Linda S. Stead, LCSW

670 Superior Ct. Ste. 103 Medford, OR 97504
Ph: 541-772-5993 Fax: 541-646-7969

REGISTRATION INFORMATION

Patient Name_____Today's Date_____
Phone No._____Cell Phone_____Other_____Msg OK?_____
Mailing Address_____City_____State_____ZIP_____
Social Security Number_____Age_____Date of Birth_____
Occupation_____Employer_____Work Phone_____
Marital Status: S___ M___ Sep___ Div___ W____ Education_____
Spouse/Significant Other_____Date of Birth_____
Spouse/Significant Other Employer_____Work Phone_____
Emergency contact person_____Relationship_____Phone_____

MEDICAL HISTORY

Severe Illnesses_____
Surgeries_____
Accidents_____Allergies_____
Current Medications_____
Previous Mental Health Care_____
Personal Physician_____How were you referred to this office_____
Reason for visit today_____

OFFICE POLICIES

Please initial to show that you have read and understand the Office Policy Information provided_____

ASSIGNMENT AND RELEASE

I assign directly to Heartline Mental Health Practitioners all medical benefits, if any, otherwise payable to me for services rendered. I hereby authorize Heartline Mental Health Practitioners to release all information necessary to secure the payment of benefits. I authorize the use of my signature on all my insurance submissions.

I understand that I am financially responsible for all charges whether or not paid by insurance. I certify that the above information is true and accurate to the best of my knowledge.

_____ _____
Signature of Insured Date

FOR UPDATE USE ONLY:

I have reviewed the above information. To the best of my knowledge, the above information is current and updated with changes.

_____ _____
Signature of Insured Date

CONSENT TO USE OR DISCLOSE CLINICAL INFORMATION

I authorize Linda Stead, LCSW to **use and disclose** the health and clinical information of

_____ for the purpose of **Treatment, Payment and Health Care Operations**.
(Name of client)

- **Treatment** (includes activities performed by a practitioner, facility, program, nurse, office staff, and other types of health care professionals providing care to you, coordinating or managing your care with third parties, and consultations with and between other health care providers. This consent includes treatment provided by any practitioner who covers my/our practice by telephone as the on-call practitioner).
- **Payment** (includes activities involved in determining your eligibility for health plan coverage, billing and receiving payment for your health benefit claims, and utilization management activities which may include review of health care services for clinical necessity, justification of charges, precertification and preauthorization).
- **Health Care Operations** (includes the necessary administrative and business functions of our office).

You may review Linda Stead, LCSW **"*Notice of Privacy Practices*"** for additional information about the uses and disclosures of information describe in the CONSENT prior to signing this CONSENT. Please verify that you have received a copy of our ***Notice*** by placing your initials here:_____.

Because we have reserved the right to change our privacy practices in accordance with the law, the terms contained in the ***Notice*** may change also. A summary of the ***Notice*** will be posted in the lobby of our office indicating the effective date of the ***Notice*** in the upper right-hand corner. We will offer you a copy of the ***Notice*** on your first visit to us after the effective date of the then current ***Notice***. We will also provide you with a copy of the ***Notice*** upon your request.

As more fully explained in the ***Notice***, you have the right to request restrictions on how we use and disclose your protected health information for treatment, payment, and health care operations purposes. ***We are not required to agree to your request.*** If we do agree, we are required to comply with your request unless the information is needed to provide you emergency treatment. Other practitioner/providers who provide call coverage for our office are required to use and disclose your protected health information consistent with the ***Notice***.

I understand that I have the right to revoke this CONSENT provided that I do so in writing, except to the extent that [name of practitioner/provider/practitioner/provider group] has already used or disclosed the information in reliance on this CONSENT.

_____ _____ (or)
(Date) (Signature of client)

_____ _____
(Date) (Signature of person authorized by law)

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ETHICAL STANDARDS AND PRACTICES

The following answers some important and frequently asked questions concerning this practice. Please read the following information carefully and let us know if there is any part you do not understand.

I Treatment Philosophy

Psychotherapy has both benefits and risks. It also requires an investment of your time and energy in order to make the process of therapy most successful. It will begin with an evaluation of your needs. Next, I will develop and discuss a treatment plan in accordance with your goals and aims. Occasionally individuals may go through periods in therapy which may result in emotional discomfort, changes in their relationships, or temporary worsening of their symptoms. This should subside as the work progresses. Remember, you always retain the right to request changes in treatment or to refuse treatment at any time.

II Health Insurance

If you are using a health insurance benefit as payment for these services, you need to be aware of what this means. Your health plan requires cooperation between client, provider and insurance company to provide services as efficiently as possible.

