Stefanie Von Ohlen, LCSW
FL Lic # SW7268

CONSENT FOR TREATMENT
I authorize Stefanie Von Ohlen to provide me with psychotherapy services. I make this request freely and without coercion. I understand I will be informed of the benefits and risks of treatment. Additionally, I understand that Stefanie Von Ohlen will provide professional experience and pertinent information concerning her licensing status. **_____ INITIAL**

I hereby acknowledge that I have been given an opportunity to read and receive a copy of the HIPPA Notice of Privacy Practices. If I have questions regarding the HIPPA Notice or my privacy rights, I can contact Stefanie Von Ohlen. **_____ INITIAL**

FINANCIAL POLICY AGREEMENT
Please note that Stefanie Von Ohlen does not interact with insurance companies on your behalf unless required by the insurance company. Cash, personal checks, or credit cards are accepted as forms of payment. It is the client's responsibility to obtain authorization and confirm co-pays prior to the first session.

CANCELLATION POLICY
A 24-hour notice is required for cancellation of an appointment. YOU WILL BE CHARGED $50.00 if cancellation is made with less than a 24-hour notice, or if you do not show for your appointment. The credit card listed below will be automatically charged $50.00. Please initial that you have read, understand, and agree to the terms of this cancellation policy. _____ INITIAL

Checks returned for insufficient funds are subject to prosecution under the laws of the State of Florida. You will be charged a $35.00 service charge on a returned check. Please note that this office does refer delinquent accounts to a collection agency when satisfactory arrangements cannot be made, and our provider/patient relationship may be affected.

I certify that the information on this form is correct and I authorize Stefanie Von Ohlen to deliver professional psychotherapy services to me and/or my dependent family members. I understand I may terminate services at any time I wish. I agree to pay the agreed upon charges in full. I certify that I understand the above information and have had the opportunity to ask questions for clarification as needed. **_____ INITIAL**

I have read the financial policy agreement, confidentiality disclosure, and consent for treatment including appointments and fees. I understand my provider and myself will review treatment, and I am encouraged to ask questions concerning treatment at any time during the treatment process. My signature represents my understanding of, and agreement to all of the terms stated herein for the entire term of my psychotherapeutic relationship with Stefanie Von Ohlen.

_____ _____
Patient/Guardian/Parent Signature Date

_____ _____
Printed Patient/Guardian/Parent Name Date

_____ _____
Additional Patient/Guardian/Parent Signature (if applicable) Additional Printed Patient/Guardian/Parent Name (if applicable)

Address_____

City_____ State_____ Zip_____

Home Phone_____ Cell Phone_____ Okay to Leave Voicemail? Y / N

Email_____

DOB_____ Last 4 digits of SSN # _____

Credit Card # _____ Exp_____ CVC_____

Please initial if you agree to receiving communication from the office of Stefanie Von Ohlen via text messaging and/or email: _____Text _____Email

BACKGROUND INFORMATION

Name_____ Date_____

1. Please describe the reason for seeing me:

2. History of past treatment:

3. List of medications you are currently taking:

4. If you are currently working, please describe your work situation:

5. Briefly describe your family of origin and your relationship with them:

6. Education:

7. Describe your current family situation:

8. Describe your current social interactions:

Stefanie Von Ohlen, LCSW

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HIPAA NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you may be used and disclosed and how you can get access to review it carefully.

What is HIPAA?

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) is a federal guideline, which requires health care providers to inform clients of their right to record privacy. Your healthcare information is personal and private, and Stefanie Von Ohlen is committed to protecting you confidentiality. We need your medical, psychological, and/or legal information to provide you with quality care, but we have certain obligations regarding how we may use and disclose your information. This notice will tell you about the ways in which we may use and disclose your personal information, as well as describe your rights to privacy.

FCC Obligations Required by Law

- Protect the health information that identifies you.
- Provide you with a notice of our information practices, policies, and procedures.
- Abide by the terms of the notice currently in effect.

How We May Use and Disclose Your Information

- ***For your treatment***. We may use your medical, psychological, and/or legal information to provide you with mental health services. Other employees (if applicable) in our practice may also use this information when coordinating different parts of your treatment. Some people outside our office may need access to some or all of your information. They may include specific family members, referring physicians, treating psychiatrists, attorneys, probation offices, department of children and family service workers, or others involved in your care.
- ***For payment of your service.*** We may use your medical, psychological, and/or legal information about you so that the services you receive at this office may be billed to and payment received from either yourself, your insurance company, or a third party. An example would be when we would need to disclose information to an insurance company to authorize treatment.
- ***For healthcare operations.*** We may use and disclose information for office operation. These uses and disclosures are necessary to run our office and make sure all of our clients receive quality care. For example, we may use your information to review our treatment and services, or to evaluate our staff.
- ***For appointment reminders***. We may use your information to contact you as a reminder of an upcoming appointment.
- ***As required by law.*** We may disclose your information when required to do so by federal, state, or local law. For example, when you are referred by a court or children and family services for an evaluation or attendance at a program.
- ***To avert a serious threat to health or safety.*** We may disclosure your information if it is necessary to prevent foreseeable and serious risk of harm to yourself or others. The disclosure would only be to someone who could prevent the harm, including the police.
- ***As a result of you waiving your rights to confidentiality.*** This may occur, for example, should you file a lawsuit.

