Lorraine Rose, PhD
(310) 274-7228 cell (310) 367-2639
Lic. #PSY12803
5655 Lindero Canyon Rd. Ste 726
Westlake Village, CA 91362

Confidential Client Information

Name _____ Birth Date_____ Age _____

Address _____ City _____ Zip _____

Cell Phone (_____) _____ Home Phone(_____)_____

In case of emergency notify_____Phone(_____)_____

Physician_____Phone(_____)_____

Psychiatrist_____ Phone(_____)_____

Other_____ Phone(___)_____

e-mail_____

Insurance Carrier :_____

ID #_____ Plan_____

Group #_____

Who holds the Insurance Plan_____Their DOB____/___/____

Consent for Billing Insurance and Credit Card:

I give permission to Dr. Rose to bill and release information to my insurance company for reimbursement purposes. I also release payment from the insurance carrier to Dr. Rose. I understand if my insurance fails to pay for services received, I will be financially responsible for all services rendered. I also understand that Insurance companies cannot be billed for missed sessions and I will be responsible for the full cost of a session (contracted rate) when I cancel less than 24 hours ahead. I understand that I will be charged Dr. Rose's usual rate of $225 for scheduled appointment that are not attended (no shows).

_____ _____

Signature Date

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Name:_____

Reason for seeking therapy:_____

_____

Please circle the symptoms you are currently experiencing.

	Mild	Moderate	Severe	How Long
Depressed Mood	1	2	3	_____
Hopelessness	1	2	3	_____
Suicidal Thoughts	1	2	3	_____
Appetite Changes	1	2	3	_____
Weight change	1	2	3	_____
Poor Concentration	1	2	3	_____
Obsessive Thoughts	1	2	3	_____
Strange Thoughts	1	2	3	_____
Tension/Anxiety	1	2	3	_____
Panic Attacks	1	2	3	_____
Memory Problems	1	2	3	_____
Compulsive Behavior	1	2	3	_____
Hostility or Anger	1	2	3	_____
Violent Acts	1	2	3	_____
Social Isolation	1	2	3	_____
Sexual Problems	1	2	3	_____

Describe Your Drug or Alcohol Use:

_____

Have you ever been arrested? Yes No

Any medical problems? _____

Current Medications (incl. non-prescription):_____

_____

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Consent for Treatment

As your therapist, I look forward to working with you and want to give you some important information about the services you will receive. This consent form will provide a clear framework for our work together and will facilitate our working relationship. Please feel free to discuss any questions with me.

1). **Confidentiality:** As your therapist, I am legally prohibited from revealing to another person that you are in therapy with me, nor can I reveal what you have said to me in any way that identifies you without your written permission. However, in the following instances, your right to confidentiality must be set aside as required by law or professional guidelines:

A. Instances of actual or suspected physical or sexual abuse, emotional cruelty, or neglect of a child or an elder or dependent adult must be reported to the appropriate protective services.

B. If I have a reason to believe that a client poses an unavoidable and imminent danger of violence to another person (or to another's property), I must warn whomever may be in danger,
and I must notify the appropriate authorities.

C. If a court has ordered your treatment with me, or if I am served with a subpoena. For example, in the context of a legal proceeding in which you raise your own psychological state as an issue, I am required to release information to the court, or may have to appear in court.

D. If you as a client reveal a serious intent to harm yourself, I am ethically bound to do what I can to help you keep safe, which may involve notifying others who may be of help.

E. If you have an unpaid balance due and efforts to resolve payment have been unsuccessful, I reserve the right to break confidentiality in an attempt to collect any outstanding fees owed.

F. In order to provide the best possible service to my clients, I consult with other licensed professionals, from time to time, for additional therapeutic input. In these consultations, I make every effort to protect your anonymity. Unless you object, I will not tell you about these consultations unless I feel that it is important to our work together.

