Identifying Information, Informed Consent, and Notice of Privacy Practices

Jeffrey Young, PHD, CBSM
Psychologist (PSY 15577)
Sleep, Mood, & Anxiety Disorders
16550 Ventura Boulevard Suite 405
Encino, California 91436
Tel: 818-905-7121
Fax: 818-453-8961
j.young@ucla.edu
www.behavioralsleepmedicine.com
Assistant Clinical Professor (vol), UCLA Department of Psychiatry & Biobehavioral Science
Clinical Supervisor, USC Department of Clinical Psychology/Clinical Science
Certified in Behavioral Sleep Medicine by the American Academy of Sleep Medicine (136)

Welcome to my practice!

Below you will find an outline of important information that relates to the professional practice of psychology. I realize that reading through this very detailed material with its legalistic tone can be a bit tedious; however, it is in your best interest to have a good understanding of both the legal and ethical elements that guide the practice of professional psychology before beginning the assessment and treatment process.

It is useful to point out that any licensed health clinician is subject to the rules and guidelines that you will read about below. This is to say that there is nothing here that is outside the norm. However, because psychologists and other mental health professionals are likely to work with more sensitive and private information, we work to outline these points in much greater detail than what you might find in other health specialties.

Please make note of all the areas where you are asked to either **Initial or Sign.** Your initial or signature indicates your understanding and agreement.

Additionally, you should feel free to leave any portion of this form unsigned or any portion of any attached questionnaires blank, should you want additional clarification from me of any questions or concepts.

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Today's Date _____

Name _____

Date of Birth/Age _____

Driver's License/ID No. _____

Insurance Company: _____
Please have your insurance card and Photo ID with you so that I can make a copy for your records

Address (where confidential clinical or billing information can be sent)

_____

Phone Numbers (for each number please indicate **Cell, Home, or Work** and if a message can be left with either a person who may answer or on voice mail): Identify the **Best Number**.

_____

_____

_____

Reason for seeking Treatment _____

_____

Please list below other clinicians who are currently involved in your healthcare.

Psychologist: Name, City, State, and Phone

_____

Primary Care Physician: Name, City, State, and Phone

_____

Psychiatrist: Name, City, State, and Phone

_____

Who referred you to my office? Name, City, State, and Phone

_____

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General Principles of Nature of Psychotherapy and Psychological Assessment

Psychotherapy is a collaborative process that is designed to help relieve psychological/emotional distress, improve behavioral functioning, and improve overall life satisfaction. Collaborative here means that we are both involved in the process of deciding a best course of action and that your input and your participation in the work is essential to getting the best results. You should understand that my role as your psychologist is not to necessarily push you in one direction versus another but to help increase your level of clarity around the issues you present so that you can make more effective decisions.

Although my approach to psychotherapy is informed by many schools of thought, the primary modality I use is called Cognitive-Behavioral Therapy which is often referred to as CBT. Simply put, CBT examines your thoughts and behaviors, your assumptions about yourself, others, and the world. Its aim is to understand how these factors influence your how you feel and behave. CBT also provides strategies to help you more effectively navigate the problems you are having. CBT is a very well researched and highly regarded form of psychotherapy and is used by many clinicians to help people with depression, anxiety, stress, sleep, and relationship difficulties.

Psychotherapy can be a very enjoyable process which can ultimately lead to substantial improvements in functioning and life satisfaction. However, there are some risks involved: These risks include experiencing periodic increases in sadness, anger, frustration, guilt, or may involve your deciding to alter the nature of the relationships you have with others or, perhaps, even to terminate these relationships which may then carry its own set of risks and benefits.

Additionally, while I maintain that there is every reasonable expectation that you can be helped by our work together (e.g., improved mood or sleep, maintenance of a level of functioning through continuous support), I cannot guarantee that you will ultimately benefit from treatment. To this point, we will be discussing, as indicated, your experience of therapy and my approach to make sure that you are getting what you want from treatment. **If you are feeling stuck in some way and not feeling that you are making the kind of progress you want, you should always feel free to discuss this with me**. We will address this concern by discussing our therapy process together. Similarly, if I feel that progress is not being made, I will address this concern with you as well. In either case, this may involve a decision to shift my approach with you or may involve exploring whether another clinician might be of greater help to you.

You should be aware that in addition to CBT psychotherapy, other forms of treatment do exist. This would include other forms of psychotherapy as well as psychotropic medications (e.g., Antidepressants). I understand that Dr. Young will advise me regarding these options, if indicated, and will make appropriate referrals, if needed. I do not prescribe medications or recommend or supervise the use of over the counter preparations. While I might have substantial scientific knowledge of many of these biological preparations, and will gladly discuss what I know, any direct advice must come from a licensed prescriber and you should rely on his or her expertise when deciding whether to start, stop, or modify any biological preparation.