Health insurance companies usually limit mental health coverage to:

1. Services that are determined “medically necessary”. Medically necessary may be defined as presentation of a covered DSM IV Axis I diagnosis (these are acute symptoms).
2. Conditions that are able to be treated by short-term, problem-focused, goal-oriented approaches whenever possible.

This may mean your insurance company may cover a limited number of office sessions to work on your problem as intensely as possible with the focus of eliminating acute symptoms. I am contracted with insurance companies to provide these services within these conditions.

Many insurance companies review cases for quality assurance and preauthorization purposes. Your case may be reviewed by a utilization review/ quality assurance group set up by the insurance company. I will maintain, to the best of our ability, your confidentiality in this process.

III Office Policies
Please see separate page containing my office policies in detail.

IV Confidentiality
I abide by the laws and ethical principles that govern privilege and confidentiality. I will not disclose any information about you or your treatment without your written consent by way of signed release. There are some exceptions to this standard:

- It is legally required of me that I act so as to prevent physical harm to yourself or to others when there is “clear and imminent” danger of that happening.
- I am legally required to report cases of ongoing child, elder and disabled abuse.
- I may have to release clinical information regarding you to insurance carriers as required for payment or review of your claim.
- I may have to release your records when ordered to do so by court subpoena. However, I will discuss this with you beforehand and request written release from you if I judge this to be in your best in your best interest.
- On occasion, clinicians consult with colleagues about their work. If your case were ever discussed it would be confidential and without your name or identifying information.

V Release of Information
Please sign below to show that you have read and understand this information.

_____ _____
Signature Date

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OFFICE POLICY INFORMATION

OFFICE HOURS: I currently am in the office Mondays and Tuesdays only, 10 AM to 5 :30 PM.

FINANCIAL POLICY: You will be asked to pay the portion of your visit that is not covered by your insurance. I bill primary and secondary insurances. If you do not have insurance, full payment is expected at the time of service; I accept cash, check or credit/debit cards. Please be sure we have accurate and up-to-date information. If you have any changes of address, phone, or insurance information please give me the update immediately.

INSURANCE: Your health insurance may or may not cover mental health care services. I am a member of several panels and networks. Please check with your insurance company to verify your outpatient mental health benefits; these may differ from your regular medical benefits. Check to see whether I am listed on your insurance company's mental health panel. Preauthorization is often required. Please familiarize yourself with your insurance requirements. Lack of pre-authorization may result in non-payment by your insurance company.

I bill insurance as a courtesy. However, I wish to stress that our contract for payment is with you, not the insurance company. Please understand that if there is a problem with payment from your insurance company you will still be required to pay your bill with me. I may be able to supply you with benefit information as quoted by your insurance company, but I still do not assume responsibility for the accuracy of this information. I do not guarantee payment from your insurance company. Please understand that I may not be able to calculate your portion of the bill correctly until your claim has been processed by your insurance company. I reserve the right to collect any unpaid amount from you.

APPOINTMENTS: You will always be seen as promptly as possible. There is no receptionist so just have a seat in the waiting room and I will come out to get you. Once you are an established client, I encourage you to use my online scheduling program to make or cancel appointments. It's easy and convenient. You can find that at www.schedulicity.com or go to very bottom of the Contact Me page of my website at www.lend-an-ear.com where you will find a link to Schedulicity.

TECHNOLOGY: My email is not secure so use that only if you are comfortable with that. My phone and text services are secure. Emails and texts are used for business needs rather than therapy. I have the capability of doing TeleMental Health session via Zoom so let me know if you require or prefer that. I use a HIPPA compliant version of Zoom, so it is completely confidential.

CANCELLATIONS AND MISSED APPOINTMENTS: If you must cancel or change an appointment, please give me 24 hours' notice. Schedulicity will not allow you to cancel an appointment withing 24 hours of the time so you will have to call me. If you cancel with less than 24 hours' notice or do not show up for an appointment, you may be charged for the time reserved. Insurance will not pay for this charge.

EMERGENCY SERVICES: Outside my regular office hours, as an established client you may call me at (541)646-7959 if you are having a psychiatric emergency. Please do not text or email, as I may not get that communication in a timely way. Also note that appointment cancelations are not an emergency. Just leaving me a voicemail is sufficient.

