

LUCY T. SMITH, PHD

CLINICAL PSYCHOLOGIST

Client Information Form

Date: _____

Name: _____ Age: _____ DOB: _____

Address: _____

Street

Apt

City

State

Zip

Phone: Home _____ Is it okay to leave a message? No Yes

Cell _____ Is it okay to leave a message? No Yes

Work _____ Is it okay to leave a message? No Yes

E-mail: _____ Gender: _____ Ethnicity/Race: _____

Marital/Relationship Status: Single Married Partnered Separated Divorced Widowed Other: _____

Children (list name/age of each): _____

Who do you currently live with? _____

Religious Affiliation/Spirituality: _____

Education Information:

If not currently in school, what is your highest level of education: _____

If currently in school:

School Name: _____ Major: _____

Class: Freshman Sophomore Junior Senior 5th Year Graduate

School Status: Full-time Part-time Continuing Education

Employment Information:

Employment: Full-time Part-time # Hours/Week: _____

Occupation/Employer: _____

Other Health/Service Providers (e.g., Primary Care Physician, Psychiatrist, Therapist, Dietician, etc.):

Name: _____ Provider Role: _____ Phone: _____

Name: _____ Provider Role: _____ Phone: _____

Name: _____ Provider Role: _____ Phone: _____

Emergency Contacts:

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

Prior Mental Health Treatment:

Have you ever been hospitalized for a psychological or psychiatric issue? YES NO

If yes, please describe:

Have you ever received treatment for mental health or substance use concerns? YES NO

If yes, please provide dates, type of treatment, provider information, duration, and helpfulness below.

Any history of suicidal thoughts or attempts? YES NO

If yes, when?

Medical History:

When was your most recent physical exam? _____ Allergies: _____

Please list all current medications: _____

Significant medical concerns or conditions:

History of head injury, seizures, or loss of consciousness?

Legal History:

Have you ever been arrested or convicted of a legal violation? YES NO

If yes, please describe:

Referral Source:

Referred to Dr. Lucy Smith by: _____

May I contact your referral source to acknowledge the referral? YES NO

Reason for Visit:

What are the main reasons you are seeking treatment? Please check all that apply.

- | | | |
|--|---|---|
| <input type="checkbox"/> Sadness/Depression | <input type="checkbox"/> Hopelessness | <input type="checkbox"/> Perfectionism |
| <input type="checkbox"/> Anxiety/Worry | <input type="checkbox"/> Irritability | <input type="checkbox"/> Eating/Weight Concerns |
| <input type="checkbox"/> Fear | <input type="checkbox"/> Anger | <input type="checkbox"/> Overexercise |
| <input type="checkbox"/> Stress | <input type="checkbox"/> Low Self-Esteem | <input type="checkbox"/> Body Dissatisfaction |
| <input type="checkbox"/> Physical Symptoms | <input type="checkbox"/> Sleep Difficulties | <input type="checkbox"/> Obsessions/Compulsions |
| <input type="checkbox"/> Grief/loss | <input type="checkbox"/> Suicidal Thoughts | <input type="checkbox"/> Panic attacks |
| <input type="checkbox"/> Work/School Difficulties | <input type="checkbox"/> Self-Harm | <input type="checkbox"/> Loneliness/Isolation |
| <input type="checkbox"/> Relationship Difficulties | <input type="checkbox"/> Thoughts of Harming Others | <input type="checkbox"/> Impulsiveness |
| <input type="checkbox"/> Traumatic Experience | <input type="checkbox"/> Sexual Difficulties | <input type="checkbox"/> Identity Concerns |
| <input type="checkbox"/> Self-acceptance | <input type="checkbox"/> Alcohol or Substance Use | <input type="checkbox"/> Fatigue |
| <input type="checkbox"/> Other: _____ | <input type="checkbox"/> Worthlessness or Guilt | <input type="checkbox"/> Trouble Concentrating |

LUCY T. SMITH, PHD

CLINICAL PSYCHOLOGIST

12830 Hillcrest Rd, D-114 ▪ Dallas, TX 75230 ▪ 972-386-0511 ▪ lucy@drlucysmith.com

Psychological Services Agreement

Welcome to my private practice. This document contains important information about my professional services and business policies. Please read it carefully and write down any questions you might have so that we can discuss them at our next meeting. When you sign this document, it will represent an agreement between us.

