by Dr. Sharma, or I will be charged the full replacement cost of the item.
8. I will be assessed a \$25 fee for any checks returned by the bank for insufficient funds.
9. After normal business hours, I can call Dr. Sharma's cell phone at 210.884.9092 if I have an urgent matter that cannot wait until the next business day. *If I have a life threatening emergency, I must call 911, go to a hospital emergency room, or contact my physician.*
10. If I do not have any contact with Dr. Sharma for four weeks, she will assume I am ready to terminate and will discharge me from her services.

Name of Client or Guardian

Date

Signature of Client or Guardian

Notice of Psychologists' Policies and Practices to Protect the Privacy of Your Health Information

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

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

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

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

II. Uses and Disclosures Requiring Authorization

I may use or disclose PHI for purposes outside of treatment, payment, and health care operations when your appropriate authorization is obtained. An "*authorization*" is written permission above and beyond the general consent that permits only specific disclosures. In those instances when I am asked for information for purposes outside of treatment, payment and health care operations, I will obtain an authorization from you before releasing this information. I will also need to obtain an authorization before releasing your psychotherapy notes. "*Psychotherapy notes*" are notes I have made about our conversation during a private, group, joint, or family counseling session, which I have kept separate from the rest of your medical record. These notes are given a greater degree of protection than PHI.

You may revoke all such authorizations (of PHI or psychotherapy notes) at any time, provided each revocation is in writing. You may not revoke an authorization to the extent that (1) I have relied on that authorization; or (2) if the authorization was obtained as a

condition of obtaining insurance coverage, and the law provides the insurer the right to contest the claim under the policy.

III. Uses and Disclosures with Neither Consent nor Authorization

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

- **Child Abuse:** If I have cause to believe that a child has been, or may be, abused, neglected, or sexually abused, I must make a report of such within 48 hours to the Texas Department of Protective and Regulatory Services, the Texas Youth Commission, or to any local or state law enforcement agency.
- **Adult and Domestic Abuse:** If I have cause to believe that an elderly or disabled person is in a state of abuse, neglect, or exploitation, I must immediately report such to the Department of Protective and Regulatory Services.
- **Health Oversight:** If a complaint is filed against me with the State Board of Examiners of Psychologists, they have the authority to subpoena confidential mental health information from me relevant to that complaint.
- **Judicial or Administrative Proceedings:** If you are involved in a court proceeding and a request is made for information about your diagnosis and treatment and the records thereof, such information is privileged under state law, and I will not release information, without written authorization from you or your personal or legally appointed representative, or a court order. The privilege does not apply when you are being evaluated for a third party or where the evaluation is court ordered. You will be informed in advance if this is the case.
- **Serious Threat to Health or Safety:** If I determine that there is a probability of imminent physical injury by you to yourself or others, or there is a probability of immediate mental or emotional injury to you, I may disclose relevant confidential mental health information to medical or law enforcement personnel.
- **Worker's Compensation:** If you file a worker's compensation claim, I may disclose records relating to your diagnosis and treatment to your employer's insurance carrier.

IV. Patient's Rights and Psychologist's Duties

Patient's Rights:

- *Right to Request Restrictions* –You have the right to request restrictions on certain uses and disclosures of protected health information about you. However, I am not required to agree to a restriction you request.
- *Right to Receive Confidential Communications by Alternative Means and at Alternative Locations* – You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations. (For example, you may not want a family member to know that you are seeing me. Upon your request, I will send your bills to another address.)
- *Right to Inspect and Copy* – You have the right to inspect or obtain a copy (or both) of PHI and psychotherapy notes in my mental health and billing records

used to make decisions about you for as long as the PHI is maintained in the record. I may deny your access to PHI under certain circumstances, but in some cases you may have this decision reviewed. On your request, I will discuss with you the details of the request and denial process.

- *Right to Amend* – You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. I may deny your request. On your request, I will discuss with you the details of the amendment process.
- *Right to an Accounting* – You generally have the right to receive an accounting of disclosures of PHI for which you have neither provided consent nor authorization (as described in Section III of this Notice). On your request, I will discuss with you the details of the accounting process.
- *Right to a Paper Copy* – You have the right to obtain a paper copy of the notice from me upon request, even if you have agreed to receive the notice electronically.

Psychologist's Duties:

- I am required by law to maintain the privacy of PHI and to provide you with a notice of my legal duties and privacy practices with respect to PHI.
- I reserve the right to change the privacy policies and practices described in this notice. Unless I notify you of such changes, however, I am required to abide by the terms currently in effect.
- If I revise my policies and procedures, I will provide you with a written copy during your office visit.

V. Complaints

If you are concerned that I have violated your privacy rights, or you disagree with a decision I made about access to your records, you may speak with me directly.

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

VI. Effective Date, Restrictions and Changes to Privacy Policy

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

Please sign the attached form acknowledging that you have been provided with a copy of this notice.

**Acknowledgement of Receipt of Notice
Regarding the Privacy of Your Health Information**

In compliance with HIPAA regulations, Dr. Poonam Sharma has provided me with a copy of the "Notice of Psychologists' Policies and Practices to Protect the Privacy of Your Health Information."

Client's Signature

Date

Authorization to Use and Disclose Protected Health Information

This form, when completed and signed by you, authorizes me to release protected information from your clinical record to the person you designate.

I authorize my psychologist, Poonam Sharma, Ph.D., to release the following Information:

- Psychological evaluation
- Progress notes
- Summary of record
- All information
- Other _____

This information should only be released to:

- My physician
- My attorney
- The person who referred me
- My previous therapist
- Family member
- Other _____

Name, address, and/or telephone number of person to whom information is to be released:

I am requesting that my psychologist release this information for the following reasons: ("at the request of the individual" is all that is required if you are my patient and you do not desire to state a specific purpose.)

This authorization shall remain in effect until _____ or 180 days from the date of this signed authorization.

You have the right to revoke this authorization, in writing, at any time by sending such written notification to my office address. However, your revocation will not be effective to the extent that I have taken action in reliance on the authorization or if this authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

I understand that my psychologist generally may not condition psychological services upon my signing an authorization unless the psychological services are provided to me for the purpose of creating health information for a third party.

I understand that information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient of your information and no longer protected by the HIPAA Privacy Rule.

Signature of Patient or Personal Representative

Print Name

Date