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Effective Date: 12/01/2004

PATIENT PRIVACY NOTICE

I am committed to preserving the privacy of your personal health information. In fact, I am required by law to protect the privacy of your clinical information and to provide you with a notice describing:

HOW CLINICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN ACCESS THIS INFORMATION

- I am required by law to have your written consent before I use or disclose to others clinical information for purposes of providing or arranging for your health care, the payment for or reimbursement of the care that I provide to you and the related administrative activities supporting your treatment.
- I may be required or permitted by certain laws to use and disclose your clinical information for other purposes without your consent or authorization.
- As my client, you have important rights relating to inspecting and copying your clinical information that I maintain, amending or correcting that information, obtaining an accounting of my disclosures of your clinical information, requesting that I communicate with you confidentially, requesting that I restrict certain uses and disclosures of your health information, and complaining if you think your rights have been violated.
- I have available a detailed NOTICE OF PRIVACY PRACTICES which fully explains your rights and our obligations under the law. I may revise our NOTICE from time to time. The effective date at the top right hand of this page indicates the date of the most current NOTICE in effect.
- You have the right to receive a copy of my most current NOTICE in effect. If you have not yet received a copy of my current NOTICE, please ask and I will provide you with a copy.
- If you have any questions, concerns or complaints about the NOTICE or your clinical information, please contact **Linda Stead, LCSW** at **541-772-5993**.

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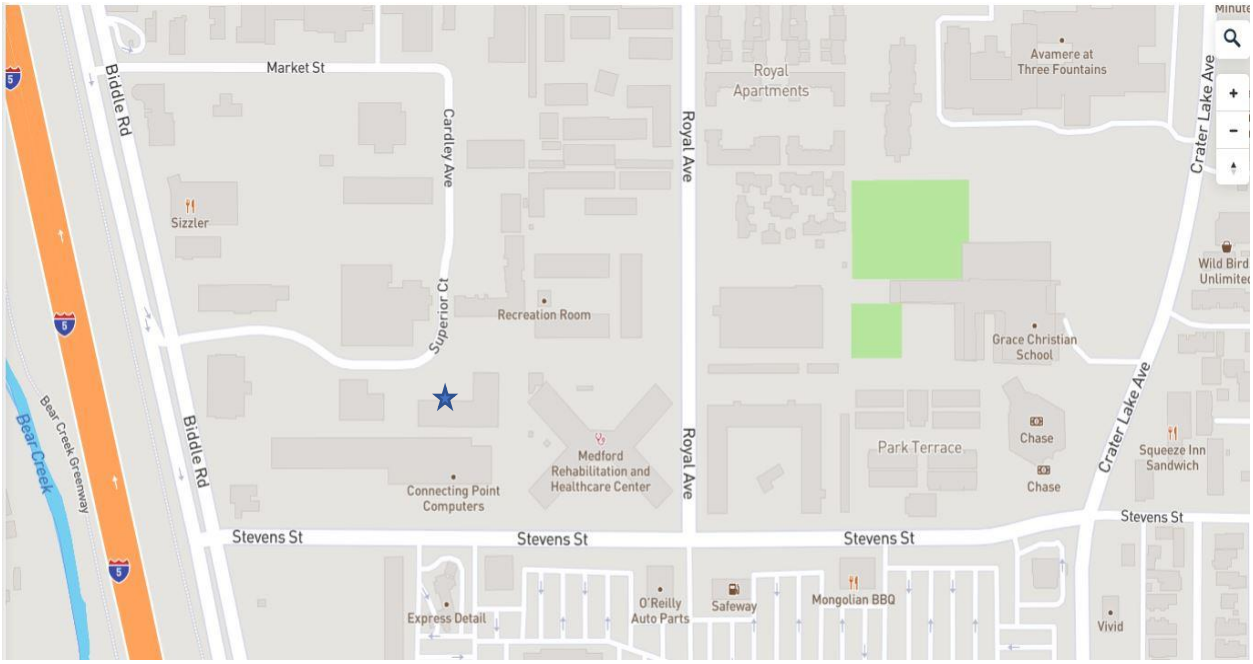

Coming from the south, take exit 27 and go to city center. Follow Riverside to Jackson St. and turn right, staying left at the light. This becomes Biddle Rd. In about 2 blocks, turn right onto Superior Ct. Landmark: Franz bakery on the corner. Continue one block to where Superior makes a left turn and instead continue on into a large parking lot. Suite #103 is on the right.

Coming from the north, take exit 30 and go toward the city center. Turn left on McAndrews then continue on McAndrews until it goes under the freeway. Take the next right onto Biddle. Continue down Biddle until you see Franz Bakery on your left and turn left onto Superior Ct. Continue one block to where Superior makes a left turn and instead continue on into a large parking lot. Suite #103 is on the right.