PSYCHOLOGICAL SERVICES

I believe psychotherapy to be a collaborative journey between therapist and client. The therapeutic relationship is essential. Therapy involves a large commitment of time, money, and energy, so it is important that you feel comfortable with the person you select as your therapist. I strive to develop a collaborative partnership characterized by warmth, openness, authenticity, and a nonjudgmental stance. You are a very important and active part of the therapeutic process.

My Orientation

I tend to employ an integrated theoretical orientation, comprised primarily of cognitive-behavioral (CBT), insight-oriented, and experiential perspectives. I believe that individuals are complex and multifaceted beings and that psychological problems are best conceptualized on multiple levels. CBT most strongly targets thoughts and behaviors, insight-oriented processes target increased understanding and insight, and experiential strategies target emotions and body connection. This holistic approach allows for flexibility and thoroughness in working with individuals.

Benefits and Risks of Therapy

Psychotherapy can have benefits and risks. Since therapy often involves discussing unpleasant aspects of your life, you may experience uncomfortable feelings like sadness, guilt, anger, frustration, loneliness, and helplessness. It is normal for people to feel worse before they feel better. Therapy is undoubtedly hard work and is truly a process – it is hard to predict how quickly it will “work” or what specific effects it will have. However, psychotherapy has also been shown to have benefits for people who go through it. Therapy often leads to reduced stress and anxiety, improved self-esteem, better relationships, solutions to specific problems, and significant reductions in feelings of distress. It is important to note that there are no guarantees of what you will or will not experience.

Appointments

Your appointment time is reserved for you. Therapy sessions normally last 45-50 minutes, and we normally meet 1x/week. Sessions may be longer or more frequent if we decide this would be useful for you. In addition, sessions may occur less frequently (every 2-4 weeks) as we near the end of treatment. Regular attendance is recommended to ensure continuity and to enhance the effectiveness of therapy.

Cancellation Policy and Charge for Missed Appointments

I ask for 48 hours notice if you need to cancel or reschedule your appointment. **I charge the regular fee for clients who miss appointments or who cancel appointments with less than 48 hours notice.**

Charge for Phone Consultations

There is a charge at the agreed upon session fee for all phone conversations that exceed ten minutes. The charge is pro-rated.

Telephone Accessibility and Emergencies

I monitor my messages frequently and will make every effort to return your call within 24 hours of when you make it. If you are difficult to reach, please leave me some times when you will be available. **Should you have a true clinical emergency that requires immediate attention or action, you will need to call 911 or go to the nearest emergency room.** If I will be unavailable for an extended time, I will provide you with the name of a colleague to contact, if necessary.

Other Forms of Communication

At times clients prefer to communicate between sessions via e-mail or text messaging. This information exchange generally involves logistical matters such as scheduling and appointment changes. It might also be used for scheduled, brief check-ins during the week (e.g., regarding homework assignments). **E-mail or text messaging should not be used as a means to contact me in an emergency.** In addition I do not conduct therapy via e-mail or text messaging. These mediums are less secure; therefore privacy and confidentiality may be compromised. *Please see the Communications and Social Media Policy for more information.*

Professional Fees and Payments

My standard fee for psychological services is \$200.00 per 45/50-minute session. This fee covers telephone consultations with other professionals, such as dietitians, physicians, and psychiatrists. In addition to psychotherapy sessions, I charge this amount for other services you may need or request, such as report writing, telephone conversations lasting longer than 10 minutes, session time beyond the standard 45/50 minutes, preparation of records or treatment summaries, and any other service you may request of me. Fees for these services are prorated based on your normal session fee.

Payment is due in full at each session. For your convenience, I accept cash, checks, or credit cards. **There will be a \$30 administrative fee for all returned checks.** If your account has not been paid for more than 60 days and arrangements for payment have not been agreed upon, I reserve the option of using legal means to secure the payment. This may involve hiring a collection agency or going through small claims court. In most collection situations, the only information I release regarding a patient's treatment is his/her name, the nature of services provided, and the amount due. If such legal action is necessary, its costs will be included in the claim. By signing this agreement, you authorize me to employ the services of an outside collection agency or attorney to seek payment of all unpaid fees.

