Rachel Krasner, LMSW
171 Village Parkway NE, Building 8A
Marietta, GA 30067
404-520-1762

Patient Registration Information

Patient Name: _____ Date: _____

Address: _____

City/State/Zip: _____

Phone Numbers: Home (_____) _____ Cell (_____) _____

Date of Birth: _____ Age: _____ Gender: _____

Grade: _____ School: _____

Referred by? _____ Relationship: _____

May we thank this person for referring you? Yes _____ No _____

For patients under 21 years of age, please provide information for reaching each parent/guardian

Mother's Name: _____ Best number to be reached at: _____

Father's Name: _____ Best number to be reached at: _____

Responsible Party: Self ____ Parent ____ Other ____

A treatment plan will be developed based on your assessments and goals you are committed to achieving. Please identify specific issues and goals you would like to address while working together.

_____

_____

_____

_____ _____ _____
Date Signed Client Signature Parent Signature/Legal Guardian

Therapist's Initials: _____

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Patient Confidentiality of Records

The confidentiality of patient records maintained by this therapist is protected by Federal law and regulations. Generally, the therapist may not say to another person that a client attends therapy and cannot disclose any information identifying the patient unless:

1) The patient consents in writing;
2) The disclosure is allowed by a court order; or
3) The disclosure is made to medical personnel in a medical emergency or to qualified personnel for research, audit, or program evaluation.

Violation of the Federal law and regulations by a program is a crime. Suspected violations may be reported to appropriate authorities in accordance with Federal regulations.

Federal law and regulations do not protect any information about a crime committed by a patient either at the program or against any person who works for the program or about any threat to commit such a crime.

Federal laws and regulations do not protect any information about suspected child abuse or neglect from being reported under State law to appropriate State or local authorities. Staff is required by law to report child or elder abuse to the Department of Family and Children Services without consent or authorization from the client.

See 42 U.S.C. 290dd-3 and 42 U.S.C. 290ee-3 for Federal laws and 42 C.F.R. Part 2 for Federal regulations. Approved by the Office of Management and Budget under control No. 0930-0099

Signature of Client _____ Date _____

Signature of Parent/Guardian is necessary: _____

Therapist's Initials: _____

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Informed Consent and Administrative Policies

Welcome. The following information is meant to inform you about my policies and my understanding of our professional relationship. Therapy is a relationship that requires open communication. If you have any questions about these or any other aspects of your psychotherapy, please feel free to bring them up at any time.

Professional Background and Philosophy:

I am a Licensed Master of Social Worker. I have a Master's degree in Social Work from the University of Georgia. I believe that all individuals and families have the capacity to thrive. It is a privilege to work with you in helping you do so. It is impossible to guarantee specific results regarding therapy. However, we will work together to achieve the best possible results for you. It is essential that you are actively involved in setting your goals.

Fee:

My regular fee is $215 per fifty-minute psychotherapy session, $130 per thirty-minute psychotherapy session, and $290 per the initial assessment/meeting. My fees are the same for individuals, couples and families. I do not charge for brief phone calls, but do charge for longer calls (5 minutes or more.) Fees for these calls will be charged to the credit card on file or will be due at the next appointment and are as follows: 5 minutes: $21.50, 10 minutes: $43.00, 15 minutes: $64.50, 20 minutes: $86.00, etc. – each minute equates to $4.30. If you are late for your appointment, that amount of time is deducted from our session. Payment is due in full at the time of service, unless prior arrangements have been made. At the end of each session, you will receive a receipt that you can submit to your insurance company for reimbursement. At this time, I am not associated with any insurance panels. I accept credit card (Visa, American Express, and Mastercard), check, or cash. If you choose to pay by check, please note that there is a $25 charge for any returned checks.

*Fee Increase: You will be given 2 months advance notice if I increase my fees.

If I am ever needed in court, you will be charged at my hourly rate for the day ($215 x 9 hours - $1,935) plus whatever the amount is of clients I am unable to move for the day to other places in the week – this could be anywhere between zero clients to nine clients; I will always do my best to move clients to other days in the week.

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Cancellations:

If you cannot keep your appointment time, please give me **at least 24 hours notice** so that I can make the time available for others. **If you cancel with less than 24 hours notice or you miss a scheduled appointment, you will be charged for that appointment**. If you are going to be more than 15 minutes late for your appointment, please let me know by calling **404-520-1762**. Please leave a message if you do not reach me directly. Otherwise, if you are more than 15 minutes late, I may assume you are not coming and may be unavailable. If this happens, you will still be charged for the missed appointment. Fees are not prorated if you are late.