G. Please be aware that computer and email communication, unless encrypted, are relatively easily accessed by unauthorized people and privacy and confidentiality can be compromised. If you communicate private information to me via email, I will assume that you have made an informed decision to take the risk that such communications may be intercepted. Additionally, my voicemail, is through google voice and has the same conditions listed above.

H. If you have a virtual session with me, the session with be through an encryption protected venue. Please be in a private space for your session.

In all of the above cases, it is incumbent upon me to release only that information necessary to appropriately carry out my responsibilities -- your confidentiality still remains an ethical priority.

2). **Sessions:** Your weekly appointment time is reserved for you. Therapy sessions are normally 50 minutes. Appointment cancellations must be made 24 hours in advance, otherwise, you are responsible for the fee for such sessions. (Insurance companies do not reimburse for missed sessions). Please text me for appointment changes at (310) 367-2639.

3). **Payment for Services:** You are expected to pay for services at the time of our session, unless we have agreed on other arrangements. My fee is $300 per 50 minute session. Any fee change is negotiated in good faith; it is your responsibility to notify me if your financial situation changes. My fees may change over the course of treatment, but with consideration to your financial ability to continue in treatment. Typically, fees will be raised once yearly. Fees for writing a psychological report or court appearances will be $300 per hour, including travel time. In general, it is important to discuss with me any issues that arise connected to our financial arrangements, so that these do not hinder our working relationship. You also have the right to have an estimated cost for anticipated services. In other words, we will set a fee and an estimated amount of time that we will work together. We will reassess the fee and future sessions after that set period of time.

Past due payments -- Payment for services which is past due over 120 days may be subject to collection through the use of a collection agency. However, efforts will be made to make other arrangements with you as needed.

4). **Telephone Accessibility:** I am available during normal working hours at (310) 367-2639 and will return calls as soon as possible should you need to speak to me between sessions. I do not charge fees for telephone consultations that are less than 10 minutes. Consultations of greater length will be pro-rated based on your hourly fee. If you have an emergency between sessions or after working hours, you may need to go to the nearest emergency room or access a suicide prevention hot line at 310-391-1253.

5). **Patient Rights:** In addition to confidentiality, as spelled out above, you have the right to end your therapy at any time, for whatever reason, without any moral, legal or financial obligation, except for fees already incurred. You have the right to question any aspect of your treatment with me, and to expect that I will work with you to meet your needs for adjunctive or alternative treatment. You also have the right to expect that I will maintain professional and ethical boundaries by not entering into other personal, financial, or professional relationships with you, all of which would greatly compromise our work together.

Psychotherapy involves a partnership between therapist and client. As your therapist, I will contribute knowledge, skills, and a willingness to do my best. The determination of success, however, will ultimately depend upon your commitment to your own personal growth and care.

Please feel free to ask any questions or discuss any of this information with me. Your signature below indicates that you have read and understand this information, and have received a copy of this consent form.

Name of Client	Signature of Client/Responsible Party	Date

Name of Client	Signature of Client/Responsible Party	Date

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HIPAA NOTICE OF PRIVACY PRACTICES

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

II. IT IS MY LEGAL DUTY TO SAFEGUARD YOUR PROTECTED HEALTH INFORMATION (PHI).
By law I am required to insure that your PHI is kept private. The PHI constitutes information created or noted by me that can be used to identify you. It contains data about your past, present, or future health or condition, the provision of health care services to you, or the payment for such health care. I am required to provide you with this Notice about my privacy procedures. This Notice must explain when, why, and how I would use and/or disclose your PHI. Use of PHI means when I share, apply, utilize, examine, or analyze information within my practice; PHI is disclosed when I release, transfer, give, or otherwise reveal it to a third party outside my practice. With some exceptions, I may not use or disclose more of your PHI than is necessary to accomplish the purpose for which the use or disclosure is made; however, I am always legally required to follow the privacy practices described in this Notice.

Please note that I reserve the right to change the terms of this Notice and my privacy policies at any time as permitted by law. Any changes will apply to PHI already on file with me. Before I make any important changes to my policies, I will immediately change this Notice and post a new copy of it in my office. You may also request a copy of this Notice from me, or you can view a copy of it in my office.