Legal action

If legal actions occur in which I am requested or subpoenaed to provide testimony (either by you or another party), you will be responsible to pay me directly for the following services: (a) the time spent preparing for court, (b) the time spent for transportation to/from court, and (c) the time spent in court. Because of the difficulty of legal involvement, I charge **\$400.00 per hour** for preparation and attendance at any legal proceedings. Payment for the estimated number of hours is due 10 days prior to the court date and must be paid in the form of a cashier's check.

Insurance and Managed Care

If you have insurance coverage and plan to file for reimbursement, you will be given a detailed statement that contains my provider information and your relevant diagnostic code(s). The statement may then be attached to one of your insurance claim forms, which you may file for reimbursement. If you are relying on your insurance company to reimburse you for part or all of the charges for therapy, it is important that you have thoroughly reviewed and understand your insurance company's reimbursement policies, the amount of your deductible, the percentage your company will reimburse you for outpatient psychotherapy, and any limitations to treatment that may be a dimension of your policy. The contract for reimbursement is between you and the insurance company, rather than between the insurance company and me.

Client Rights

You have several important rights as a client.

1. You have the right to ask questions about the process and course of therapy.
2. You have the right to voice any concerns or complaints about our work together. I truly welcome your feedback directly. In addition, you are welcome to contact the Texas State Board of Examiners of Psychologists with any concerns about unethical or unfair treatment by me or any other psychologist. My Texas license number is 34601.
3. You have the right to decide not to receive therapeutic assistance from me. If you wish, I will provide you with the names of other qualified professionals whose services you might prefer.
4. You have the right to end therapy at any time. I ask you to contact me by phone or in person to let me know of your decision. And if possible, it is often helpful to discuss this decision within the context of therapy to process the closure of our relationship.
5. You 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.

Confidentiality

In general, law protects the privacy of all communications between a patient and a psychologist, and I can only release information about our work to others with your written permission. But there are a few exceptions:

1. Instances of active or suspected abuse (physical, emotional, or sexual) or neglect of a child, an elder, or a dependent adult must be reported to the appropriate protective services.
2. If I believe that a client is threatening serious bodily harm to another, I may be required to take protective actions. These actions may include notifying the potential victim, contacting the police, or seeking hospitalization for the patient.
3. If a client reveals a serious intent to harm himself/herself, I am ethically bound to take steps to help maintain his/her safety. I may be obligated to seek hospitalization for the client or to contact family members or others who can help provide protection.
4. If a judge orders my testimony/records or, in the context of a legal proceeding, a client raises his/her own psychological state as an issue, I may be required to release the client's confidential information to the court.
5. When a client reports that a previous counselor or therapist has sexually abused the client, the current psychologist has a legal duty to report that abuse to the proper authorities. Such a report need not include the client's name.
6. I may occasionally find it helpful to consult other professionals about a case. During a consultation, I make every effort to avoid revealing the identity of my client. The consultant is also legally bound to keep the information confidential. If you don't object, I will not tell you about these consultations unless I feel that it is important to our work together.

Professional Records

The laws and standards of my profession require that I keep treatment records. These records include information about your reasons for seeking treatment, relevant diagnoses, treatment goals, progress towards those goals, medical and social history, treatment history, any past treatment records I receive from other treatment providers, documentation of any professional consultations, billing records, and copies of any professional documents generated during the course of treatment (e.g., informed consent forms, release of information forms, letters sent at your request). Except in unusual circumstances that involve danger to yourself and/or others, you may examine and/or receive a copy of your clinical record if you request it in writing. Because these are professional records, they can be misinterpreted and/or upsetting to untrained readers. I recommend that you review them in my presence so that we can discuss the contents or that you have them forwarded to another mental health professional. Patients will be charged an appropriate fee for any professional time spent in responding to information requests.