Confidentiality & Exceptions:

Confidentiality is an essential part of the therapeutic process and is a commitment that I make to you. Consistent also with the mental health laws of Georgia, I will not release any information about you without your written consent. There are specific exceptions to the commitment of confidentiality:

- When I consult with other mental health professionals about our therapy - specific identifying information is not necessary in that instance.
- When I feel as though you are a threat to your own or someone else's safety.
- When a minor child is endangered by abuse or neglect.

In each of these instances, I will make every effort to speak with you before I speak with anyone else. If you are seeing another healthcare provider, it may at times be necessary to exchange information regarding your treatment. In those cases, you will be asked to complete an authorization to release information.

Please review the Notice of Privacy Practices provided to you as part of this new client information. It describes in more detail your rights with regard to Protected Health Information. By signing this Administrative Policies sheet, you are acknowledging your receipt of the Notice of Privacy Practices.

Communication and Emergency Contact: I do my best to return phone calls within 24 hours; however, occasionally there are unavoidable delays. Also, routine calls received after 6pm and on the weekends will be returned the next business day. If you need to speak with me immediately, please indicate so on my voice mail and I will make every effort to call you back as soon as I possibly can. In case of emergencies, dial 911.

Text Messaging and Emails

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While I do communicate via text and email, I will not have a therapeutic conversation using technology. If you decide to cancel an appointment within the 24 hour cancellation period, please wait for a confirmation from me to confirm your cancellation. **You will be charged for the appointment if you cancel with less than 24 hours notice.**

Termination:

If you decide that you would like to terminate our therapeutic relationship, I do request a termination session to discuss any feelings associated with termination. This session is intended to provide closure for both you and myself.

Please note that all initial paperwork must be redone if a year has passed since our last session.

Client Signature:

Your signature indicates that you have reviewed and understand this document, have had all questions answered to your satisfaction, and agree to adhere to the policies. A copy for your records has also been received.

_____ _____
Client Signature Date
(or signature of parent if client is a minor)

Therapist's Initials: _____

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Notice of Privacy Practices

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. WE HAVE A LEGAL DUTY TO SAFEGUARD YOUR PROTECTED HEALTH INFORMATION (PHI).

We are legally required to protect the privacy of your health information. We call this information "protected health information," or "PHI" for short, and it includes information that can be used to identify you that we've created or received about your past, present, or future health or condition, the provision of health care to you, or the payment of this health care. We must provide you with this notice about our privacy practices that explains how, when, and why we use and disclose your PHI. With some exceptions, we may not use or disclose any more of your PHI than is necessary to accomplish the purpose of the use or disclosure. We are legally required to follow the privacy practices that are described in this notice.

However, we reserve the right to change the terms of this notice and our privacy policies at any time. Any changes will apply to the PHI we already have. Before we make an important change to our policies, we will promptly change this notice and provide you with an updated copy.

HOW WE MAY USE AND DISCLOSE YOUR PROTECTED HEALTH INFORMATION.

We use and disclose health information for many different reasons. For some of these uses or disclosures, we need your prior consent or specific authorization. Below, we describe the different categories of our uses and disclosures and give you some examples of each category.

Uses and Disclosures Relating to Treatment, Payment, or Health Care Operations Require Your Prior Written Consent. We may use and disclose your PHI with your consent for the following reasons:

1. **For treatment.** We may disclose your PHI to physicians, nurses, medical students, and other health care personnel who provide you with health care services or are involved in your care. For example, if you require a special diet for an eating disorder, we may disclose your PHI to the food services department in order to coordinate your care.
2. **To obtain payment for treatment.** We may use and disclose your PHI in order to bill and collect payment for the treatment and services provided to you.

WHAT RIGHTS YOU HAVE REGARDING YOUR PHI

You have the following rights with respect to your PHI:

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A. **The Right to Request Limits on Uses and Disclosures of Your PHI**. You have the right to ask that we limit how we use and disclose your PHI. We will consider your request but are not legally required to accept it. If we accept your request, we will put any limits in writing and abide by them except in emergency situations. You may not limit the uses and disclosures that we are legally required or allowed to make.

B. **The Right to Choose How We Send PHI to You**. You have the right to ask that we send information to you to an alternate address (for example, sending information to your work address rather than your home address) or by alternate means (for example, e-mail instead of regular mail). We must agree to your request so long as we can easily provide it in the format you requested.

C. **The Right to See and Get Copies of Your PHI**. In most cases, you have the right to look at or get copies of your PHI that we have, but you must make the request in writing. If we don't have your PHI but we know who does, we will tell you how to get it. We will respond to you within thirty (30) days

after receiving your written request. In certain situations, we may deny your request. If we do, we will tell you, in writing, our reasons for the denial and explain your right to have the denial reviewed.