III. HOW I WILL USE AND DISCLOSE YOUR PHI.
I will use and disclose your PHI for many different reasons. Some of the uses or disclosures will require your prior written authorization; others, however, will not. Below you will find the different categories of my uses and disclosures, with some examples.

A. Uses and Disclosures Related to Treatment, Payment, or Health Care Operations Do Not Require Your Prior Written Consent. I may use and disclose your PHI without your consent for the following reasons:
1. **For treatment. or health care operations.**

2. **To obtain payment for treatment.** I may use and disclose your PHI to bill and collect payment for the treatment and services I provided you. Example: I might send your PHI to your insurance company or health plan in order to get payment for the health care services that I have provided to you. I could also provide your PHI to business associates, such as billing companies, claims processing companies, and others that process health care claims for my office.

3. **Other disclosures.** Examples: Your consent isn't required if you need emergency treatment provided that I attempt to get your consent after treatment is rendered. In the event that I try to get your consent but you are unable to communicate with me (for example, if you are unconscious or in severe pain) but I think that you would consent to such treatment if you could, I may disclose your PHI.

B. Certain Other Uses and Disclosures Do Not Require Your Consent. I may use and/or disclose your PHI without your consent or authorization for the following reasons:

1. When disclosure is required by federal, state, or local law; judicial, board, or administrative proceedings; or, law enforcement.

2. **If disclosure is compelled by a party to a proceeding before a court of an administrative agency pursuant to its lawful authority.**

3.**If disclosure is required by a search warrant lawfully issued to a governmental law enforcement agency.**
4. **If disclosure is compelled by the patient or the patient's representative pursuant to California Health and Safety Codes or to corresponding federal statutes of regulations,** such as the Privacy Rule that requires this Notice.
5.**To avoid harm.** I may provide PHI to law enforcement personnel or persons able to prevent or mitigate a serious threat to the health or safety of a person or the public (i.e., adverse reaction to meds).
6**. If disclosure is compelled or permitted by the fact that you are in such mental or emotional condition as to be dangerous to yourself or the person or property of others, and if I determine that disclosure is necessary to prevent the threatened danger.**
7. **If disclosure is mandated by the California Child Abuse and Neglect Reporting law.** For example, if I have a reasonable suspicion of child abuse or neglect.
8. **If disclosure is mandated by the California Elder/Dependent Adult Abuse Reporting law.** For example, if I have a reasonable suspicion of elder abuse or dependent adult abuse.
9. **If disclosure is compelled or permitted by the fact that you tell me of a serious/imminent threat of physical violence by you against a reasonably identifiable victim or victims.**
10. **For public health activities.** Example: In the event of your death, if a disclosure is permitted or compelled, I may need to give the county coroner information about you.
11. **For health oversight activities.** Example: I may be required to provide information to assist the government in the course of an investigation or inspection of a health care organization or provider.
2.1**For specific government functions.** Examples: I may disclose PHI of military personnel and veterans under certain circumstances. Also, I may disclose PHI in the interests of national security, such as protecting the President of the United States or assisting with intelligence operations.
3.1 **For research purposes.**
4.1 **For Workers' Compensation purposes.**
5.1 **Appointment reminders and health related benefits or services.**
6.1**If an arbitrator or arbitration panel compels disclosure,** when arbitration is lawfully requested by either party, pursuant to subpoena duces tectum (e.g., a subpoena for mental health records) or any other provision authorizing disclosure in a proceeding before an arbitrator or arbitration panel.
7.1**If disclosure is required or permitted to a health oversight agency for oversight activities authorized by law.**
8.1**If disclosure is otherwise specifically required by law.**

C. Certain Uses and Disclosures Require You to Have the Opportunity to Object.

1. Disclosures to family, friends, or others. I may provide your PHI to a family member, friend, or other individual who you indicate is involved in your care or responsible for the payment for your health care, unless you object in whole or in part. Retroactive consent may be obtained in emergency situations.