Minors and Parents

Patients under 18 years of age who are not emancipated should be aware that the law may allow parents to examine their child's treatment records. Privacy in psychotherapy is often critical to building rapport with the therapist, and this therapist-client rapport is crucial for successful progress. Because of this, when working with adolescents, I will discuss beforehand with the client and his/her parents the nature of our communication and how confidentiality will work in our relationship. Typically, I will provide parents with general information about treatment progress, and I wholeheartedly welcome parents' feedback and insight regarding their adolescent. I immediately inform parents of serious safety issues (if the adolescent is in imminent danger of harming himself/herself or someone else) or issues related to abuse. Other than the above-stated topics, I protect the confidentiality of the adolescent with whom I am working. *Please see the Parent Agreement for Therapy with Children and Adolescents for additional information about my guidelines in working with minors.*

Consent for Services

Please initial by each item below.

- _____ I understand the nature of the proposed treatment, and I give my informed consent for psychological treatment by Lucy Smith, PhD.
- _____ I understand that the fee for service is \$200 per 45-50 minute therapy hour.
- _____ I understand that the counseling session is 45-50 minutes in length.
- _____ I agree to pay for any missed appointments or late cancellations. To avoid a fee, please give at least 48 hours advanced notice if you need to cancel or reschedule an appointment.
- _____ I agree to pay for any phone conversations that exceed 10 minutes. I understand that the fee will be prorated based on my normal session fee. I also agree to pay for other services I might need or request, such as report writing, session time beyond the standard 45/50 minutes, and preparation of records or treatment summaries. I understand that fees for these services will be prorated based on my normal session fee.
- _____ I understand that if I am experiencing a medical or psychiatric emergency, I have been advised to dial 911 or go to the nearest emergency room, and I agree to abide by these instructions.

I have read and understand the contents of this Psychological Services Agreement. My questions about these policies have been answered. I agree to the professional and financial terms described above, as indicated by my signature below.

Signature of Client or Authorized Representative

Date Signed

Printed Name of Client or Authorized Representative

LUCY T. SMITH, PHD

CLINICAL PSYCHOLOGIST

12830 Hillcrest Rd, D-114 ▪ Dallas, TX 75230 ▪ 972-386-0511 ▪ lucy@drlucysmith.com

Credit Card Authorization Form

Dr. Lucy Smith requires that all clients keep an active credit card on file. This payment method will be used in the following situations:

Regardless of payment preferences outlined below, I authorize Lucy T Smith, PhD to charge the credit card on file in the following situations (*please initial by each item below*):

- _____ If I do not show up for a scheduled session (fee charged at the time of the session).
- _____ If I forget payment in the form of cash or check (fee charged at the time of the session).
- _____ If I cancel my appointment with less than 48-hours notice (fee charged at the time of late cancellation).
- _____ To pay for other services you may need or request, such as report writing, telephone conversations lasting longer than 10 minutes, session time beyond the standard 45/50 minutes, and preparation of records or treatment summaries. Fees for these services are prorated based on your normal session fee.

I prefer to (*please check one*):

- Pay at the time of each session with this credit card.
- Pay at the time of each session via cash or check.

CREDIT CARD INFORMATION:

Credit Card Type: Visa MasterCard Discover American Express

Account Number: _____ - _____ - _____ - _____

Cardholder's Name (as it appears on card): _____

Exp. Date: _____ CVV2 (3 or 4 digit code on back): _____ Billing Zip Code: _____

Cardholder Signature

Date Signed

Client Name

LUCY T. SMITH, PHD

CLINICAL PSYCHOLOGIST

12830 Hillcrest Rd, D-114 ▪ Dallas, TX 75230 ▪ 972-386-0511 ▪ lucy@drlucysmith.com

Communications and Social Media Policy

This document outlines my office policies related to communications and the use of Social Media. Please read it to understand how I conduct my practice, how I conduct myself on the Internet as a mental health professional, and how you can expect me to respond to various interactions that may occur between us via electronic means.

If you have any questions about anything within this document, I encourage you to bring them up when we meet.

