Client Information

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone (H) _____ (C) _____ (W)_____

*** At times I call to confirm/cancel appointments. Please circle phone numbers that are ok for me to contact you at. May I leave a message? Yes_____ No_____ ***

Date of Birth: _____ Age: _____ Social Security #: _____

Employer: _____ School: _____

Teacher: _____ School Counselor: _____

Please list all individuals living at home:_____

Medical Information

Family Doctor/ Pediatrician: _____

Clinic: _____

Please List all medications: _____

How were you referred? _____

Consent for Treatment

Patient Name: _____

I authorize Anne Lindgren and Associates, P.C. to provide counseling, payment and healthcare operations for me or the above minor. I understand that I may revoke this authorization in writing at any time.

_____

Patient/Guardian Signature Date

Relationship to Patient: _____

Insurance Information

Patient's Name: _____

Social Security #:_____ Date of Birth: _____ Gender: _____

Address: _____

City: _____ State: _____ Zip: _____

Insured's Name: _____

Date of Birth: _____ Relationship to Patient: _____

Address: _____

City: _____ State: _____ Zip: _____

Primary Insurance Company Name: _____

Address: _____ Phone #: _____

City: _____ State: _____ Zip: _____

Insured's ID #:_____ Group #: _____

Secondary Insurance Company Name: _____

Address: _____ Phone #: _____

City: _____ State: _____ Zip: _____

Insured's ID #:_____ Group #: _____

Please Initial:

_____ I authorize use of this form on all my insurance submissions.

_____ I authorize release of information to all my insurance companies.

_____ I understand that I am responsible for my bill.

_____ I authorize my provider to act as my agent to help me to obtain payment from my insurance company.

_____ I authorize payment direct to my provider.

_____I permit a copy of this authorization to be used in place of the original.

_____

Printed Name Date

_____

Signature on File (of policy holder(s))

INFORMED CONSENT

Therapy often leads to a significant reduction in distressing feelings, resolution of specific problems, improved relationships, and better coping skills. You may realize that old patterns, unresolved issues or memories have been preventing you from living life to the fullest. In therapy, you can discover ways to get "unstuck," but while you are doing this work, you may experience unsettling or unfamiliar emotions. When you make changes in your life, your relationships may change too. Those closest to you may be supportive of the changes or may feel unsettled by them. Sometimes your loved ones will have some adjustments to make as well.

My goal for you is to feel better and have the quality of life you really desire. Nevertheless, there are no guarantees. I will be available to help you with issues that arise, but there are some things you can do to get more out of your therapy.

If you make therapy a priority, the work will progress more quickly. This will mean spending some time outside of the therapy thinking about your work. Your "homework" may involve reading, writing, or other exercises.

Be patient with yourself. You may have been living with anxiety, sadness, or distress for some time, and it is going to take time to resolve these issues.

Feel free to talk with me about any issues that seem to arise because of therapy. When you have trouble with emotions or feel reluctant to come to therapy, it is important for us to discuss these issues so they can be resolved.

COMPLETING TREATMENT

The therapist and the client have an intuitive sense when therapy usually comes to an end. When I begin to recognize this ending as near, I will discuss it with you. If you feel you have

met the goals you set out to accomplish, and then please share this with me. We will plan how to address any remaining issues and when to end treatment. Ending therapy is not a casual process and can be some of our most important work. If you decide to end therapy prior to discussing this, then we need to meet at least one more session to review our work to date, our goals and accomplishments, any work left to be done and what options you have at that time.

Privacy Act

We value the trust you place in us and will work diligently to maintain your trust. This document describes our privacy practices and our commitment to keeping your confidential information secure. You have the right to request a copy of this document. In an effort to effectively process insurance claims and service our clients, it is sometimes necessary for us to receive information from, as well as disclose information to, healthcare providers, government agencies, insurance companies, health benefit plans or other authorized personnel. Such information may come from enrollment forms, medical claims information, medical reports and other sources and forms as necessary to provide services or process claims.

The information received may include name, social security number, claim information, and employment information. This list provides some examples of the type of information that may be received or released by our clinic.

My Commitment

I will protect, according to the strict standards of security and confidentiality, any information shared with me.

I will limit the collection and use of information to the minimum required to provide superior service.

I will permit only authorized employees, who are properly trained in the handling of personal information, to have access to that information. I use physical, electronic, procedural and computer access controls.

I will not share your personal information for any purpose other than to provide services to my clients, conduct a health benefit or insurance transaction, as disclosed to you, to which you consent or as otherwise required by law.

I may provide to you, upon written request, a record of any subsequent disclosures or medical record information made to Anne Lindgren.

I will work with you to keep all personal information accurate. This requires that you notify me of any change in your personal information. I will correct any inaccurate information, if possible.

You have the right to review your file and request that I amend it if the information is incorrect.

You may request a copy of your file and that request will be granted unless I am required by law or ethics to refuse the request.

When I Disclose Information and limits of privacy:

I may disclose information to third parties upon your written request/authorization.

I may disclose information to another person or entity in order to conduct a health benefit or insurance transaction/function, or for the purpose of allowing the person or entity to administer a health benefit plan, conduct a health benefit or insurance transaction/function.

I may disclose personal information to comply with law or legal process to which I am subject, including a facially valid administrative or judicial order, search warrant, subpoena or lawful discovery request.

I may disclose information for the purpose of conducting an audit.

I may disclose personal information to a person engaged to provide services to enable Anne Lindgren to perform a service, health benefit or insurance transaction/function.

I may disclose, at some future time, personal information not presently disclosed, as permitted by law.

If you have any questions concerning this privacy notice, please contact us.