If you request copies of your PHI, we will charge you a base fee of $25.00. Each page after ten (10) pages will cost $.82 for each page. Instead of providing the PHI you requested, we may provide you with a summary or explanation of the PHI as long as you agree to that and to the cost in advance.

D. **The Right to Get a List of the Disclosures We Have Made**. You have the right to get a list of instances in which we have disclosed your PHI. The list will not include uses or disclosures that you have already consented to, such as those made for treatment, payment, or health care operations, directly to you, to your family, or in our facility directory. The list also won't include uses and disclosures made for national security purposes, to corrections or law enforcement personnel, or before April 14, 2003.

We will respond within thirty (30) days of receiving your request. The list we will give you will include disclosures made in the last six years unless you request a shorter time. 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. We will provide the list to you at no charge, but if you make more than one request in the same year, we will charge you $5.00 for each additional request.

E. The Right to Correct or Update Your PHI. If you believe that there is a mistake in your PHI or that a piece of important information is missing, you have the right to request that we correct the existing information or add the missing information. You must provide the request and your reason for the request in writing. We will respond within 60 days of receiving your request. We may deny your request in writing if the PHI is (i) correct and complete, (ii) not created by us, (iii) not allowed to be disclosed, or (iv) not part of our

records. Our written denial will state the reasons for the denial and explain your right to file a written statement of disagreement with the denial. If you don't file one, you have the right to request that your request and our denial be attached to all future disclosures of your PHI. If we approve your request, we will make the change to your PHI, tell you that we have done it, and tell others that need to know about the change to your PHI.

F. The Right to Get This Notice by E-Mail. You have the right to get a copy of this notice by e-mail. Even if you have agreed to receive notice via e-mail, you also have the right to request a paper copy of this notice.

HOW TO COMPLAIN ABOUT OUR PRIVACY PRACTICES

If you think that we may have violated your privacy rights, or you disagree with a decision we made about access to your PHI, you may file a complaint with the person listed in the paragraph below. You also may send a written complaint to the Secretary of the Department of Health and Human Services at Region IV, Office for Civil Rights, U.S. Department of Health and Human Services, Atlanta Federal Center, Suite 3B70, 61 Forsyth Street, SW., Atlanta, Georgia 30303-8909. Voice Phone (404) 562-7886; Fax (404) 562-7881; TDD (404) 331-2867; E-mail: OCRComplaint@hhs.gov. We will take no retaliatory action against you if you file a complaint about our privacy practices.

PERSON TO CONTACT FOR INFORMATION ABOUT THIS NOTICE OR TO COMPLAIN ABOUT OUR PRIVACY PRACTICES
If you have any questions about this notice or any complaints about our 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: Rachel Krasner, 171 Village Parkway NE, Marietta, GA 30067

Effective date of this notice: This notice went into effect on April 14, 2003.
By signing this document, you acknowledge that you are aware of your patient rights.

_____ _____
Patient Signature Date

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Credit Card Authorization Form

Admission into therapy with Rachel Krasner, LMSW requires that a credit card in good standing be left on file for automatic payment. For your protection this information will not be shared with anyone.

By signing this form, I authorize Rachel Krasner, LMSW to charge the credit card listed below for payment of therapy fees. I understand that my signature on this form will serve as authorized signature on the credit card charge slip. This authorization is valid until all fees are collected. I certify that I am authorized to use this credit card.

Rachel Krasner, LMSW will provide a receipt of transaction upon request. Fees will be submitted to Credit Card Company following each session.

Cardholder Information & Billing Address

Cardholder name		Telephone
Address		
City	State	Zip
Email		

Card Information

☐ MasterCard ☐ Visa ☐ American Express

_____

Credit Card Number

_____ _____

Expiration date Card Security Code*

*This three digit security code can be found in the signature box on the back of your card; for American Express it is the four digit code on the front of the card

Cardholder signature_____ Date _____

Therapist's Initials: _____

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AUTHORIZATION TO RELEASE INFORMATION

Client Name: _____

Birth Date: _____

I REQUEST AND AUTHORIZE Rachel Krasner, LMSW TO:

_____ Release To: _____ Request From:

_____
(Name)

_____
(Address)

_____
(City/State/Zip Code)

(PHONE) _____ (EMAIL) _____

Information released may include mental health privileged or confidential information, alcohol, drug or other treatment information. Certain communications are privileged and not subject to release without your consent under state and/or federal law.

After considering the above statement, I authorize Rachel Krasner, LMSW to furnish information regarding my treatment to the above person or organization. I also agree to hold harmless Rachel Krasner, LMSW from all liability that may arise from the release of information requested.

I understand that this authorization may be revoked by me at any time, except when information released in accordance with state or federal law.

_____ _____ _____
Date Signed Client Signature Parent Signature/Legal Guardian

Therapist's Initials: _____