COMMUNICATIONS

Communication in the Therapy Relationship

The main form of communication in our work together is face-to-face communication during our therapy sessions. However, it may become useful during the course of treatment to communicate by phone, email, text message (e.g., "SMS"), facsimile, or other electronic methods of communication. Be informed that these methods, in their typical form, are not confidential means of communication. If you use these methods to communicate with me, there is a reasonable chance that a third party may be able to intercept and eavesdrop on these messages. The kinds of parties that may intercept these messages include, but are not limited to:

- People in your home or other environments who can access your phone, computer, or other devices that you use to read and write messages. (In addition, such devices might also store records of your phone calls and voicemail messages.)
- Your employer, if you use your work email to communicate with me.
- Third parties on the Internet such as server administrators and others who monitor Internet traffic.

Communications Policies

- I respond to emails, text messages, and phone calls as soon as possible. My response time is typically faster for emails and text messages. I typically respond to all communication within 24-hours of receipt during normal business hours.
- All electronic communication will become a part of your medical record.
- Electronic communication is best used for administrative purposes (i.e., appointment scheduling, billing). It is typically more helpful to communicate about clinical issues during our scheduled session times. If something arises between sessions, please feel free to contact me to set up a time to discuss in person or over the phone.
- Sometimes when working with adolescents, parents will send me periodic emails with clinically relevant information that they want to share with me. This can be helpful as a time effective and convenient way to relay information to me. However, please be aware that if you choose to send such clinical information via unsecure electronic means, there is always the risk of your privacy being breached. In addition, I tend to respond to such messages solely with an acknowledgement that I received the information. If you instead desire to have a more in-depth conversation about such clinical issues, please contact me to schedule an appointment.
- **If you have a crisis or emergency, you may call me or send me an email or text message. However, you should also call 911 or go to the nearest emergency room.**
- All faxes sent to my office are received as e-faxes, which make them vulnerable to the same potential breaches in security as email and text messages.
- Your email/text communication will not be forwarded to a third party without your expressed permission, unless you have already signed a release for me to communicate with a professional or unless required by law.

SOCIAL MEDIA POLICY

Friending

I do not accept friend or contact requests from current or former clients on any social networking site (Facebook, LinkedIn, etc.). I believe that adding clients as friends or contacts on these sites can compromise your confidentiality and our respective privacy. It may also blur the boundaries of our therapeutic relationship. If you have questions about this, please bring them up when we meet and we can talk more about it.

Following

I do not follow current or former clients on blogs or Twitter. My reasoning is that I believe casual viewing of clients' online content outside of the therapy hour can create confusion in regard to whether it's being done as a part of your treatment or to satisfy my personal curiosity. In addition, viewing your online activities without your consent and without our explicit arrangement towards a specific purpose could potentially have a negative influence on our working relationship. If there are things from your online life that you wish to share with me, please bring them into our sessions where we can view and explore them together, during the therapy hour.

Use of Search Engines

It is NOT a regular part of my practice to search for clients on Google or Facebook or other search engines. Extremely rare exceptions *may* be made during times of crisis. If I have a reason to suspect that you are in danger and you have not been in touch with me via our usual means (coming to appointments, phone, or email) there *might* be an instance in which using a search engine (to find you, find someone close to you, or to check on your recent status updates) becomes necessary as part of ensuring your welfare. These are unusual situations and if I ever resort to such means, I will fully document it and discuss it with you when we next meet.

Location-Based Services

If you use location-based services on your mobile phone, you may wish to be aware of the privacy issues related to using these services. I do not place my practice as a check-in location on various sites such as Foursquare, Gowalla, Loopt, etc. However, if you have GPS tracking enabled on your device, it is possible that others may surmise that you are a therapy client due to regular check-ins at my office on a weekly basis. Please be aware of this risk if you are intentionally "checking-in" from my office or if you have a passive LBS app enabled on your phone.

Business Review Sites

You may find my psychology practice on sites such as Yelp, Healthgrades, Yahoo Local, Bing, or other places which list businesses. Some of these sites include forums in which users rate their providers and add reviews. Many of these sites comb search engines for business listings and automatically add listings regardless of whether the business has added itself to the site. If you should find my listing on any of these sites, please know that my listing is NOT a request for a testimonial, rating, or endorsement from you as my client. The American Psychological Association's Ethics Code states under Principle 5.05 that it is unethical for psychologists to solicit testimonials: "Psychologists do not solicit testimonials from current therapy clients/patients or other persons who because of their particular circumstances are vulnerable to undue influence." Of course, you have a right to express yourself on any site you wish. But due to confidentiality, I cannot respond to any review on any of these sites whether it is positive or negative. I urge you to take your own privacy as seriously as I take my commitment of confidentiality to you.