Finally, you should know that you have no obligation to take any psychological tests that you may find uncomfortable and that you have no obligation to answer any questions that you do not feel comfortable answering. You also may end or suspend your treatment at any time without concern.

My Signature below affirms my understanding and acceptance of the above.

_____

Name (Print) ***Signature*** ***Date***

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Privacy Practices (Effective Date April 14, 2003)-HIPAA and Confidentiality Limits

The confidentiality of your records is closely safeguarded and protected in accordance with the standards set forth by The Health Insurance Portability and Accountability Act of 1996 (**HIPAA**) and general ethical practice principles.

In the majority of cases no one but you or I, or other professionals involved in your care, will have access to your Protected Health Information (PHI).

However, there are some **exceptions** that allow me to release your PHI to concerned parties (e.g., police & other government agencies, hospitals, family members, attorneys/judges) without your prior consent. Conditions meeting these standards include:

**You pose a danger to yourself or others (e.g., suicide, physical harm to identifiable party) _____Initial

**You become gravely disabled (e.g., severely impaired judgment/basic survival impaired)_____Initial

There is a reasonable suspicion that you are either a victim or perpetrator of Child, Dependent Adult, or Elder abuse (abuse can be physical, severe emotional, or financial). Most recently, ***knowingly* streaming child pornography from the internet or possessing child pornography is now reportable _____Initial

**Valid Subpoenas for records and/or testimony. A request made by a Judge. A request by the Federal Government under Patriot or Freedom Act (if still enacted) _____ Initial

**I am also aware that if I enter my psychological status as an issue in a legal proceeding, the right to the confidentiality of this relationship may have been waived in so doing. _____Initial

**Health Oversight: If a complaint is filed against me with the California Board of Psychology, the Board has the authority to subpoena confidential mental health information from me relevant to that complaint. _____ Initial

Additionally

**I understand that I have the right to inspect, amend, and receive copies of my PHI. _____ Initial

**I understand that I may complain about the use of PHI to either the Department of Health & Human Services and/or California Board of Psychology _____ Initial

**I also acknowledge that once PHI is handed over to you or to another party you authorize that Dr. Young cannot control the extent to which your PHI is safeguarded by that party. _____ Initial

Please note that Dr. Young will always strive to give only the minimum necessary amount of information to any party so as to satisfy the specific needs of that party and I will always attempt to contact you directly before complying with any valid request to ensure that you are aware that a request has been made (contacting you may be prohibited under the patriot/freedom act).

_____

Name (Print) *Signature* *Date*

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Contact with your referring clinician and other clinicians involved in your care.

This might be another psychologist who is treating you for another problem, or a physician prescribing medication. I understand that Dr. Young will wish to speak with these clinicians and your referring clinician as needed to properly coordinate care (this may involve sending a written report). If you have any concern with me speaking to any clinician you may identify as providing treatment, please let me know and we will discuss it. _____Initial

Contact with persons who are outside your professional care.

Unless the circumstance is covered by state law and/or covered in the HIPPA section, OR you have signed a release or given verbal consent:
I cannot give out any information or even confirm or disconfirm that you are a patient even if this person is a family member, spouse/partner, or is paying for your treatment. _____ Initial

Contact Person in Case of Emergency

Emergency Contact (Name, Phone, Relationship).

_____

I understand that the emergency contact you have identified will only be used in an emergency or at a time when I feel you might be in some danger. The information I share in this circumstance would be limited to only that which is necessary to resolve the situation _____ Initial

Contact with Persons or Entities with whom I have a Business Associates Agreement

Dr. Young will ensure that any person or business entity that might have access to any of your health information will have signed a **Business Associates Agreement**. Doing so obligates that person or entity to maintain the security and confidentiality of your health information in accordance with HIPPA regulations. For example, my Electronic Health Record system (Office Ally) has signed a business associates agreement. _____ Initial

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Record Keeping

Legal and Ethical standards require me to keep a formal written record of the care provided to you and to safeguard that record within the limits of the law.