D. Other Uses and Disclosures Require Your Prior Written Authorization. In any other situation not described in Sections IIIA, IIIB, and IIIC above, I will request your written authorization before using or disclosing any of your PHI. Even if you have signed an authorization to disclose your PHI, you may later revoke that authorization, in writing, to stop any future uses and disclosures (assuming that I haven't taken any action subsequent to the original authorization) of your PHI by me.

IV. WHAT RIGHTS YOU HAVE REGARDING YOUR PHI

These are your rights with respect to your PHI:

A. The Right to See and Get Copies of Your PHI. In general, you have the right to see your PHI that is in my possession, or to get copies of it; however, you must request it in writing. If I do not have your PHI, but I know who does, I will advise you how you can get it. You will receive a response from me within 30 days of my receiving your written request. Under certain circumstances, I may feel I must deny your request, but if I do, I will give you, in writing, the reasons for the denial. I will also explain your right to have my denial reviewed. If you ask for copies of your PHI, I will charge you not more than $.25 per page. I may see fit to provide you with a summary or explanation of the PHI, but only if you agree to it, as well as to the cost, in advance.

B. The Right to Request Limits on Uses and Disclosures of Your PHI. You have the right to ask that I limit how I use and disclose your PHI. While I will consider your request, I am not legally bound to agree. If I do agree to your request, I will put those limits in writing and abide by them except in emergency situations. You do not have the right to limit the uses and disclosures that I am legally required or permitted to make.

C. The Right to Choose How I Send Your PHI to You. It is your right to ask that your PHI be sent to you at an alternate

address (for example, sending information to your work address rather than your home address) or by an alternate method (for example, via email instead of by regular mail). I am obliged to agree to your request providing that I can give you the PHI, in the format you requested, without undue inconvenience. I may not require an explanation from you as to the basis of your request as a condition of providing communications on a confidential basis.

D. The Right to Get a List of the Disclosures I Have Made. You are entitled to a list of disclosures of your PHI that I have made. The list will not include uses or disclosures to which you have already consented, i.e., those for treatment, payment, or health care operations, sent directly to you, or to your family; neither will the list include disclosures made for national security purposes, to corrections or law enforcement personnel, or disclosures made before April 15, 2003. After April 15, 2003, disclosure records will be held for six years.

I will respond to your request for an accounting of disclosures within 60 days of receiving your request. The list I give you will include disclosures made in the previous six years (the first six year period being 2003-2009) unless you indicate a shorter period. The list will include the date of the disclosure, to whom PHI was disclosed (including their address, if known), a description of the information disclosed, and the reason for the disclosure. I will provide the list to you at no cost, unless you make more than one request in the same year, in which case I will charge you a reasonable sum based on a set fee for each additional request.

E. The Right to Amend Your PHI. If you believe that there is some error in your PHI or that important information has been omitted, it is your right to request that I correct the existing information or add the missing information. Your request and the reason for the request must be made in writing. You will receive a response within 60 days of my receipt of your request. I may deny your request, in writing, if I find that: the PHI is (a) correct and complete, (b) forbidden to be disclosed, (c) not part of my records, or (d) written by someone other than me. My denial must be in writing and must state the reasons for the denial. It must also explain your right to file a written statement objecting to the denial. If you do not file a written objection, you still have the right to ask that your request and my denial be attached to any future disclosures of your PHI. If I approve your request, I will make the change(s) to your PHI. Additionally, I will tell you that the changes have been made, and I will advise all others who need to know about the change(s) to your PHI.

F. The Right to Get This Notice by Email You have the right to get this notice by email. You have the right to request a paper copy of it, as well.

V. HOW TO COMPLAIN ABOUT MY PRIVACY PRACTICES

If, in your opinion, I may have violated your privacy rights, or if you object to a decision I made about access to your PHI, you are entitled to file a complaint with the person listed in Section VI below. You may also send a written complaint to the Secretary of the Department of Health and Human Services at 200 Independence Avenue S.W. Washington, D.C. 20201. If you file a complaint about my privacy practices, I will take no retaliatory action against you.