You should also be aware that if you are using these sites to communicate indirectly with me about your feelings about our work, there is a good possibility that I may never see it. If we are working together, I hope that you will bring your feelings and reactions to our work directly into the therapy process. This can be an important part of therapy, even if you decide we are not a good fit. None of this is meant to keep you from sharing that you are in therapy with me whenever and with whomever you like. Confidentiality means that I cannot tell people that you are my client and my Ethics Code prohibits me from requesting testimonials. But you are more than welcome to tell anyone you wish that I am your therapist or how you feel about the treatment I provide to you, in any forum of your choosing. If you do choose to write something on a business review site, I hope you will keep in mind that you may be sharing personally revealing information in a public forum. I urge you to create a pseudonym that is not linked to your regular email address or friend networks for your own privacy and protection.

Consent for Transmission of Protected Health Information by Non-Secure Means

I consent to allow Dr. Lucy Smith to use unsecured email and mobile phone text messaging to transmit to me the following protected health information:

(Please initial each that you are consenting to.)

- _____ Information related to the scheduling of sessions or other appointments.
- _____ Information related to billing and payment.
- _____ Referral information when relevant.
- _____ Responses to email or text messages that I sent to Dr. Smith of my own accord.
- _____ Brief clinical information or updates that Dr. Smith feels is better communicated in writing (for reasons of either clarity or convenience).

In addition, I offer automated appointment reminders that can be sent via email or text message 48-hours prior to your scheduled appointment time. These messages are sent via unsecure methods so have the same potential risks as outlined above. If you would like to receive these reminder notifications, please initial below (you can select either email or text messaging or both options):

- _____ I would like to receive appointment reminders via email. Please use the following email address:

- _____ I would like to receive appointment reminders via text messaging to the following cell phone number:

- _____ None of the above. I will remember my appointments on my own.

I will be making use of some of the wonderful features included in the client portal of the electronic medical record system I use in my practice. Here are some of the great options that will be available to clients who create an account on this system:

- Ability to schedule appointments directly online
- Access to view and print your invoices
- Secure online messaging

If you would like to take advantage of this online system, please provide an email address you would like to use to set up an account, and I will send you a welcome letter through the system:

Email address: _____

I have been informed of the risks, including but not limited to my confidentiality in treatment, of transmitting my protected health information by unsecured means. I understand that I am not required to sign this agreement in order to receive treatment. I also understand that I may terminate this consent at any time. I also express understanding of Dr. Smith's policies regarding Social Media.

Signature of Client or Authorized Representative

Date Signed

Printed Name of Client or Authorized Representative

LUCY T. SMITH, PHD

CLINICAL PSYCHOLOGIST

12830 Hillcrest Rd, D-114 ▪ Dallas, TX 75230 ▪ 972-386-0511 ▪ lucy@drlucysmith.com

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, 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.

You may revoke all such authorizations of PHI 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.

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 contact The Texas State Board of Examiners of Psychologists at 512-305-7700.

You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services. This address can be provided upon request.

I reserve the right to change the terms of this notice and to make the new notice provisions effective for all PHI that I maintain. I will provide you with a revised notice by verbal or written communication.

LUCY T. SMITH, PHD

CLINICAL PSYCHOLOGIST

12830 Hillcrest Rd, D-114 ▪ Dallas, TX 75230 ▪ 972-386-0511 ▪ lucy@drlucysmith.com

Patient Name: _____

Parent Name: _____
(if applicable)

Address: _____

Notice of Privacy Practices Acknowledgment of Receipt Form

Your signature below indicates that you have received a copy of the Notice of Privacy Practices. If you have any questions about the Notice of Privacy Practices, please ask Lucy T. Smith, PhD.

Client Signature

Date

OR

Parent Signature

Date

OR

Legal Guardian Signature

Date

Legal Guardian Relationship to Patient