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 this information. Please read it carefully. Effective date: 4/14/2003

This Notice of Privacy Practices describes how we may use and disclose your protected health information to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. “Protected health information” is information about you, including demographic information that may identify you and that relates to your past, present, future physical or mental health or condition and related health care services.

USES AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Your protected health information may be used and disclosed by your clinician, our office staff, and others outside of your office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the clinician’s practice, and any other use required by law.

TREATMENT

We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a clinician to whom you have been referred to ensure that the clinician has the necessary information to diagnose or treat you.

PAYMENT

Your protected health information will be used as needed to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

HEALTHCARE OPERATIONS

We may use or disclose, as needed your protected health information in order to support the business activities of you clinician's practice. These activities include, but are not limited to quality assessment activities, employee review activities, licensing, marketing and fund raising activities, and conducting of arranging for other business activities. We will call you by name in the waiting room when your clinician is ready to see you. We may use or disclose your protected health information as necessary to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. The situations include: as required by law, public health issues as required by law, communicable diseases: health oversight: abuse or neglect, food and drug administration requirements, legal proceedings, law enforcement, coroners, funeral directions, and organ donation research criminal activity, military activity and nation security, workers compensation.

Other permitted and required uses and disclosures will be made only with you consent, authorizations or opportunity to object unless required by law.

Limits of Confidentiality

We are dedicated to preserving the confidentiality and privacy of all our clients. Some state laws, however, specify certain circumstances when mental health clinicians and professionals may be required to break confidentiality.

1. If the clinician has reasonable cause to believe that a child under the age of eighteen years is suffering

from serious physical or emotional injury resulting from abuse inflicted upon the child (including sexual

abuse), or from neglect (including malnutrition), the clinician is required to report that information to the authorities;

2. If the client presents a clear and present danger to self and refuses to accept appropriate treatment, the clinician may release relevant information to protect the client;

3. If the client communicates to the clinician an actual threat of physical violence against a clearly identified or reasonably identifiable victim(s), relevant information may be released to protect the potential victim(s);

4. If the client has a history of physical violence which is known to the clinician, and the clinician has a

reasonable basis to believe that there is a clear and present danger of physical violence against a clearly

identified or reasonably identifiable victim(s), relevant information may be released to protect the potential victim(s);

5. If there is a threat of imminently dangerous activity by the client against self or another person(s), the

clinician may disclose client communications for the purpose of placing or retaining the client in

a psychiatric hospital;

6. If the client introduces a mental condition as an element of claim or defense in a legal proceeding (except one involving child custody or adoptions) the judge may order the clinician to disclose confidential client communications;

7. In any case of child custody or adoption, the judge may order the clinician to disclose confidential client communications if the judge determines that the clinician has evidence bearing significantly on the client's ability to provide suitable care or custody and it is more important to the welfare of the child that the communication be disclosed than the relationship between the client and the clinician be protected (in cases of adoption, or dispensing the consent to adoptions, the judge must determine that the patient has been informed that communications to the clinician would not be privileged);

8. If, after the death of a client, any party acting on behalf of the decedent introduces evidence of the client's mental condition as an element of claim or defense, the judge may order the clinician to disclose confidential client communications;

9. The clinician may provide diagnostic or treatment information to an insurance company or review board, non-profit hospital or medical service corporation, or health maintenance organization for the purpose of administration or provision of benefits and expenses;

10. If the clinician has reasonable cause to believe that an elderly person (over age 60) or handicapped or disabled person over the age of 17 has died or is suffering abuse by the client, the clinician may be obligated to report this information to the proper state agency.

11. Information acquired by a clinician in the course of professional practice may be disclosed to another appropriate professional as part of a professional consultation;

12. If a judge compels the clinician to reveal confidential client information.

Apart from the above-listed expectations, client information may only be shared upon the express written consent of the patient or parent/guardian.

If you have any questions about confidentiality or this statement, please feel free to ask your clinician.

Social Media Policy

This document outlines my office policies related to use of social media. Please read it to understand 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 on the internet.

If you have any questions about anything within this document, I encourage you to bring them up when we meet. As new technology develops and the internet changes, there may be times when I need to update this policy. If I do so, I will notify you in writing of any policy changes and make sure you have a copy of the updated 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.

Business Review Sites

You may find my practice on sites such as Yelp, Healthgrades, Yahoo Local, Bing, or other places which list businesses. Some of these sites include forums in which uses 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 mental health professionals to solicit testimonials. Of course, you have a right to express yourself on any site you wish. However, 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 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. Confidentiality means that I cannot tell people you are my client and my Ethics Code prohibits me from requesting testimonials. You are more than welcome to tell anyone you wish that I'm your therapist or how you feel about the treatment I provided to you, in any forum of your choosing.

My signature below acknowledges that I have read and understand the policies contained herein:

_____

Printed Name Signature Date

Credit Card Authorization Form

In the event that an insurance check is sent to you instead of Anne Lindgren and Associates, this authorization form will be used to charge for the cost of services rendered.

Additionally, the client is responsible for any fee not covered by insurance and is responsible for keeping the therapist informed of any change in the insurance coverage. The patient is also responsible for obtaining all referral information required for insurance reimbursement.

We require a 48-Hour Notice of Cancellation. Individuals who fail to properly cancel/reschedule appointments will be charged for sessions. Including no shows or being more than 15 minutes late for a scheduled appointment. Insurance companies will not pay these charges; therefore, the patient is responsible for the fee.

I hereby authorize Anne Lindgren and Associates to charge my

Visa/Mastercard/American Express/Discover (circle one)

Account number:_____Expiration Date:_____

CVV2 code number (on back of card):_____

_____

Card Holder printed name Card Holder signature Date

_____

Card Holder Billing Address