Special Situation

- ***Worker's Compensation and EAP Services***. We may release information about you to either the Worker's Compensation Bureau or an EAP service. Worker's compensation provides benefits for work-related injuries and associated trauma. EAP services refer clients on behalf of an employer for appropriate services.
- ***Public Health Records.*** Your information may be disclosed for public health safety, such as:
    - To report abuse or neglect of yourself, with your permission.
    - To prevent the spread of or to control disease, injury, or disability.
    - To report adverse reactions to medications, or problems with any products.
    - To notify clients of a recall of products they may be using.
    - To notify a person of the risk of spreading or contracting disease after exposure.
    - To report child and/or elder abuse or neglect.
- ***Law Enforcement, Probation, or Children and Family Services.*** If required to receive either an evaluation or attend a court-ordered program, it will be necessary to disclose some or all of your information:
    - In response to court ordered treatment, condition of probation or other government agency requirements, including subpoenas, warrants, or similar processes.
    - About any criminal conduct while at our office, or any plans to commit such offenses.
    - About any behavior that is in direct violation of your probation or other government agency requirements.
    - About any dangerous child-rearing practices, suspected child or elder abuse/neglect, and threats of harm to self or others.

Your Rights Regarding Your Information

- ***Right to inspect and copy.*** You have the right to request access and to copy your information. This includes medical, legal and psychological information, but does not include psychotherapy notes. To inspect or copy your file, you must submit your request in writing to Stefanie Von Ohlen, 900 Central Ave., Suite 302, St. Petersburg, FL 33705. We may charge you a nominal fee for the cost of copying, mailing, or other associated costs related to your request. Our standard policy is to release information to your current provider upon receiving a written request upon your written authorization. We may deny your request to inspect and copy certain information. If you are denied access to your information, you may request that it be forwarded to another healthcare provider.
- ***Right to amend.*** You have the right to ask us to change or amend any information you feel is incorrect or incomplete. You also have the right to ask for this amendment for as long as the information is held in this office. An amendment request must be made on writing, including the reason for the change. Your request may be denied if it is not made in writing, or does not include the reason for the amendment. In addition, your request may also be denied if you ask us to amend information that:
    - Was not created by us.
    - Is not part of the information kept by or for this office.
    - Is not part of the information which you would be permitted to inspect or copy.
    - Is accurate and complete.
- ***Right to accounting of disclosures.*** You have the right to an accounting of disclosures. This is a list of any disclosures made of your information for any reason that the above is stated. Your request for this list must be in writing. Your request must state a specific time period and cannot include dates prior to April 2018. The first list you request within a 12 month period will be free. For all subsequent lists, you may be charged a fee. We will notify you of the fee, and you may choose to withdraw or modify your request.
- ***Right to request restrictions.*** You have the right to request a restriction or limitation of your information. This includes the amount of information we provide to a family member or others involved with your care or payment of it. We are not required to agree with your request. If we do agree, we will comply with your request unless the information is needed to provide emergency care. Request for restriction of information must be in

writing and must include what information you want to limit, whether you want to limit our use, disclosures, or both, and to whom you want the limits to apply.

- ***Right to request confidential communications.*** You also have the right to request that we communicate with you about your situation in a certain way. For example, you may request that we contact you only at work and not at home. Again, your request must be in writing and express how or where you want to be contacted, if at all. We will honor all reasonable requests and not ask for a reason.
- ***Right to a paper copy of this notice.*** You have the right to a paper copy of this notice. This is your copy. Please take it with you. Should you lose it, please ask for another at any time.

Changes to This Notice

We reserve the right to change this notice. We reserve the right to make a revised notice effective for information we already have, or for the information collected in the future.

Complaints

If you believe that your rights to privacy have been violated, you have the right to file a complaint with either this office or with the Secretary of the Department of Health and Human Services.

Other Uses of Information

If at any other time your medical, psychological, and/or legal information has been requested by an outside entity, or you wish to disclose this information to outside entities, such as new physicians, mental health providers, law firms, research organizations, etc., a separate specific authorization will need to be completed.

By signing this consent form, you have also agreed to allow Stefanie Von Ohlen psychotherapy notes to be included with the rest of your record. This will allow access to your entire file by all Stefanie Von Ohlen mental health professionals, in the event they provide consultation, or cover for another provider.

Other uses and disclosures of information not covered by this notice, or the laws that apply to use, will be made only with your express written consent. If you provide us with permission to use or disclose your information, you may revoke that permission at any time in writing. If you revoke your permission, we will no longer use or disclose the information for the reason covered in your request. You understand that we cannot take back any disclosures we have already made and that we are required to retain our records of the services that we provided to you.