VI. PERSON TO CONTACT FOR INFORMATION ABOUT THIS NOTICE OR TO COMPLAIN ABOUT MY PRIVACY PRACTICES

If you have any questions about this notice or any complaints about my privacy practices, or would like to know how to file a complaint with the Secretary of the Department of Health and Human Services, please contact me at: Lorraine Rose, PhD., 9107 Wilshire Blvd., Suite 475 Beverly Hills, CA, 90210, (310) 274-7228.

HIPAA NOTICE OF PRIVACY PRACTICES

I ACKNOWLEDGE THAT I HAVE RECEIVED A COPY OF DR. ROSE'S HIPPA PRIVACY PRACTICES WHICH DESCRIBES HOW MEDICAL INFORMATION ABOUT ME MAY BE USED AND DISCLOSED AND HOW I CAN GET ACCESS TO THIS INFORMATION.

Patient Name: _____

Signature_____ **Date:** _____

Patient Name: _____

Signature: _____ **Date:** _____

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Credit Card Authorization

I, _____
(Print Name)

authorize Lorraine Rose, PhD to charge my credit card for psychotherapy sessions, missed sessions or sessions not covered by insurance, in the amount shown below. I understand that I will be charged for sessions and cancellations made less than 24 hrs. in advance at the contracted rate. Scheduled sessions that are not attended are "No shows" and charged at the standard rate of $300.

Client Name: _____

Client Name _____

Name on card: (if different than above) _____

Billing Address: _____

City, State, Zip: _____

Phone with area code: _____

Email address to send receipts: _____

Card number: _____

Expiration date: _____ Security code on back: _____ (last 3 digits printed on the signature panel)

Card type (check one): ____ VISA _____ MasterCard _____ Amex _____ Discover

This card is a: credit card _____ debit card _____ (please indicate one)

Amount: $ For 50 minute sessions

$ For co-pay

$ 300.00 For no show

_____ _____
Signature Date

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AUTHORIZATION FOR USE/DISCLOSURE OF CONFIDENTIAL INFORMATION

By completing this form, you are authorizing the disclosure and/or use of individually identifiable health information, as outlined below, consistent with California and Federal law concerning the privacy of such information. All information requested must be provided for this Authorization to be valid.

Use and disclosure of Mental Health Information:

Client Name: _____ **Date of Birth:** ___/___/

My Therapist,_____is authorized to (*check all that apply*):

2. Release or disclose records and/or information to
3. Obtain or use records and/or information from
4. Mutually discuss and exchange records and/or information

This Information should only be released to: _____
name or function of person or organizations to whom the information is to be released

Specific Information to be Released/Obtained (*Please select only one*):

4. All health/mental health information including diagnosis and treatment received.
5. Only the following records or type of information:_____

***Please specify if any information is to be excluded*:**_____

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

This authorization shall become effective immediately and expire in one year and a photocopy or facsimile of this form is to be considered as valid as the original.

Please note: If you have authorized the disclosure of your mental health information to someone who is not legally required to keep it confidential, it may be redisclosed and may no longer be protected. California law prohibits recipients of your health information from redisclosing such information except with your written authorization or as specifically required or permitted by law.

Your Rights:

- You may refuse to sign this Authorization.
- You may revoke this Authorization only by delivering your revocation in writing to_____(therapist). Your revocation will be effective when your therapist receives it. However, this revocation will not extend to information that was already obtained or released (used or disclosed) prior to the revocation.
- You have the right to receive a copy of this Authorization.
- You may inspect or obtain a copy of your mental health information, within the limits of California and federal laws.
- Neither treatment, payment, enrollment nor eligibility for benefits will be conditioned on your providing or refusing to provide this Authorization.

_____ _____

Signature of Client/Parent/Guardian: **Date:**

Your Relationship to the Client: _____

To Revoke Authorization Only: Authorization Revoked: ___/___/__ _____