Your record (PHI) may include but is not limited to:

Notes on your reported history (Psychological, Medical, Social), assessment forms, treatment plan, progress in treatment, consults and reports from other clinicians, relevant email and phone contacts between you and me, your descriptions of life stressors and reactions to them. Not every record will necessarily contain all of these elements. Generally, I try to maintain records that give at the very least a general sense of the problem worked on, progress, and any revision to the general treatment plan. I may or may not formally include a psychiatric diagnosis in your record even though diagnostic possibilities may be documented. _____Initial

I understand that Dr. Young uses a **HIPAA compliant Electronic Health Record** system that is provided by the company, **Office Ally**. I have a **Business Associates Agreement with Office Ally**. All or parts of your health record will be transmitted and stored in an encrypted and secure state on this system. Some parts of your record may be stored in traditional paper files which are under lock and key or as an encrypted file (a file deemed unable to be readable) on my computer. _____Initial

I understand that Dr. Young may change his record keeping practices without notice (for example, changing health record companies) but that any change will comply with the highest standards as prescribed by law and ethics _____Initial

Audio or Video Recordings of Sessions

Audio and/or Video recordings of sessions constitutes a record of sorts and is prohibited by office policy and state law ***unless there is mutual written consent***. I (Dr. Young) and you (or persons you authorize as adjuncts to your treatment-family members attending a session, for example) are not allowed to make Audio and/or Video recordings of sessions that take place in the office or by phone unless there is a mutual written consent agreement. _____ Initial

Use of Email/Text to Communicate with me and/or other Clinicians

At this point, I do not have the HIPPA compliant email or texts which limits their confidentiality. I prefer, at this point, to have confidential information left on my office line 818-905-7121 and to send and receive information such as reports via fax (818-453-8961). Please do not text as I do not look at texts routinely._____ Initial

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My Availability

My time for in-office appointments and phone sessions can vary during the week depending upon what obligations I have scheduled out of the office (e.g., teaching schedule). However, I do make every effort to see you at a time most convenient for you.

I do check phone messages often and can typically get back to you within a few hours, if not sooner. However, because I do not have a live person 24 hour answering service, I cannot guarantee that I can get back to you immediately if an emergency situation were to arise. As such, if you find that you are faced with a psychological and/or medical emergency, please call **911 or go to your Nearest Emergency Room**. Then, as soon as feasible, you, a trusted person, or a medical staff member should call me and leave a message.

If I plan to be away for an extended period of time such that I will not be able to respond to calls, I will arrange to have a licensed colleague available for you to call, if needed.

If you call me, and do not hear back within 24 hours, please contact me again -- not all messages get through for various reasons (typically calls get dropped or are unreadable).

I acknowledge and understand Dr. Young's availability and its limits _____Initial

Fees are as follows:

$200.00 for a 1.5 hour Initial Evaluation Session _____ Initial
$150.00 for a 60 minute Follow-Up session (Regular/Minimum hourly Fee) _____ Initial
These fees are also applied to sessions done by phone

Fees are due at the end of each session and can be paid using cash or check.

Cancellations: Please give at least 24 hours in advance or a full charge may be made. Typically, no charge is made if the appointment is made up within a week's time. _____Initial

Legal Work: If Dr. Young needs to be involved in a legal proceeding the fee for those services (if applicable by law) will be negotiated at that time and will likely be at minimum $300.00/Hour for any work performed. The reason for this higher fee is that legal work often leads to a significant disruption of practice (e.g., being in court instead of office). You should know that I do not become involved in or have the proper training to participate in child custody matters.
Also, please let me know now, if you are currently involved or expect to be involved in a lawsuit or other legal matter which might require or compel me to deliver testimony and records or create a report on your behalf. Also, let me know now if a child custody issue is active or pending. I ask this so that we can have a clear understanding of what is at issue from the outset and have an opportunity to discuss the matter before assessment or treatment begins. _____Initial

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Use of Insurance/Third Party Payment

I understand that Dr. Young does not work directly with any insurance companies other than **UCLA Medical Group** and that Dr. Young does not have the capability to directly submit bills to insurance companies other than UCLA Medical Group. Dr. Young will, however, gladly give you a statement that you can submit to your insurance company for reimbursement. _____Initial

Although, rare, if additional PHI (e.g., Progress Notes, Conversations with Insurance Peer Review) is needed from an insurance company other than UCLA Medical Group, I understand that Dr. Young reserves the right to charge the hourly rate above to provide this service. _____Initial

Additionally, I understand that Dr. Young has opted-out of Medicare. This formal opt-out allows him to see patients who have Medicare and to negotiate a private rate and contract. Please let me know, if you are a Medicare patient as you will need to sign an acknowledgement required by the Medicare office. _____Initial

I understand that I am ultimately responsible for payment even if I am using insurance for full or partial reimbursement and even if your treatment is being paid for by another party. _____Initial

By my signature below

1) I hereby acknowledge that I understand and agree to the provisions of all 8 pages of this document and have had any questions regarding this document answered to my satisfaction by Dr. Jeffrey Young.
2) I have received a copy of the HIPPA portion of this Document.

Patent Name (print) Signature Date

_____

Jeffrey Young, PHD, CBSM (Signature) Date

My Signature above indicates and affirms that after reviewing your history and treatment needs I feel that I can be of good service to you (assessment, treatment, or both). The date of Dr. Young's signature is the date that you became a patient of record.

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Patient Copy

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